



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Failures in Care
Coordination and Reviewing
a Patient's Death at the VA
Salt Lake City Healthcare
System in Utah



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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection at the VA Salt Lake City Healthcare System (facility) in Utah to assess allegations that

- A lack of care coordination caused a delay in care when a patient, recently discharged from a non-VA community hospital, was unable to get anticoagulation medications filled by the facility;
- The Chief of Pharmacy refused to hire pharmacists at the Idaho Falls community-based outpatient clinic (CBOC) and, because of this refusal, the patient died; and
- The Orem CBOC relocated to a new site but the new clinic space was not ready for use and in response, the Facility Director ordered patients bussed from the Orem CBOC to the main campus in Salt Lake City for blood work and appointments, increasing the risk of contracting [COVID-19](#).¹

During the inspection process, the OIG identified a concern that the facility failed to conduct an accurate internal review of the patient's care.

Synopsis of Events

The patient was in their 30's with a history of multiple medical problems.² On a day in 2020 (day 1), the patient was admitted to a non-VA community hospital for cough and shortness of breath. The patient was started on supplemental oxygen and given [enoxaparin](#) to treat a [saddle pulmonary embolism](#). On Friday (day 4), the patient reported feeling better and requested to be discharged to home. Prior to discharge, the non-VA community hospital arranged for the patient to receive home oxygen and notified the facility of the patient's need. At 2:57 p.m., the non-VA community hospital faxed a copy of the patient's discharge summary to the Idaho Falls CBOC and at 4:46 p.m. faxed a copy of the [apixaban](#) prescription. The apixaban prescription was for 30 days of medication. The Idaho Falls CBOC closed at 4:30 p.m. and staff did not receive the prescription until Monday (day 7). The patient called the Idaho Falls CBOC on Monday (day 7) asking to speak with the patient's assigned nurse care manager to discuss the need for the apixaban. The nurse care manager entered an anticoagulation consult on Monday (day 7) and left a message for the patient on day 8 advising of the status of the consult and the importance of taking the medication daily.³ The patient died on day 8.

¹ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

² The OIG uses the singular form of they (their) in this instance for privacy purposes.

³ VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015. Anticoagulation medications are commonly used for the treatment and prevention of [thromboembolism](#) in both inpatient and outpatient settings.

Healthcare Inspection Results

The OIG did not substantiate a lack of care coordination between the non-VA community hospital and the facility at the time of the patient's discharge; however, the OIG substantiated that facility staff caused a delay in the patient's anticoagulation medication prescription being filled by the facility. The non-VA community hospital provided the patient with a discharge summary, a prescription and savings cards for a one-month supply of apixaban, education on apixaban, and called the patient to follow up post-discharge. In addition, on the day of discharge, the non-VA community hospital faxed a copy of the discharge summary and the apixaban prescription to the Idaho Falls CBOC.

The patient's nurse care manager caused a delay in care by not communicating on Monday (day 7) with the patient about the request for assistance with filling the apixaban prescription, or with the covering provider about the patient's request and to inform the provider that the patient had been off anticoagulation medicine since Friday (day 4). The patient's nurse care manager recognized and documented the patient's urgent condition and entered an anticoagulation consult. However, the nurse care manager knew that the consult would not be answered until the following day because the anticoagulation pharmacist was on leave.

The cause of death was unknown as an autopsy was not performed. The patient had a recent history of saddle pulmonary embolism and was off anticoagulation medication since Friday (day 4). If the nurse had pursued other actions on Monday (day 7), the patient may have gotten the necessary medications or been advised to return to the nearest emergency department for evaluation and treatment. The OIG was unable to determine whether receiving the anticoagulation medicine on Monday (day 7) would have prevented the patient's death the following day.

In response to the patient's death, the facility conducted an internal review to discover the root cause of the event. However, the facility did not fully review the facts and circumstances surrounding the event, and because of this, facility leaders were unable to determine if an [institutional disclosure](#) was warranted. VHA requires the facility to conduct an institutional disclosure if it is determined that an [adverse event](#) was the result of an act of commission or omission of care.⁴

The OIG did not substantiate that the Chief of Pharmacy refused to hire pharmacists at the Idaho Falls CBOC or that having a part-time clinical pharmacist at the Idaho Falls CBOC would have allowed the patient to have the medication filled. The Chief of Pharmacy ensured access to remote pharmacy services through the availability of the pharmacy staff located at the Pocatello CBOC and a part-time Veterans Integrated Service Network 19 clinical pharmacist.

⁴ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

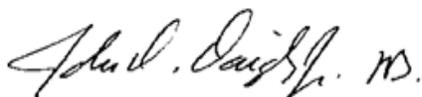
The OIG substantiated that the Orem CBOC moved to a new location and that the new CBOC was delayed in opening. The facility, in anticipation of the delay, developed and implemented a contingency plan including extending the lease on the old Orem CBOC and using a Mobile Vet Center to provide limited services during the transition. Because the facility took actions to address the delay, the OIG made no recommendations.

The OIG did not substantiate that the Facility Director ordered to have patients bussed from the Orem CBOC to the main facility in Salt Lake City for blood work and appointments, and that this caused an increased risk of patients getting infected with COVID-19. Orem CBOC patients had the option to receive care at multiple locations and through VA Video Connect throughout COVID-19 and during the transition from the old to the new Orem CBOC. The facility did not offer routine transportation to and from the Orem CBOC; rather, patients called the facility's transportation service to arrange for transportation. The OIG found no evidence that patients or staff were infected with COVID-19 through the use of the transportation services from the Orem CBOC to the main campus.

The OIG made three recommendations to the Facility Director related to conducting a clinical care review of the patient, reviewing [root cause analysis](#) processes, and determining the need for an institutional disclosure.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.



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Contents

Executive Summary i

Abbreviations v

Introduction 1

Scope and Methodology 3

Summary of Events 4

Inspection Results 5

 1. Allegation: Lack of Care Coordination Caused a Delay in Care 5

 2. Concern: Internal Review Inaccuracies 8

 3. Allegation: Pharmacy Staffing and Resources 9

 4. Allegation: Relocation of the Orem CBOC 10

Conclusion 12

Recommendations 1–3 13

Appendix A: VISN Director Memorandum 14

Appendix B: Facility Director Memorandum 15

Glossary 20

OIG Contact and Staff Acknowledgments 22

Report Distribution 23

Abbreviations

CBOC	community-based outpatient clinic
EHR	electronic health record
OIG	Office of Inspector General
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted an inspection at the VA Salt Lake City Healthcare System (facility) in Utah to assess allegations related to coordination of care, delay in care, and pharmacy hiring practices that led to a patient's death, and the delayed relocation of a community-based outpatient clinic (CBOC).

Background

The facility, part of Veterans Integrated Service Network (VISN) 19, is comprised of the George E. Wahlen VA Medical Center and nine CBOCs.¹ The facility is designated a complexity Level 1a, the highest complexity, and has 99 hospital beds.² From October 1, 2019, through September 30, 2020, the facility served 67,780 patients.

Idaho Falls CBOC

The Idaho Falls CBOC is located approximately 214 miles from the facility and provides primary, specialty, and mental health care, and laboratory services. The Idaho Falls CBOC does not have pharmacy services located on-site. According to pharmacy leaders and staff, VISN 19 provided a remote, part-time clinical pharmacist to co-manage the care of patients with [diabetes mellitus](#), as well as answer medication questions, write prescriptions, order labs, and complete limited physical assessments of patients via telephone, instant messaging, and consultation.³ In addition, the clinical pharmacists and pharmacy technician located at the Pocatello CBOC supported the pharmacy needs of the Idaho Falls CBOC by telephone, instant messaging, and consultation.⁴ Staff at the Idaho Falls and Pocatello CBOCs were not able to dispense medications at the time of the OIG inspection. Medications were dispensed through the facility or a contract with community pharmacies.

¹ The facility's nine CBOCs included six in Utah at the following locations: Ogden, Orem, Price, Roosevelt, St. George, and South Jordan; two in Idaho at Idaho Falls and Pocatello; and one in Elko, Nevada.

² VHA Office of Productivity, Efficiency and Staffing, accessed July 15, 2021, <http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx>. (This is an internal VA website not publicly accessible.) The VHA Facility Complexity Model categorizes medical facility by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex. Level 3 facilities are the least complex.

³ The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

⁴ At the time of the OIG inspection, the Pocatello CBOC, approximately 52 miles from the Idaho Falls CBOC, had a full-time clinical pharmacy specialist, two part-time clinical pharmacy specialists, and a full-time pharmacy technician.

Anticoagulation Medications

Anticoagulation medications are commonly used for the treatment and prevention of [thromboembolism](#) in both the inpatient and outpatient setting.⁵ Anticoagulation medications can provide substantial benefits as well as the potential for significant patient harm. If doses of the medication are missed or if the medication is not adequately dosed, there is an increased risk of developing thromboembolic complications, including [pulmonary embolism](#). If the medication level is too high, there is an increased risk of bleeding complications. The Veterans Health Administration (VHA) requires all medical centers to “maintain a well-organized anticoagulation management program that ensures patients receive appropriate care and follow-up, a smooth transition between the inpatient and outpatient setting, and address continuity and safety concerns.”⁶ The Joint Commission identified the administration of anticoagulation medications as a National Patient Safety Goal because of “complex dosing requirements, insufficient monitoring, and inconsistent patient compliance.”⁷

Allegations and Related Concern

On October 31, 2020, the OIG received anonymous complaints alleging

- A lack of care coordination caused a delay in care when a patient, recently discharged from a non-VA community hospital, was unable to get anticoagulation medications filled by the facility;
- The Chief of Pharmacy refused to hire pharmacists at the Idaho Falls CBOC and, because of this refusal, the patient died; and
- The Orem CBOC relocated to a new site but the new clinic space was not ready for use and in response, the Facility Director ordered patients bussed from the Orem CBOC to the main campus in Salt Lake City for blood work and appointments, increasing the risk of contracting [COVID-19](#).

The patient, who was admitted and treated at a non-VA community hospital for blood clots, died four days after discharge. Although the non-VA community hospital prescribed an anticoagulation medication, the patient did not obtain the medication prior to the patient's death on the morning of day 8. The patient had contacted the Idaho Falls CBOC on Monday morning

⁵ VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.

⁶ VHA Directive 1033.

⁷ The Joint Commission sets health care standards and accredits health care facilities, accessed March 8, 2021, <https://www.jointcommission.org/about-us/facts-about-the-joint-commission>. National Patient Safety Goals, 3.05.01, accessed March 2, 2021, <https://www.jointcommission.org/standards/standard-faqs/ambulatory/national-patient-safety-goals-npsg/000002244/?p=1>.

(day 7) for assistance in obtaining the medication. The OIG noted that the facility failed to conduct a comprehensive internal review of the patient's care.

Scope and Methodology

The OIG initiated the inspection on November 18, 2020, and conducted a virtual site visit from January 11–26, 2021.

The OIG team interviewed the patient's spouse, facility leaders, and relevant providers and staff.⁸

The OIG team reviewed the patient's electronic health record (EHR) as well as pertinent VHA and facility policies and procedures related to primary care, pharmacy, and COVID-19; relevant nurse competency records; issue briefs; [root cause analysis](#) (RCA); emails and documentation related to the relocation of the Orem CBOC; and Resource Committee meeting minutes from January 2020 through December 2020. The OIG team reviewed the patient's care for one week in 2020 (day 1 through day 7).

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁸ The OIG team interviewed the Facility Director; Chiefs of Staff, Pharmacy, Logistics, Primary Care, Human Resources, Quality Management, Transportation, and Community Care; the Associate Director for Patient Care Services; relevant Idaho Falls CBOC staff; a social worker; Patient Safety Managers; pharmacy staff; Chair of the Resource Committee; an Infection Control nurse; a transportation assistant; and the Orem CBOC manager.

Summary of Events

The patient was in their 30's with a history of obstructive [sleep apnea](#), [morbid obesity](#), diabetes mellitus, [panuveitis](#), and [hypertension](#).⁹ On a day in 2020 (day 1), the patient presented to a non-VA community hospital complaining of cough and shortness of breath, and was admitted. [Computerized tomography](#) imaging revealed an acute [saddle pulmonary embolism](#) with extensive pulmonary emboli. COVID-19 testing was negative. The patient was started on supplemental oxygen and [enoxaparin](#), and gradually improved.

On Friday (day 4), the patient reported feeling better and requested to be discharged from the hospital. Prior to discharge, the non-VA community hospital arranged for home oxygen. At discharge, the patient was provided a prescription for [apixaban](#) and a savings card.¹⁰ The non-VA community hospital faxed a copy of the patient's discharge summary to the Idaho Falls CBOC at 2:56 p.m. and faxed a copy of the apixaban prescription at 4:46 p.m.¹¹ Per the discharge summary, the facility would provide refills for the patient's apixaban.

The OIG was told that on day 5, a nurse from the non-VA community hospital followed up with the patient. The patient reported not filling the apixaban prescription due to the cost of the medication, even with the discount card. The patient planned to wait until Monday (day 7) to contact VA for assistance in obtaining the medication. The nurse recommended that the patient not wait until Monday (day 7) for the apixaban and that a second discount card would be left at the non-VA community hospital's emergency department.

On Monday morning (day 7), the facility home oxygen coordinator reported receiving notice of the requirement to continue the patient on home oxygen. In addition, the patient telephoned the Idaho Falls CBOC and informed a medical support assistant of a recent hospitalization at a non-VA community hospital, a diagnosis of "blood clot in [the] lung," and discharge to home. The patient requested to have an apixaban prescription filled through the facility. The patient reported having no apixaban since being discharged from the non-VA community hospital on Friday (day 4). The medical support assistant attempted to contact the patient's Patient Aligned Care Team (PACT) nurse care manager, who was teleworking that day, but was not able to. The medical support assistant then notified another nurse care manager of the patient's call.¹² The other nurse care manager did not speak with the patient but did speak with the patient's nurse care manager by telephone and instant messaging. The patient's nurse care manager entered an

⁹ The OIG uses the singular form of they (their) in this instance for privacy purposes.

¹⁰ The cost of a 30-day supply of apixaban is approximately \$500.00. The maker of apixaban offers financial assistance (savings cards) through either a \$10.00 co-pay card or a free trial offer. Both require activation through the maker's website or telephone service.

¹¹ The Idaho Falls CBOC closed at 4:30 p.m.

¹² The other PACT nurse care manager was located within the Idaho Falls CBOC but was assigned to a different PACT team.

anticoagulation consult, but reported not speaking with the covering provider and not contacting the patient.¹³

The next day (day 8), the patient's nurse care manager documented telephoning the patient and leaving a voice message advising of the "lifesaving value of taking the medication due to [the patient's] recent [saddle] pulmonary embolus." Later that day, the patient's nurse care manager reported learning of the patient's death.¹⁴

Inspection Results

1. Allegation: Lack of Care Coordination Caused a Delay in Care

The OIG did not substantiate a lack of coordination of care between the non-VA community hospital and the facility at the time of the patient's discharge; however, the OIG substantiated that facility staff caused a delay in the patient's anticoagulation medication prescription being filled by the facility.

Care Coordination

VHA defines care coordination as "the integration of health care services and navigation through complex health care systems."¹⁵ VHA instructs the primary care team to provide care coordination by working with non-VA facilities to help patients receive the care they need and want without unnecessary duplication of services or avoidable inconvenience.¹⁶

On Friday afternoon (day 4), the patient was discharged to home from the non-VA community hospital with a prescription and a savings card for apixaban, and patient education information about saddle pulmonary embolism and apixaban. At or around the time of discharge, the non-VA community hospital faxed the discharge summary to the Idaho Falls CBOC requesting a follow-up appointment with the patient's primary care provider within one week and refills of apixaban to be provided by the facility, and a copy of the apixaban prescription.¹⁷ Facility staff told the OIG that they did not become aware of the patient's hospitalization until Monday (day 7).

The patient's spouse told the OIG that on day 5, the patient attempted to have the apixaban prescription filled at a local pharmacy but reportedly did not have it filled due to concerns of the cost of the medication. Although the non-VA community hospital provided the patient with a

¹³ The patient's primary care provider was on leave on Monday (day 7).

¹⁴ The patient died during sleep at home and the coroner did not perform an autopsy due to the family's wishes.

¹⁵ VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended on May 26, 2017.

¹⁶ VHA Handbook 1101.10(1).

¹⁷ The prescription was written for 74 pills. The first refill would have been due on November 23, 2020.

savings card at discharge and offered a second savings card during a follow-up phone call on day 5, the OIG could not determine which savings cards the patient was given or the extent of the conversation between the patient and the local pharmacy.

The OIG concluded that the non-VA community hospital provided the patient with a discharge summary and education on apixaban, as well as provided the patient's primary care team with faxed copies of the discharge summary and apixaban prescription on the day of discharge.

Delay in Care

VHA policy states that "When a patient requests health care, the patient's request is evaluated promptly by the Patient Aligned Care Team (PACT) staff member. PACT staff must offer clinically indicated care to the patient that is respectful of the patient's preferences and appropriate for the safe delivery of care."¹⁸ The policy further identifies that effective communication between PACT staff and patients as essential in coordinating care and protecting patient safety. VHA recognizes the importance of informal communication amongst PACT staff to enhance prompt exchange of information. Communication "enhances the team's ability to provide the right information at the right time to the right person." Communication amongst PACT staff allows "each person a voice in making decisions that affect the care of the patient and team function."

On Monday (day 7), at 9:46 a.m., the patient called the Idaho Falls CBOC and spoke to a medical support assistant. The patient reported being discharged from a non-VA community hospital on Friday (day 4) and requested assistance getting a prescribed medication (apixaban) filled.¹⁹ At the time of this call, the patient had been off anticoagulation medication since being discharged from the non-VA community hospital on Friday (day 4). The medical support assistant was unsuccessful in reaching the patient's nurse care manager, who was teleworking. The medical support assistant notified another nurse care manager located within the Idaho Falls CBOC about the patient's request. The other nurse care manager contacted the patient's nurse care manager via personal telephone, and relayed the patient's message and request. In addition, the other nurse care manager sent an instant message at 10:08 a.m. to the patient's nurse care manager stating that the "patient needs to know [the patient's] situation is a matter of life or death" and that a patient with a similar situation was sent back to the emergency room.

Approximately 90 minutes later, at 11:47 a.m., the other nurse care manager sent a second instant message to the patient's nurse care manager stating that the covering provider asked about the patient and the prescribed apixaban. At 12:46 p.m., the patient's nurse care manager responded via instant message that the patient's nurse care manager would "likely reach out to [the covering provider]" as the patient's nurse care manager had not done an anticoagulation

¹⁸ VHA Handbook 1101.10(1).

¹⁹ The information was obtained through interviews and documentation provided by facility staff.

consult before. At 12:47 p.m., the other nurse care manager sent an instant message stating that “even if [the patient] can get a sample [of the apixaban] [the patient] can’t go without it for a few dyas [days] while we figure it out.” At 12:54 p.m., the patient’s nurse care manager responded to the instant message with, “I will call the patient to see what we can work out in the meantime.” The patient’s nurse care manager placed an anticoagulation consult at 1:22 p.m. on Monday (day 7).

The patient’s nurse care manager told the OIG team that the patient needed to take the anticoagulation medication daily. However, the patient’s nurse care manager entered the anticoagulation consult knowing that the anticoagulation pharmacist was on leave and that the consult would not be addressed until the following day.²⁰ Facility staff told the OIG that it was standard practice to enter an anticoagulation consult when a patient was prescribed anticoagulation medication. The OIG was told that the patient’s nurse care manager had never entered an anticoagulation consult prior and that the provider usually entered it.

The OIG team found no documented evidence that the patient’s nurse care manager contacted or attempted to contact the patient until day 8 at 10:16 a.m. The nurse care manager documented leaving a voice mail message informing the patient of the current status of the medication request, as well as advising the patient of “the life-saving value of taking the medication due to [the patient’s] recent PE [saddle pulmonary embolism].” During the interview with the OIG, the patient’s nurse care manager confirmed not contacting the patient on Monday (day 7).

The OIG team found no documented evidence that the patient’s nurse care manager discussed the patient’s medication request with the covering provider. When asked by the OIG, the patient’s nurse care manager admitted never contacting the covering provider and that in retrospect it would have been a good idea to have discussed the patient’s situation with the covering provider. During interviews, the OIG explained the patient’s case to the patient’s provider, Chief of Staff, and the Chief of Primary Care, and asked what they would have done in this situation. All responded that they would have advised the patient to return to the nearest emergency department for immediate care.

The OIG concluded that although the patient’s nurse care manager recognized and documented the patient’s urgent condition and the necessity to take anticoagulation medication daily, the patient’s nurse care manager failed to take action by either calling the patient or discussing the patient’s request with the covering provider. The cause of death is unknown as an autopsy was not performed. The patient had a recent history of saddle pulmonary embolism and had not received anticoagulation medicine since Friday (day 4). Had the CBOC staff pursued other actions on Monday (day 7), the patient may have received the prescribed medication or been

²⁰ VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015. The anticoagulation management program refers to a coordinated program where anticoagulation providers manage veterans on anticoagulation medications in inpatient and outpatient settings.

reevaluated and received treatment at a non-VA community hospital emergency department. The OIG was unable to determine whether receiving the medication on Monday afternoon (day 7) would have prevented the patient's death on day 8.

2. Concern: Internal Review Inaccuracies

In response to the patient's death, the facility conducted an internal review to discover the root cause of the event.

Following an [adverse event](#), VHA allows facility leaders to conduct protected and non-protected internal reviews to gain a better understanding of what occurred.²¹ Protected reviews, including root cause analysis and [peer review for quality management](#), are confidential and non-punitive in nature.²² Non-protected reviews, including [administrative investigations](#) and [focused clinical care reviews](#), allow for the results of the reviews to affect a staff member's privileges or personnel status. When facility leaders determine that an adverse event is the result of an act of commission or omission, such as the failure to institute an appropriate therapeutic intervention, VHA policy requires disclosure to patients who have been injured by adverse events.²³ An [institutional disclosure](#) is one type of disclosure.²⁴

In response to the patient's death, facility leaders initiated an RCA team in late 2020, to determine the root cause and contributing factors of the patient's death. The RCA process included the RCA team interviewing staff, evaluating the patient's care, and reviewing relevant documents. The team developed a Final Understanding of Events and identified Action Plans to address the root causes. The RCA team presented the final RCA to facility leaders and the Facility Director signed the RCA approximately six weeks after initiation. The OIG team reviewed the completed RCA and interviewed relevant staff and RCA team members about the RCA's Final Understanding of the Event and Action Plans.

The RCA uncovered gaps in facility processes but also contained several inaccuracies in its facts and findings. While the RCA did not review the clinical care provided to the patient, the events under review should have led the facility to conduct a peer review, a focused clinical care review, or an administrative investigation, which would have focused on the care provided by a clinician at the time of the event. Based on the findings, the facility would then determine if an institutional disclosure was warranted.

The OIG concluded that the RCA contained inaccuracies including an Action Plan not supported by facts and findings. Accurate RCA facts and findings would have allowed for the identification

²¹ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018; VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

²² VHA Directive 1190; VHA Handbook 1050.01.

²³ VHA Handbook 1050.01.

²⁴ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

of gaps in knowledge, the need to assign responsibility or inquire further about adequacy and timeliness of care and provided opportunities for training and education. Because the facility did not conduct a complete and accurate review of the clinical care, leaders could not determine if an institutional disclosure was warranted.

3. Allegation: Pharmacy Staffing and Resources

The OIG did not substantiate that the Chief of Pharmacy refused to hire pharmacists at the Idaho Falls CBOC or that having a part-time clinical pharmacist at the Idaho Falls CBOC would have allowed the patient to have medication filled.

VHA states that CBOCs may be operational from one to seven days per week and may provide support services such as pharmacy.²⁵ VHA recommends, at minimum, 1.0 full-time equivalent clinical pharmacist for every 3,600 patients or three full-time primary care provider panels.²⁶ Every November, facility service line managers present expected staffing needs to facility leaders through a process called 4Cast.²⁷ If additional staffing requirements arise during the year, those requests are presented to the Resource Management Committee for consideration.

From October 1, 2019, through September 30, 2020, the Idaho Falls CBOC provided care to 3,186 unique patients. The number of unique patients served did not meet VHA's guidance for a dedicated full-time clinical pharmacist to be assigned to the Idaho Falls CBOC.²⁸ In addition, due to budgetary limitations, the facility instituted a hiring freeze. Instead, to meet the clinical pharmacy needs of the patients, the Idaho Falls CBOC relied on two full-time and one part-time clinical pharmacists, and a pharmacy technician located at the Pocatello CBOC, and through an assigned VISN 19 part-time clinical pharmacist.²⁹ The Chief of Pharmacy ensured that the clinical pharmacist and pharmacy technician located at the Pocatello CBOC, as well as the part-time VISN 19 clinical pharmacist, were available to Idaho Falls CBOC staff and patients through the use of consults, telephone calls, emails, and instant messages.

²⁵ VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019.

²⁶ VHA Directive 1108.11(1), *Clinical Pharmacy Services*, July 1, 2015, amended June 29, 2017.

²⁷ "4Cast is a web-based toolset designed to support annual Business and Operational Planning best practices." Additionally, 4Cast assists the facility's leadership in business planning, including full-time equivalent needs of services.

²⁸ Because of budgetary and staffing limitations, the Chief of Pharmacy looked at the number of patients receiving care at the Idaho Falls CBOC rather than the number of providers.

²⁹ The Pocatello CBOC provided care to 4,758 patients between October 1, 2019, and September 30, 2020. One of the clinical pharmacists at the Pocatello CBOC was designated to provide anticoagulation services. National Certification Board for Anticoagulation Providers, accessed March 8, 2021, <https://ncbap.org/>. Pharmacists with a Certified Anticoagulation Care Provider certification work to "improve the quality of patient care through recognition and promotion of specialized knowledge and skills pertaining to antithrombotic therapy."

The OIG team found that the Chief of Pharmacy requested additional staffing through the facility's 4Cast process and Resource Management Committee. In interviews, the OIG team was told that not all CBOCs needed to have a pharmacist on-site, and that no request for CBOC clinical pharmacists had been denied.

On Friday (day 4), the non-VA community hospital faxed the patient's apixaban prescription to the Idaho Falls CBOC at 4:46 p.m. It was reported to the OIG that because the Idaho Falls CBOC closed at 4:30 p.m., CBOC staff did not receive the fax until the morning of Monday (day 7). The OIG team concurred with the assigned VISN 19 clinical pharmacist statement that having a full- or part-time pharmacist located at the Idaho Falls CBOC would not have affected the outcome for this patient because the CBOC was closed when the fax was sent from the non-VA community hospital.

The OIG team concluded that the Idaho Falls CBOC did not have a dedicated clinical pharmacist because the CBOC's patient count did not meet VHA guidelines. The Chief of Pharmacy hired staff as needed utilizing the 4Cast and Resource Management Committee as appropriate. The OIG team also concluded that because the fax for the apixaban prescription came in after-hours, having a full- or part-time clinical pharmacist on staff at the Idaho Falls CBOC would not have benefited this patient.

4. Allegation: Relocation of the Orem CBOC

The OIG substantiated that the Orem CBOC relocated to a new location and that the new CBOC was delayed in opening. However, facility leaders, in anticipation of the delay, developed and implemented a contingency plan; therefore, the OIG did not make a recommendation. The OIG did not substantiate that the Facility Director ordered patients bussed from the Orem CBOC to the main facility in Salt Lake City for blood work and appointments, and that this caused an increased risk of patients getting infected with COVID-19.

Relocated CBOC

According to VHA, CBOCs are outpatient clinics that provide primary and mental health services and may include specialty or subspecialty services.³⁰ VHA utilizes CBOCs to make access to health care easier and more convenient, and expects care to be "consistent, safe, and high quality."³¹

According to the Facility Director, the Orem CBOC was relocated due to increased demand and the need for more space. The facility's Lease Committee ensured that the design for the new CBOC was completed, secured the building permit, and set an opening date for September 2020,

³⁰ VHA Directive 1229 (1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019.

³¹ VHA Directive 1229 (1).

as the lease for the old CBOC expired on September 30. Because of COVID-19, the new Orem CBOC had construction and manufacturing delays.³² The lease agreement for the old CBOC was extended by 30 days. To ensure that patients did not experience a break in care if further delays occurred, the facility developed a contingency plan to use a Mobile Vet Center unit to provide limited patient care.³³ The Orem CBOC patients received a letter regarding the move of the CBOC and how to access care.

The old CBOC closed on Friday, October 30, 2020, and no appointments, labs, or vaccines were scheduled for that day. PACT staff were available to triage patients via the Mobile Vet Center located in the old CBOC's parking lot. On Monday, November 2, the Mobile Vet Center relocated eight miles away to the parking lot of the new Orem CBOC. During the move period and throughout COVID-19, Orem CBOC patients had the option to receive care through VA Video Connect or in-person at the main campus in Salt Lake City.³⁴ For urgent needs, patients could be seen at the South Jordan VA Clinic (CBOC) or at approved non-VA urgent care sites.³⁵ The new Orem CBOC opened and began providing care to patients on Tuesday, December 1.

The OIG team concluded that while COVID-19 related construction and manufacturing delays caused a 30 day setback in the opening of the new Orem CBOC, facility leaders developed and implemented a contingency plan to ensure the continuity of care for patients.

Bussing of Patients

The OIG team found no evidence that the Facility Director ordered the bussing of patients from the Orem CBOC to the main facility for blood work and appointments. Orem CBOC patients had the option to receive care at the CBOC or via VA Video Connect.

According to interviews, the facility does not offer routine bus [van] service between the Orem CBOC and the main campus. If a patient needed care at the main campus and was unable to drive, the patient called the facility's Transportation Department to arrange for van service to and from the main campus.

To ensure the safety of patients and staff, the facility developed procedures on transporting patients and cleaning processes post-transportation.³⁶ The infection control specialist provided

³² Manufacturing delays consisted of equipment and supplies for the buildout and furnishing of the space.

³³ A VA Vet Center provided the Orem CBOC with a Mobile Vet Center. The Mobile Vet Center allowed Orem CBOC staff to manage walk-in patients, facilitate coordination for VA Video Connect appointments, administer flu shots, and draw blood specimens for testing.

³⁴ The Orem CBOC is located 41 miles from the main facility in Salt Lake City. VA Video Connect is a secure and private method used to virtually connect veterans with VA healthcare providers.

³⁵ The South Jordan VA Clinic is located 29 miles from the Orem CBOC.

³⁶ Veterans Transportation Service, *Patient Transport Personal Protective Equipment and Vehicle Cleaning/Disinfection Standard Operating Procedure*. The Standard Operating Procedure applied when the facility transported patients via van service to or from the CBOC or the main campus in Salt Lake City.

training to transportation staff on how to use personal protective equipment and cleaning and disinfecting vehicles.³⁷ Between March 1 and December 20, 2020, six patients were transported from the Orem CBOC to the main campus. Facility staff told the OIG team that no complaints were received from patients regarding transportation, and no reports of positive COVID-19 cases for these patients or the van drivers were received as a result of using the transportation service.

The OIG team concluded that the facility does not offer routine van service from the Orem CBOC to the main campus. When indicated, the facility provides van service for patients needing care at the main campus.

Conclusion

The OIG did not substantiate a lack of care coordination between the non-VA community hospital and the facility at the time of the patient's discharge; however, the OIG substantiated that facility staff caused a delay in the patient's anticoagulation medication prescription being filled by the facility. The non-VA community hospital provided the patient with a discharge summary, a prescription and savings cards for a one-month supply of apixaban, education on apixaban, and called the patient to follow up. In addition, the non-VA community hospital faxed a copy of the discharge summary and the apixaban prescription on the day of discharge to the Idaho Falls CBOC.

The patient's nurse care manager caused a delay in care by communicating on Monday (day 7) with the patient about the request for assistance with filling the apixaban prescription, or with the covering provider about the patient's request and to inform the provider that the patient had been off anticoagulation medication since being discharged on Friday (day 4). The patient's nurse care manager recognized and documented the patient's urgent condition and entered an anticoagulation consult. However, the nurse care manager knew that the consult would not be answered until the following day because the anticoagulation pharmacist was on leave. The cause of death was unknown as an autopsy was not performed. The patient had a recent history of saddle pulmonary embolism and was off anticoagulation medication. If the patient's nurse care manager had pursued other actions on Monday (day 7), the patient may have gotten the necessary medications or been advised to return to the nearest emergency department for evaluation and treatment. The OIG was unable to determine whether receiving the anticoagulation medicine on Monday (day 7) would have prevented the patient's death the following day.

In response to the patient's death, the facility conducted an internal review to discover the root cause of the event. The RCA uncovered gaps in facility processes but also contained several inaccuracies in its facts and finding. The facility did not fully review the clinical care provided to

³⁷ Personal protective equipment included gowns, gloves, face shields, masks, and hand sanitizer.

the patient, and because of this, facility leaders were unable to determine if an institutional disclosure was warranted.

The OIG did not substantiate that the Chief of Pharmacy refused to hire pharmacists at the Idaho Falls CBOC or that having a part-time clinical pharmacist at the Idaho Falls CBOC would have allowed the patient to have medication filled. The Idaho Falls CBOC did not meet VHA's guidance to have a clinical pharmacist located within the clinic. The Chief of Pharmacy ensured remote pharmacy services through the availability of the pharmacy staff located at the Pocatello CBOC and a part-time VISN 19 clinical pharmacist.

The OIG substantiated that the Orem CBOC moved to a new location and that the new CBOC was delayed in opening. The facility, in anticipation of the delay, developed and implemented a contingency plan that included extending the lease of the old Orem CBOC and using a Mobile Vet Center to provide limited services during the transition. Because the facility took action to address the delay, the OIG made no recommendations.

The OIG did not substantiate that the Facility Director ordered to have patients bussed from the Orem CBOC to the main facility in Salt Lake City for blood work and appointments, and that this caused an increased risk of patients getting infected with COVID-19. Orem CBOC patients had the option to receive care at multiple locations and through VA Video Connect throughout COVID-19 and during the transition for the old to the new location of the Orem CBOC. The facility did not offer routine transportation to and from the Orem CBOC; rather, patients call the facility's transportation service to arrange for transportation. The facility developed and implemented procedures and provided training for staff when transporting patients during COVID-19 to ensure limited exposure and the safety of patients and staff. The OIG team found no evidence that patients or staff were infected with COVID-19 through the use of transportation services from the Orem CBOC to the main campus.

Recommendations 1–3

1. The VA Salt Lake City Healthcare System Director conducts a clinical review of the care provided to the patient on Monday (day 7), by Idaho Falls Community-Based Outpatient Clinic staff, and takes action as warranted.
2. The VA Salt Lake City Healthcare System Director reviews the processes involved in conducting root cause analyses to ensure that final reports contain complete and accurate information.
3. The VA Salt Lake City Healthcare System Director determines if an institutional disclosure is warranted following the completion of the clinical review of this patient's care and takes action as necessary.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 24, 2021

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Failures in Care Coordination and Reviewing A Patient's Death at the VA Salt Lake City Healthcare System in Utah

To: Director, Office of Healthcare Inspections (54HL08)

Director, GAO/OIG Accountability Liaison Office (VHA 10B GOAL Action)

1. I have reviewed the findings within the Healthcare Inspection—Failures in Care Coordination and Reviewing A Patient's Death at the VA Salt Lake City Healthcare System in Utah. I agree with the findings of the review.

(Original signed by:)

Ralph T. Gigliotti, FACHE
VISN 19, Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 21, 2021

From: Shella Stovall, Director, VA Salt Lake City Healthcare System, Utah (660/00)

Subj: Healthcare Inspection—Failures in Care Coordination and Reviewing A Patient's Death at the VA Salt Lake City Healthcare System in Utah

To: Ralph Gigliotti, Director, Rocky Mountain Network (10N19)

I have reviewed the findings within the Healthcare Inspection – Failures in Care Coordination and Reviewing A Patient's Death at the VA Salt Lake City Healthcare System in Utah. I agree with the findings of the review.

The plan of corrective actions and target dates have been established.

For additional questions, please feel free to contact Melissa Hobbs, Chief of Quality, Safety, Value and High Reliability.

(Original signed by:)

Kimberly R. Denning

Associate Director, Patient Care System

For Shella Stovall, MNA, RN

Director, VA Salt Lake City Healthcare System

Facility Director Response

Recommendation 1

The VA Salt Lake City Healthcare System Director conducts a clinical review of the care provided to the patient on Monday (day 7), by Idaho Falls Community-Based Outpatient Clinic staff, and takes action as warranted.

VA Salt Lake City Healthcare System concurs.

Target date for completion: August 1, 2021

Director Comments

On June 15, 2021, a multidisciplinary team comprised of VA Salt Lake City's Patient Safety Manager, Risk Manager, Interim Chief of Quality, Safety, Value & High Reliability, Chief of Primary Care, Primary Care Nurse Care Manager, and Assistant Chief of Pharmacy completed a clinical care review of the clinical care delivered to a patient who was discharged with a saddle pulmonary embolism from a non-VA community hospital and expired 4 days after discharge after not filling the prescribed apixaban. The multidisciplinary team completed a thorough the review of a nurse care manager's decisions and utilization of resources, as reflected in the medical record.

Issue Identified: The Nurse Care Manager at Idaho Falls VA Clinic did not follow up with the covering provider on Monday [day 7] after being notified of the patient's discharge from a non-VA community hospital.

Issue Identified: The Nurse Care Manager at Idaho Falls VA Clinic did not document any attempt to follow up with the patient on Monday [day 7] after being notified of the patient's discharge from a non-VA community hospital.

Conclusion: The multidisciplinary clinical review team determined that most experienced, competent nurse care managers would have managed the care of the patient differently. The multidisciplinary clinical review team concluded that most experienced, competent nurse care managers would have notified the available provider at the Idaho Falls VA Clinic and would have documented telephone call attempts to reach the patient in order to recommend that the patient immediately return to the hospital emergency department for medication management.

Corrective Actions:

1. The Associate Chief Nurse of Primary Care will ensure that all nurse care managers receive training on the Heritage pharmacy (community pharmacy) program as well as provide a list of medications, to include life sustaining medications that must be filled the same day upon discharge by July 15, 2021.

2. The VA Clinic Managers will ensure that daily DMS [Daily Management System] huddles include staffing availability and cross coverage for the day. In addition, each incoming fax regarding prescriptions and discharge summaries will be discussed and assigned as appropriate. DMS huddles will be conducted by the VA Clinic Managers or designee with the expectation that all staff members will be in attendance. If staff are working remotely, a TEAMS meeting will be utilized so that all team members can be in attendance. The VA Clinic Manager or designee will email the VA Clinic Staff and Primary Care Leadership Team a summary of the DMS huddle starting daily on July 15, 2021.
3. The Associate Chief Nurse of Primary Care will review the results of the clinical care review with the nurse care manager involved in this adverse event; regarding the issues identified with clinical decisions. The Associate Chief Nurse of Primary Care will provide remedial training/education regarding triage and life sustaining medications by July 15, 2021.
4. A written standard operating procedure will be written by the Healthcare Administrative, Primary Care Service Lines and Pharmacy Service, defining the expectations of the MSA [Medical Support Assistant] and nurse care manager regarding faxed prescriptions and discharge summaries, including frequency of monitoring for incoming faxes, ensuring any prescriptions or discharge summaries are handed off to the nurse care manager, and review with the primary care provider. In addition, the new standard operating procedure will be reviewed by each VA Clinic team member by August 1, 2021.

Recommendation 2

The VA Salt Lake City Healthcare System Director reviews the processes involved in conducting root cause analyses to ensure that final reports contain complete and accurate information.

VA Salt Lake City Healthcare System concurs.

Target date for completion: July 5, 2021

Director Comments

The VA Salt Lake City Healthcare System will follow the VHA National Center for Patient Safety's Guide to Performing a Root Cause Analysis, dated February 5, 2021.

Issue Identified: The Subject Matter Expert may have been too close to the situation.

Issue Identified: Just in Time Training was conducted; however, a senior leader was not present to greet the RCA team and validate the importance of the work ahead and communicate the executive leadership team's commitment to the process.

Issue Identified: The Subject Matter Expert served as the leader of the RCA which is not recommended.

Issue Identified: There was no recorder to document meeting notes, interviews and collect any pertinent evidence that was used in determining the root cause(s).

Conclusion: The Root Cause Analysis for this adverse event did not follow the VHA National Center for Patient Safety's Guide to Performing a Root Cause Analysis.

Corrective Actions:

1. The Patient Safety Manager will ensure staff knowledgeable with processes, and who are non-invested will serve on RCAs by June 21, 2021.
2. The Patient Safety Manager will ensure that a senior leader is present to greet the RCA team by June 21, 2021.
3. The Patient Safety Manager will ensure that a recorder will be present at each RCA to document meeting notes, interviews, and collect any pertinent evidence that was used in determining the root cause(s) by July 5, 2021.
4. The Patient Safety Manager and the VISN Patient Safety Officer will review the VHA National Center for Patient Safety's random audits to ensure compliance by June 28, 2021 and monitor for 6 months.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The VA Salt Lake City Healthcare System Director determines if an institutional disclosure is warranted following the completion of the clinical review of this patient's care and takes action as necessary.

VA Salt Lake City Healthcare System concurs.

Target date for completion: July 15, 2021

Director Comments

On June 15, 2021, a multidisciplinary team comprised of VA Salt Lake City's Patient Safety Manager, Risk Manager, Interim Chief of Quality, Safety, Value & High Reliability, Chief of Primary Care, Primary Care Nurse Care Manager, and Assistant Chief of Pharmacy completed a clinical care review of the clinical care delivered to a patient who was discharged with a saddle pulmonary embolism from a non-VA community hospital and expired 4 days after discharge after not filling the prescribed apixaban. The multidisciplinary team completed a thorough review of a nurse care manager's decisions and utilization of resources, as reflected in the

medical record. The findings of the clinical care review was provided to the Chief of Staff to determine if an institutional disclosure is warranted.

Corrective Actions:

1. If the Chief of Staff determines that a disclosure is warranted, the discussion of clinically significant facts to the patient's personal representative will be completed and documented by July 15, 2021.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Glossary

To go back, press “alt” and “left arrow” keys.

administrative investigation. “An impartial inquiry...to determine facts and collect evidence in connection with a matter of concern to the VA.”¹

adverse event. “An untoward incident, therapeutic misadventure, iatrogenic injury or other adverse occurrence directly associated with care or services provided within the jurisdiction of a medical facility, outpatient clinic, or other VHA facility.”²

apixaban. An anticoagulation medication used to treat or prevent deep vein thrombosis, a condition in which blood clots form in the blood vessels. The blood clots can travel to the lungs and can cause a pulmonary embolism.³

computerized tomography (CT). A combination of x-ray images taken from different angles around the body and the use of computer processing to create cross-sectional images of the bones, blood vessels, and soft tissues inside the body.⁴

COVID-19 (Coronavirus Disease 2019). In late December 2019, investigation of a cluster of pneumonia cases of unknown origin in Wuhan, China resulted in identification of a novel coronavirus. It is a newly identified pathogen and it is assumed there is no human immunity to the virus.⁵

diabetes mellitus. A group of diseases that affect how the body uses blood sugar (glucose).⁶

enoxaparin. A medication used to prevent deep venous thrombosis (blood clots) in the blood vessels of the legs.⁷

focused clinical care review. “A clinician-specific comprehensive clinical care review of a specific area of practice, a specific time period of practice, or both, when there is an identified concern or issue. A retrospective review of the clinician’s practice used to determine what future steps, if any will be taken.”⁸

¹ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

² VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

³ Mayo Clinic, “apixaban, (Oral Route),” accessed November 24, 2020, <https://www.mayoclinic.org/drugs-supplements/apixaban-oral-route/description/drg-20060729>.

⁴ Mayo Clinic, “CT scan,” accessed March 3, 2021, [CT scan - Mayo Clinic](https://www.mayoclinic.org/ct-scan).

⁵ Centers for Disease Control and Prevention, “Coronavirus Disease 2019 (COVID-19),” accessed November 24, 2020, [Coronavirus Disease 2019 \(COVID-19\) | 2020 Interim Case Definition, Approved April 5, 2020 \(cdc.gov\)](https://www.cdc.gov/media/releases/2020/s1124-covid-19-cases.html).

⁶ Mayo Clinic, “diabetes,” accessed November 24, 2020, <https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444>.

⁷ Mayo Clinic, “enoxaparin,” accessed November 30, 2020, <https://www.mayoclinic.org/drugs-supplements/enoxaparin-subcutaneous-route-injection-route/description/drg-20063670>.

⁸ VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

hypertension (high blood pressure). A condition in which the force of the blood against the artery walls is high enough that it may eventually cause health problems such as heart disease.⁹

institutional disclosure. A formal process by which VA officials inform the patient and the patient's representatives that an adverse event occurred during the patient's care that resulted in death.¹⁰

morbid obesity. An excess of body weight, normally defined as an individual with a body mass index greater than 35 or a body weight greater than one hundred percent of ideal body weight.¹¹

panuveitis. A form of eye inflammation that affects all layers of tissues in the eye wall.¹²

peer review for quality management. A critical review of a clinician's care performed by a peer that can result in both short- and long-term improvements in patient care by revealing opportunities for improvement.¹³

pulmonary embolism. "An obstruction of the pulmonary artery or one of its branches."¹⁴

root cause analysis. "A process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events."¹⁵

saddle pulmonary embolism. A blood clot that occurs at the bifurcation (two branches) of the main pulmonary artery.¹⁶

sleep apnea. A serious sleep disorder in which breathing starts and stops.¹⁷

thromboembolism. A blocking of a blood vessel by a particle that has broken away from a blood clot at its site of formation.¹⁸

⁹ Mayo Clinic, "high blood pressure (hypertension)," accessed November 24, 2020, <https://www.mayoclinic.org/diseases-conditions/high-blood-pressure/symptoms-causes/syc-20373410>.

¹⁰ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

¹¹ National Center for Biotechnology Information, National Institute of Health, *Obesity*, accessed March 9, 2021, [Morbidity obesity - Conditions - GTR - NCBI \(nih.gov\)](https://pubmed.ncbi.nlm.nih.gov/2812222/).

¹² Mayo Clinic, "uveitis," accessed November 24, 2020, <https://www.mayoclinic.org/diseases-conditions/uveitis/symptoms-causes/syc-20378734>.

¹³ VHA Directive 1190.

¹⁴ The Journal of the American Osteopathic Association, *Saddle Pulmonary Embolus*, Vol. 115, No. 5, accessed November 30, 2020, [Saddle Pulmonary Embolus - Journal of Osteopathic Medicine](https://www.jaoa.org/doi/abs/10.7554/jaoa.2020.115.05.001).

¹⁵ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

¹⁶ The Journal of the American Osteopathic Association, *Saddle Pulmonary Embolus*, Vol. 115, No. 5, accessed November 30, 2020, [Saddle Pulmonary Embolus - Journal of Osteopathic Medicine](https://www.jaoa.org/doi/abs/10.7554/jaoa.2020.115.05.001).

¹⁷ Mayo Clinic, "sleep apnea," accessed December 1, 2020, <https://www.mayoclinic.org/diseases-conditions/sleep-apnea/symptoms-causes/syc-20377631>.

¹⁸ Merriam-Webster, "thromboembolism," accessed March 10, 2021, <https://www.merriam-webster.com/dictionary/thromboembolism>.

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