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VETERANS HEALTH ADMINISTRATION

Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA New Mexico Healthcare System (facility) in Albuquerque to assess allegations and concerns related to care provided to a patient who was labeled as ineligible for care and senior leaders' response.[1] The OIG found facility staff's knowledge deficits and communication failures contributed to multiple process failures, which led to care deficiencies and an approximately three-month delay in the patient becoming labeled as eligible for VA health care. The OIG also identified failures with senior leaders' response to the patient's inadequate discharge in spring 2024. Although not related to the patient's care, podiatry residents were not supervised in accordance with Veterans Health Administration (VHA) policy.

Failures in Processes

In early 2024, the patient was admitted to the facility for gas gangrene of the left foot and related sepsis, underwent a transmetatarsal amputation, and was hospitalized for 12 days.[2] On the day of admission, the patient applied for VA healthcare benefits and incorrectly included profits from the sale of property and did not deduct medical and burial expenses when reporting income on the form.[3] Based on the application with incorrect information, the patient's income exceeded the threshold to receive care at the facility. During the patient's hospital stay, social work staff were aware that the patient's application for healthcare benefits was declined due to income. However, due to a lack of knowledge related to the process for correcting the information, social work staff failed to ensure that the patient's financial information was updated.

The discharge plan for the patient's hospitalization included physical and occupational therapy and a podiatry appointment. The physical and occupational therapy consult was canceled by a community care registered nurse due to the patient not having an assigned provider, and the

[1] The OIG recognizes there are instances when an ineligible patient may receive VA care or services at a facility. Examples include but are not limited to, care for emergent conditions and treatment for military sexual trauma. VA, *Health Care Benefits Overview,* Vol. 2, 2023 Edition. 38 U.S.C. § 1784A (2016).

[2] Cleveland Clinic, "Gas Gangrene," accessed March 25, 2025, https://my.clevelandclinic.org/health/diseases/24739-gas-gangrene. Gas gangrene is a medical emergency caused by a bacterial infection that releases toxins and gas, destroys tissues, causes widespread inflammation and sepsis, and can quickly be fatal. Gas gangrene must be treated immediately with high dose antibiotics and surgery to remove infected and dead tissue and requires hospitalization. UWHealth, "Transmetatarsal Amputation (TMA) and Toe Amputation," accessed March 25, 2025, https://patient.uwhealth.org/healthfacts/4892. Transmetatarsal amputation (TMA) is an operation to remove the front half of the foot, including all toes, up to the instep, leaving the ankle and heel intact. It may be done to treat a severe foot infection.

[3] According to the instructions, when applying for VA healthcare benefits, profits from the occasional sale of a home should be excluded from income, and medical, funeral, and burial expenses paid for a spouse should be reported as deductions. VA Form 10-10EZ, Instructions for Completing Enrollment Application for Health Benefits, April 2023.

medical support assistant (MSA) supervisor canceled the podiatry appointment due to the patient being labeled as ineligible. The OIG determined that staff did not follow discharge planning processes to coordinate the patient's postsurgical care.[4] The medicine attending and podiatrist reported not realizing that the patient was labeled as ineligible to receive care. The registered nurse (nurse) discharge planner believed the outpatient podiatry appointment would occur because the amputation had been performed at the facility, and reported being "hopeful" that, after the patient followed up with the Housing and Urban Development-VA Supportive Housing Program, eligibility for care at the facility would be established.[5] A social worker reported telling the patient to seek a primary care provider at the community hospital or Health Care for Homeless, however, took no additional action to coordinate follow-up care.[6] After recognizing the patient's follow-up podiatry appointment had been canceled, the podiatrist entered two additional orders for follow-up appointments; however, an advanced MSA reported canceling each order due to ineligibility status. The podiatrist was unable to explain not having inquired into the reason for cancellation and acknowledged that care could have been coordinated with a community podiatrist.

In spring 2024, the patient returned to the facility's emergency department with foot pain from the unhealed amputation site. The emergency department MSA noted 8G on the display board in the emergency department, identifying the patient as ineligible for care at the facility.[7] Emergency department providers told the OIG the display board is used to become aware of a patient's eligibility, however the emergency department provider did not recall seeing 8G and did not know what the designation meant. The emergency department provider determined that the patient needed inpatient admission but lacked knowledge of the patient being labeled as ineligible for care and, therefore, did not follow standard practice to transfer the patient to a community hospital or obtain Chief of Staff approval for admission to the facility. The patient was admitted with an open surgical wound and a soft tissue infection of the amputation site.

On the day of admission to the facility, the former chief of social work, social work supervisor, and enrollment and eligibility supervisor met to assess the patient's eligibility, however, failed to discuss relevant information related to the patient's reported income, resulting in the patient remaining labeled as ineligible for care. The social work supervisor believed that social work staff had recently gathered financial information and reassessment did not result in a change in eligibility status. The former social work chief reported being told that the patient "was not

[4] The patient had Medicare insurance.

[5] Housing and Urban Development-VA Supportive Housing Program is a collaborative program with the primary goal of moving veterans out of homelessness. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[6] According to the social worker, Health Care for Homeless is a federally qualified health center that operates its own freestanding medical clinic. The clinic offers primary medical care, psychiatric services, dental services, and an eye clinic.

[7] All patients are eligible for emergency care. Eligibility for care at the facility is only pertinent when determining if a patient should be admitted to the facility or transferred to a community hospital after stabilized.

interested in redoing the paperwork" to become eligible for care. The enrollment and eligibility supervisor, unaware that the patient's income was reported incorrectly, described conducting a review of the patient's discharge paper and exposures and determining that the patient did not meet criteria for eligibility based on those factors.

Approximately five hours after admission, the podiatrist discharged the patient and antibiotic and wound vacuum treatments were discontinued. The podiatrist told the OIG that the plan was for staff to call an ambulance for transport from the facility to a community hospital for evaluation.[8] The podiatrist reported feeling "frustrated" and acknowledged in hindsight that the other options could have been explored.

The OIG did not substantiate that the podiatrist was forced to discharge the patient. The podiatrist, who oversaw the patient's care during the spring admission, told the OIG that the social work supervisor provided instruction to discharge if the patient was medically stable and not in need of emergent surgery. The podiatrist admitted to limited experience discharging patients and believed that the social work supervisor knew more about eligibility rules, and therefore, discharged the patient. The podiatrist was unaware that the Chief of Staff had the discretion to approve the patient for continued care at the facility regardless of eligibility status.

The podiatrist also lacked experience transferring patients and asked the social work supervisor if the patient could be transferred to a community hospital. The social work supervisor consulted with the covering transfer coordinator; however, the covering transfer coordinator misinterpreted the social work supervisor's inquiry to be about *transportation* and responded that the patient was not eligible for transport. Not recognizing the transfer coordinator's response was about transportation, the social work supervisor told the podiatrist that transferring the patient was not an option.

The podiatrist documented in the patient's electronic health record (EHR), "I am forced to discharge this patient."[9] However, the podiatrist later acknowledged writing the note out of frustration. The facility risk manager and acting chief of Health Information Management Services believed that the note contained inappropriate and unprofessional language that should be corrected. The note was subsequently removed. The OIG did not substantiate that the removal of the podiatrist's note was inconsistent with VHA policy.

The OIG substantiated that on the day of the spring admission, the plan to discharge the patient to seek care at a community hospital without door-to-door transportation was inadequate. The social work supervisor sought information from the covering transfer coordinator; however, the covering transfer coordinator provided misinformation, stating the inaccurate belief that the only

[8] A wound vacuum removes pressure over the area of the wound and aids wound healing.

[9] An EHR is a "digital collection of patient health information" pertaining to clinical care. VHA Directive 1907.01(1), *VHA Health Information Management and Health Records,* April 5, 2021, amended December 11, 2023.

transport option was utilization of 911. As a result, other door-to-door transportation options were not identified. In addition, the OIG found that the patient was not provided discharge paperwork as required. The patient's nurse reported to the OIG not providing the patient with discharge paperwork due to feeling rushed. The podiatrist was aware of the plan for the patient to seek care at a community hospital but did not contact the providers to share relevant medical information stating that the patient would be reevaluated upon arrival at the community hospital. The patient's nurse and nursing officer of the day (NOD) escorted the patient to the main lobby and instructed the patient to call 911 to request transport to the community hospital. After the 911 dispatcher noted the patient could not be picked up while at the facility, the patient's nurse and NOD escorted the patient by wheelchair to a bench away from facility grounds. The patient was then transported by ambulance to the community hospital.

Prior to the patient leaving the facility, the patient's nurse escalated concerns regarding the discharge plan to the nurse manager and the NOD. The NOD relied on the podiatrist to determine whether the patient was safe for discharge and, therefore, did not elevate concerns to facility leaders. However, the NOD did not know that the patient's medical treatments, including the wound vacuum, had been discontinued and did not seek further information from staff or the patient's EHR. The OIG would expect the NOD to have been knowledgeable about transport options, gathered additional information about the situation, and recognized that discharging off facility grounds to call an ambulance for transport to a community hospital was an inadequate discharge plan.

Failures in Senior Leaders' Responses

The OIG found that the root cause analysis (RCA) chartered to review the patient's spring 2024 discharge lacked objectivity and credibility due to including a staff member involved in the patient's discharge, and an RCA action item not being implemented timely.[10] The care coordination manager recommended a staff member to participate in the RCA despite awareness that the staff member was involved in the patient's spring discharge. The care coordination manager conveyed the inaccurate belief that the recommendation was appropriate due to the staff member's knowledge of discharge planning and transportation. The interim Facility Director told the OIG of planning to charter a new RCA due to the staff member's inappropriate involvement and the belief that the RCA did not address concerns related to the patient's discharge. The interim Facility Director reported making the request during the RCA team's presentation of findings. The patient safety manager informed the OIG that the request for a new charter was not communicated to the patient safety team and thus was not completed. The OIG was unable to determine why a new RCA was not chartered due to conflicting recollections. The acting Facility Director reported being unaware of the inappropriate staff member and concurred with the RCA.

[10] An RCA is a tool that may be used to identify root causes of an adverse event and action plans for correction.

Senior leaders failed to utilize High Reliability Organization principles to identify and address deficiencies related to the patient's discharge in spring 2024. Leaders should actively seek knowledge and provide feedback on actions that were taken.[11] Neither the former nor acting Chief of Staff ensured that the involved providers were given feedback or education related to the deficiencies in the patient's admission, discharge, and coordination of care.

Deficiencies in First-Year Podiatry Resident Supervision

The OIG found that first-year, postgraduate year one, or PGY-1, podiatry residents provided patient care while on-call during nights, weekends, and holidays without on-site supervision by a more senior podiatry resident or attending podiatrist as required by VHA Directive.[12] The podiatry residency program director reported only recently becoming familiar with the directive and, after consultation with the National Podiatry Program Office, made adjustments to the on-call system to align with the directive. The OIG confirmed that subsequent changes implemented by the facility corrected the deficiency.

The OIG made 15 recommendations to the Facility Director related to knowledge deficits regarding the care of ineligible patients; the process of retracting notes from patient EHRs; steps to take if staff's attempts to escalate clinical concerns are not adequately addressed; the completion of 10-10EZR forms; ineffective communication, collaboration, and utilization of resources; leaders' awareness of responsibilities and conflicts of interests regarding RCAs; the utilization of High Reliability Organization principles; and resident supervision requirements.

VA Comments and OIG Response

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

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in the role of Acting Assistant Inspector General,
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[11] Gary L. Sculli and Robin Hemphill, "Culture of Safety and Just Culture," VHA National Center for Patient Safety, accessed May 31, 2024, https://uthscsa.edu/medicine/sites/medicine/files/2023-08/Culture%20of%20Safety%20and%20Just%20Culture.pdf; VHA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024. (This site is not publicly accessible.)

[12] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents,* November 7, 2019.

Contents

Abbreviations

ADPCS	Associate Director of Patient Care Services
COS	Chief of Staff
EHR	electronic health record
HAS	Health Administration Service
HIMS	Health Information Management Services
HRO	High Reliability Organization
NOD	Nursing Officer of the Day
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 a healthcare inspection at the VA New Mexico Healthcare System (facility) in Albuquerque to assess allegations and concerns related to the care provided to a patient who was labeled as ineligible for care and senior leaders' response.[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 22, includes a medical center and 13 community-based outpatient clinics that provide primary, mental health, and specialty care services. The Veterans Health Administration (VHA) classifies the facility as a level 1b, high complexity.[2] The facility has 167 hospital beds, 36 community living center beds, and 70 domiciliary beds. In addition, the facility has a 24-hour emergency department. From October 1, 2023, through September 30, 2024, the facility served 83,192 patients. The facility is a teaching hospital with primary affiliation with the University of New Mexico School of Medicine.

Priority Group 8G

VA healthcare eligibility is categorized into priority and sub-priority groups based on factors that include a veteran's military service history, disability rating, income level, and other benefits received.[3] VHA defines enrollment as "the acceptance of an eligible Veteran into the VA health care system and assignment to a Priority Group for the purpose of receiving the full medical benefits package."[4] Veterans assigned to priority group 8G are ineligible for care and cannot be enrolled for care at a facility due to lack of a service-connected condition and an income that exceeds the geographic threshold.[5] The 10-10EZ form is used to apply for VA healthcare

[1] The OIG recognizes there are instances when an ineligible patient may receive VA care or services at a facility. Examples include but are not limited to, care for emergent conditions and treatment for military sexual trauma. VA, *Health Care Benefits Overview,* Vol. 2, 2023 Edition. 38 U.S.C. § 1784A (2016).

[2] VHA Office of Productivity, Efficiency, and Staffing (OPES), "Facility Complexity Model Fact Sheet," October 1, 2023. The VHA Facility Complexity Model classifies medical facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex and level 3 being the least complex. A level 1b facility has "medium-high-volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs."

[3] Priority and sub-priority groups affect copay amounts and eligibility status. "VA Priority groups," VA, accessed April 30, 2024, https://www.va.gov/health-care/eligibility/priority-groups/.

[4] VHA Directive 1601A.01(3), *Registration and Enrollment*, July 7, 2020, amended April 4, 2024.

[5] VHA Directive 1601A.01(3). A service-connected condition is an illness or injury that is due to active military service and is considered for benefit determination. "Eligibility for VA disability benefits," VA, accessed November 23, 2024, https://www.va.gov/disability/eligibility/#:~:text=If%20you%20have%20a%20service,of%E2%80%94your%20active%20military%20service.

benefits. Veterans who have no service-connected conditions are required to fill out the financial disclosure section of the form and are not eligible for care if their income exceeds VA income limits by 10 percent.[6] The 10-10EZR form is used to update or correct a patient's demographics, insurance, or financial information.[7]

Veterans who are determined to be ineligible for VA health care can receive services for emergent conditions and are billed for the services they receive.[8] According to the facility's enrollment and eligibility supervisor, when new information is submitted with a 10-10EZR, the facility staff receive immediate confirmation of the veteran's tentative eligibility status. The Health Eligibility Center then provides a written notice of eligibility to veterans regarding entitlement for benefits and services.

Allegations and Related Concerns

On April 3, 2024, the OIG received an anonymous complaint alleging that after the patient was admitted to the facility, social work and enrollment and eligibility staff "forced" medical staff to stop providing care and discharge the patient due to ineligibility status. The complainant also alleged that the plan to discharge the patient to a bench "outside of the hospital building" and call 911 for transport to a local community hospital was inadequate. Further, the complainant alleged documentation related to the patient's discharge was inappropriately removed from the patient's electronic health record (EHR).[9]

The OIG reviewed the patient's EHR, identified concerns regarding the patient's eligibility for VA healthcare benefits, and opened an inspection on April 24, to assess processes related to

- postsurgical follow-up care,
- admission at the facility,
- the decision to discharge on the same day as admission and the related discharge plan,
- the removal of an EHR note documenting the events,
- staff's actions to correct information needed for eligibility, and

[6] "About VA Form 10-10EZ," VA, accessed October 18, 2024, https://www.va.gov/find-forms/about-form-10-10ez; VA, *Health Care Benefits Overview,* Vol. 2, 2023 Edition.

[7] "How to update your VA health benefits information," VA, accessed October 18, 2024, https://www.va.gov/health-care/update-health-information.

[8] VHA Directive 1601A.02(6), *Eligibility Determination*, July 6, 2020, amended March 6, 2024.

[9] An EHR is a "digital collection of patient health information" pertaining to clinical care. VHA Directive 1907.01(1), *VHA Health Information Management and Health Records,* April 5, 2021, amended December 11, 2023.

- senior leaders' response to the discharge.

During the inspection, the OIG identified an additional concern related to podiatry resident supervision.

Scope and Methodology

The OIG completed a site visit at the facility from June 10 through 13, 2024. Virtual interviews were conducted prior to and after the site visit.

The OIG interviewed 47 individuals, including VISN and facility senior leaders; service chiefs; supervisory, quality management, frontline clinical, and administrative staff; a health eligibility center program analyst; and the patient.[10]

The OIG reviewed VHA and facility policies; facility standard operating procedures, staff functional statements, and a position description; external standards and literature reviews; the patient's facility EHR, including the community hospital records that were in the EHR; documents related to eligibility; and quality management reviews. The OIG requested and reviewed non-VHA patient ambulance records obtained by subpoena.

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, as amended, 5 U.S.C. §§ 401–424. 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.

[10] For the purpose of this report, the term *senior leaders* includes the Facility Director, interim Facility Director, Chief of Staff, Associate Director of Patient Care Services, and Associate Director. The interim Facility Director reported serving in the role as the Facility Director from September 2023 through May 2024. The Facility Director reported assuming the role in June 2024. VISN leaders include the VISN Chief Medical Officer, VISN Quality Management Officer, VISN Patient Safety Manager, and VISN Business Implementation Assistant Manager.

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.

Patient Case Summary

The patient is in their 60s, served in the army from 1976 through 1978, and was discharged under honorable conditions. The patient had a history of smoking, chronic obstructive pulmonary disease, and untreated diabetes. In early 2023, the patient's spouse died and the patient's world "spiraled out of control." The patient reported selling a home to pay bills, becoming homeless, sleeping in cars outside, and having a limited support system.

The patient had not sought VHA care or VA services in decades, until initiating care by presenting to the facility's emergency department in early 2024 with complaints of left foot pain. The patient was diagnosed with gangrene of the toes, likely from frostbite, and was scheduled for an outpatient podiatry appointment three days later. The patient did not attend the scheduled outpatient podiatry appointment but presented to the facility emergency department the following day with worsening left foot pain. The podiatrist again scheduled the patient for an outpatient appointment three days later, which the patient did not attend.

The following month, the patient presented to the facility's emergency department and was admitted with sepsis from gas gangrene of the left foot, assessed by the podiatrist to be a "limb threatening infection that could very quickly become life-threatening without proper intervention."[11] The podiatrist performed an urgent transmetatarsal amputation of the left foot and admitted the patient to the surgical intensive care unit for further treatment of sepsis.[12] After 11 days of postsurgical intravenous antibiotics and wound care, the patient was discharged from inpatient care at the facility. Prior to discharge, the podiatrist made a plan to see the patient at a scheduled outpatient podiatry appointment six days later. However, on the day of discharge, the patient's scheduled appointment was canceled by a medical support assistant (MSA) supervisor noting the reason as "patient not eligible." The patient had no postsurgical follow-up visits noted in the EHR.

Twelve days later, the patient presented to a community hospital emergency department and reported bleeding and pain at the amputation site. The patient was diagnosed with a wound

[11] Cleveland Clinic, "Gas Gangrene," accessed March 25, 2025, https://my.clevelandclinic.org/health/diseases/24739-gas-gangrene. Gas gangrene is a medical emergency caused by a bacterial infection that releases toxins and gas, destroys tissues, causes widespread inflammation and sepsis, and can quickly be fatal. Gas gangrene must be treated immediately with high dose antibiotics and surgery to remove infected and dead tissue and requires hospitalization.

[12] UWHealth, "Transmetatarsal Amputation (TMA) and Toe Amputation," accessed March 25, 2025, https://patient.uwhealth.org/healthfacts/4892. Transmetatarsal amputation (TMA) is an operation to remove the front half of the foot, including all toes, up to the instep, leaving the ankle and heel intact. It may be done to treat a severe foot infection.

infection, prescribed' oral antibiotics, and discharged with instructions to call the podiatrist who performed the amputation for follow-up care.

The patient presented to the facility's emergency department one month later and reported pain at the amputation site. An emergency department provider determined the patient had an open surgical wound and a soft tissue infection of the amputation site and ordered intravenous fluids, antibiotics, and blood cultures. In the emergency department, the podiatrist debrided the nonhealing amputation wound, took wound cultures, and started broad spectrum antibiotics "until cultures return." The podiatrist documented previous challenges with outpatient care of the patient and planned wound vacuum therapy "while the patient is in the hospital" to assist with wound closure.[13] A podiatry resident ordered x-rays and applied a fresh dressing to the wound in the emergency department. The patient was transferred from the emergency department to the inpatient unit at 2:34 p.m., after which the podiatry attending placed a wound vacuum to the unhealed amputation site and determined that the patient was "nonweightbearing [*sic*] status" on the affected foot. The podiatry resident noted the plan to change the wound vacuum on a "Monday Wednesday Friday" schedule.

Later that afternoon, a social work supervisor documented meeting with the enrollment and eligibility supervisor and the former chief of social work and determining that the patient needed to be discharged if medically stable due to not being eligible for care at the facility. The social work supervisor documented informing the podiatrist and podiatry resident that the patient "needs to leave" if medically stable. The podiatry team documented being told by the social work supervisor that the patient cannot "be seen for anything at the VA … including wound care … and must be seen at [a non-VA] facility." The podiatrist removed the wound vacuum and applied a dressing to the amputation site.[14] The social work supervisor documented that the patient verbalized planning to go to the community hospital for medical care "as needed." The social work supervisor documented reviewing public transportation options with the patient and advising that the patient could call 911 for an ambulance. The social work supervisor documented that the patient was "understandably upset" and said, "but I am a Veteran and should be seen here." The patient's nurse documented that the patient was "discharged to Bench [*sic*] in front of parade grounds" by wheelchair and that the patient "called 911 to have ambulance pick [the patient] up and take [the patient] to [a community hospital]." Later that day, the patient was evaluated and admitted to a community hospital for wound care and intravenous antibiotics.

[13] A wound vacuum removes pressure over the area of the wound and aids wound healing.

[14] The podiatry attending subsequently redacted the original discharge note from the patient's EHR and replaced it with another note. The OIG reviewed both the original and replacement discharge notes and determined the notes were similar in content regarding medical decision-making and timeline.

Approximately five weeks later, the patient presented to the facility's emergency department by ambulance and reported foot pain. The attending emergency department provider determined the patient had "stump pain," and further documented that the patient was "not a veteran so medical screening exam complete," and suggested follow-up at a community hospital.

Approximately three weeks later, the patient again presented to the facility's emergency department and reported left foot pain and drainage. The enrollment and eligibility supervisor told the podiatrist that the patient's eligibility status was changed that day and the patient was now eligible for care at the facility. The patient was admitted to the facility and received wound care and antibiotics and was discharged two weeks later in stable condition, with a podiatry clinic follow-up appointment scheduled for three days after discharge.

Inspection Results

Facility staff's knowledge deficits and communication failures led to an approximately three-month delay in assisting the patient with correcting financial information and negatively affected the patient's ability to receive care at the facility. Prior to the patient's financial information being corrected, staff's knowledge and communication deficits led to process failures including

- a lack of postsurgical follow-up care coordination,
- an inpatient admission without Chief of Staff (COS) approval,
- an abrupt decision to discharge the patient,
- a missed step in the process to remove an EHR note,
- the implementation of an inadequate discharge plan, and
- an unsuccessful attempt to escalate concerns.

Additionally, the OIG identified failures with senior leaders' response to the patient's inadequate discharge plan in spring 2024. Although not related to the patient's care, podiatry residents were not supervised in accordance with VHA policy.

Failure to Correct Information Needed for Eligibility

The OIG determined that social work staff were aware that the patient's application for healthcare benefits was declined in early 2024, due to reported income, resulting in an ineligibility status. However, due to a lack of knowledge, social work staff failed to ensure that the patient's financial information was updated. Additionally, during the patient's spring 2024 admission, the former chief of social work, social work supervisor, and the enrollment and eligibility supervisor met to assess the patient's eligibility but failed to communicate relevant information that would have identified that the 10-10EZ was inaccurate.

According to the 10-10EZ form instructions, profits from the occasional sale of a home should be excluded from income. Medical, funeral, and burial expenses paid for a spouse should be reported as deductions from income. The 10-10EZR form instructions do not state that a waiting period or specific documents are required to update financial information.[15]

A program analyst from the Health Eligibility Center and the facility enrollment and eligibility supervisor confirmed neither a waiting period nor financial documents are required to make corrections to a patient's reported income using the 10-10EZR form.

Inpatient unit social work staff at the facility are responsible for collaborating with clinical and administrative staff in the ongoing assessment of barriers that could affect a patient's care. The facility's enrollment and eligibility supervisor is responsible for providing technical advice and expertise related to eligibility. Health care delivery relies on the staff's access to timely and relevant patient information. [16] Effective communication may lead to improved information flow, successful interventions, and enhanced collaboration among staff.[17]

Early 2024

The enrollment and eligibility supervisor told the OIG that, during the patient's initial visit to the facility's emergency department in early 2024, the patient completed the 10-10EZ form without including financial information required to establish eligibility.[18] An emergency department social worker encouraged the patient to follow up with staff at the enrollment and eligibility office. The following month, the patient completed the 10-10EZ form while in the emergency department, reporting an income that included the profits from the sale of a home, and the eligibility and enrollment supervisor told the OIG that as a result of the reported income the patient was labeled as ineligible for care at the facility.[19] However, the OIG found that the patient would have been labeled as eligible for care if either the sale of the home was not reported as income or medical or burial expenses had been deducted in accordance with the 10-10EZ form instructions.

Inpatient social worker 1 completed an initial discharge planning assessment and learned that the patient had sold a property to reportedly pay for medical expenses. Inpatient social worker 1 told

[15] VA Form10-10EZ, Instructions for Completing Enrollment Application for Health Benefits, April 2023; VA Form 10-10EZR, "Instructions for Completing Health Benefits Update Form," February 2023.

[16] Vinita Mujumdar and Haley Jeffcoat, "Leveraging knowledge management for better quality surgical care: An introduction," *Bulletin of the American College of Surgeons* 106, no. 3 (March 2021).

[17] Michelle O'Daniel and Alan H. Rosenstein, "Professional Communication and Team Collaboration," chap. 33 in *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*, (Rockville, MD: Agency for Healthcare Research and Quality, 2008), https://www.ncbi.nlm.nih.gov/books/NBK2637/.

[18] VHA Directive 1601A.01 (3); VHA Directive 1601A.02(6).

[19] Veterans assigned to priority group 8G are ineligible for care and cannot be enrolled for care. Therefore, for the purpose of this report, the patient's eligibility determination will be referenced as being labeled as ineligible for care.

the OIG of an intention to assist the patient with completing a 10-10EZ form, but when reviewing the EHR, learned that the patient had completed the form earlier that day. Inpatient social worker 1 relayed to the OIG an inaccurate belief, based on prior experience with another VA form, that the 10-10EZ form could not be updated the same day. Two days later, inpatient social worker 1 alerted inpatient social worker 2 that the patient had sold a home to pay for medical expenses. Inpatient social worker 2 reported informing the enrollment and eligibility supervisor that the patient had sold a home to pay for medical expenses and being told that there was a waiting period to make updates to the patient's income unless the patient provided documentation of the paid expenses. Inpatient social worker 2 reported offering to assist the patient with obtaining the documentation of expenses to update the patient's financial information but indicated that the patient declined.[20] The patient could not recall having a discussion with anyone about updating eligibility information. The enrollment and eligibility supervisor did not recall having any conversations with social work staff regarding eligibility during the patient's hospital stay in early 2024. However, the enrollment and eligibility supervisor confirmed to the OIG that the patient's financial information could have been corrected, documentation was not needed, and that the patient would have been eligible for care.

The OIG concluded that social work staff did not ensure that the patient's financial information was updated due to knowledge deficits related to the process of correcting information. The OIG was unable to determine the origin of the inaccurate information related to the correction process due to conflicting recollections of the communication between inpatient social worker 2 and the enrollment and eligibility supervisor. The OIG found that had corrections been made to accurately reflect the patient's financial exclusions and deductions, the patient would have been labeled as eligible in early 2024.

Early Spring 2024

During a discussion with the OIG, inpatient social worker 1 reported contacting the social work supervisor for guidance after learning of the patient's admission in the spring of 2024, due to a previous instruction from the former chief of social work to notify a supervisor if an unenrolled (ineligible) patient was admitted. The social work supervisor then took over responsibility for the patient from inpatient social worker 1. Inpatient social worker 1 could not recall if information regarding the medical expenses or the sale of the patient's home was shared with the social work supervisor. The social work supervisor recalled receiving "basic information, maybe from a pervious [previous] conversation" regarding the patient's early 2024 admission. The social work supervisor explained that additional information was not obtained from inpatient social worker 1,

[20] The patient told the OIG of not being able to recall the conversation and inpatient social worker 2 reported not documenting that the patient declined assistance with obtaining evidence of expenses.

the patient, or the EHR due to the belief that the financial information had recently been gathered and considered but did not result in the patient becoming labeled as eligible.[21]

The social work supervisor met with the enrollment and eligibility supervisor and former chief of social work to discuss and confirm the patient's eligibility status. The former chief of social work told the OIG of having general knowledge that the patient was labeled as ineligible for care at the facility due to income but reported being told that the patient "was not interested in redoing the paperwork." The enrollment and eligibility supervisor, unaware that the patient's income was reported incorrectly, described conducting a review of the patient's discharge papers and exposures and determining that the patient did not meet criteria for eligibility based on those factors.

The enrollment and eligibility supervisor confirmed that had relevant information, such as the patient's medical expenses, been communicated and used to complete a 10-10EZR form, the patient's eligibility would have been corrected.[22] However, because the meeting between the social work supervisor, former chief of social work, and the enrollment and eligibility supervisor did not result in the correction of the patient's eligibility status, the former chief of social work told the OIG of providing instruction to the social work supervisor to confirm that the patient had insurance and a community provider, and to notify the care team that the patient would need to be discharged to follow up with community providers.[23] The chief of Health Administration Service (HAS) acknowledged to the OIG that there was an opportunity for better collaboration between social work staff, enrollment and eligibility staff, and the patient.[24]

The OIG concluded that facility staff met to discuss the patient's eligibility status, but due to ineffective communication, collaboration, and utilization of available sources for information, the interaction did not result in the correction of the patient's eligibility status.

Process Failures

The OIG identified process failures related to the patient's care.

Lack of Postsurgical Follow-Up Care Coordination

The OIG determined that in early 2024, staff failed to follow discharge planning processes to

[21] The OIG could not follow up on the source of the misinformation as the social work supervisor could not identify who provided the information.

[22] The enrollment and eligibility supervisor told the OIG of assisting the patient with completing a new income assessment in May 2024, which made the patient eligible for care at the facility.

[23] The patient had Medicare insurance. VA does not bill Medicaid or Medicare for services provided. "VA healthcare and other insurance," VA, accessed December 10, 2024, https://www.va.gov/health-care/about-va-health-benefits/va-health-care-and-other-insurance/.

[24] The enrollment and eligibility supervisor told the OIG of being supervised by the chief of HAS. The chief of HAS reported also being responsible for overseeing medical support assistant staff.

coordinate postsurgical follow-up care for the patient. Despite having been labeled as ineligible for care 12 days prior to discharge, the patient's discharge plan included arranging services through the facility that were only available for patients labeled as eligible; services included home health care (physical and occupational therapy) and an outpatient podiatry appointment.

The discharge planning team is responsible for ensuring the safe discharge of patients.[25] Facility policy outlines responsibilities for members of the discharge planning team as follows:

- Attending physicians collaborate with staff including nurse discharge case managers and social workers to order referrals and consultations based on a patient's needs.
- Registered nurse (nurse) discharge planners ensure that clinical services are coordinated and "are in place" prior to a patient's discharge.
- Social workers coordinate the discharge planning process, identify community resources to refer patients for outpatient treatment, and ensure psychosocial services are coordinated prior to a patient's discharge.[26]

The OIG reviewed the patient's EHR and found that a community care registered nurse canceled the home health consult for physical and occupational therapy, due to the patient not having an assigned provider, and the MSA supervisor canceled the podiatry appointment due to the patient being labeled as ineligible.[27] The OIG learned through interviews and correspondence that the discharge planning team members did not successfully coordinate the patient's care due to the following:

- The medicine attending and podiatrist reported not being aware that the patient was labeled as ineligible to receive care at the facility. Further, the medicine attending could not recall receiving notification of the patient's eligibility status or why no further action was taken.
- The nurse discharge planner believed the patient would have the outpatient podiatry appointment because the amputation had been performed at the facility and reported

[25] J. Waring et al., "Hospital discharge and patient safety: review of the literature," chap. 2 in *An ethnographic study of knowledge sharing across the boundaries between care processes*, *services and organisations: the contributions to 'safe' hospital discharge*, [Southampton (UK)]: NIHR Journals Library; 2014 Sep. (Health Services and Delivery Research, No. 2.29).https://www.ncbi.nlm.nih.gov/books/NBK259995/.

[26] Facility Memorandum 122-15, *Patient Discharge Planning*, November 4, 2019. VHA Directive 0999(1), *VHA Policy Management*, March 29, 2022. The OIG recognizes the facility policy is expired, however, facility policies "… remain in effect until recertified or rescinded."

[27] The patient was labeled as ineligible and, therefore, could not be assigned to a facility primary care provider.

being "hopeful" the patient would be eligible for care after the patient followed up with the Housing and Urban Development-VA Supportive Housing Program.[28]

- Inpatient social worker 2 reported telling the patient to seek a primary care provider at the community hospital or "Health Care for Homeless," however, took no additional action to coordinate follow-up care.[29]

The OIG reviewed a communication between members of the patient's discharge planning team and found that the medicine attending, inpatient social worker 2, and nurse discharge planner were notified that the patient was labeled as unenrolled (ineligible for care at the facility). The OIG also found the nurse discharge planner's rationale to be flawed, as there was no guarantee the patient would have been accepted for entry to the Housing and Urban Development-VA Supportive Housing Program. Additionally, inpatient social worker 2 had a duty to effectively coordinate the patient's discharge plan while "providing coverage," due to being the patient's designated discharge planning social worker on the day of discharge.

The discharge plan included an order to return to the podiatry clinic at the facility, but the appointment was canceled by an MSA supervisor the same day as discharge, who stated that the cancellation was due to an ineligibility status. The MSA supervisor told the OIG of unsuccessfully attempting to contact the patient by phone and sending a cancellation notification letter to the patient's last known address. The OIG confirmed with the chief of HAS that providers are not contacted when a patient's appointment is canceled, regardless of eligibility status.

After the patient did not attend the appointment, the podiatrist reported noticing that the appointment had been canceled. The podiatrist told the OIG of making an unsuccessful attempt to call the patient and entering orders for two additional follow-up appointments. The podiatrist told the OIG of the belief that the cancellation was "odd" and was unable to explain not inquiring into the reason for cancellation. An advanced MSA told the OIG of canceling the two additional orders for follow-up appointments because the patient's chart noted "8G Patient Not Eligible." The podiatrist explained that if aware the patient was labeled as ineligible for care at the facility, efforts could have been made to coordinate care with a community podiatrist.

The OIG concluded that the patient's discharge planning team failed to perform their discharge planning responsibilities as outlined in the facility policy and did not ensure coordination of the patient's postsurgical care. Additionally, the OIG identified that arrangements could have been made for the patient to receive care from a community podiatrist had the podiatrist identified the

[28] Housing and Urban Development-VA Supportive Housing Program is a collaborative program with the primary goal of moving veterans out of homelessness. VHA Directive 1501, *VHA Homeless Programs,* October 21, 2016.

[29] According to social worker 2, Health Care for Homeless is a federally qualified health center that operates its own freestanding medical clinic. The clinic offers primary medical care, psychiatric services, dental services, and an eye clinic.

reason for the cancellation. Failure to ensure care coordination placed the patient at risk for delayed recovery from surgery and surgical site complications.

Inpatient Admission Without COS Approval

The OIG determined the emergency department provider lacked knowledge of the patient's ineligibility for care at the facility and therefore, did not consider transferring the patient to a community hospital or obtaining COS approval for admission in the spring of 2024.

According to 38 U.S.C. § 1784A, VA hospitals with emergency departments are required to stabilize a patient's medical condition prior to transfer or discharge.[30] Staff informed the OIG that a display board in the emergency department, viewable by staff, communicates patient information, including if a patient is in the 8G priority group.

The chief of the emergency department and the emergency department provider explained to the OIG that patients ineligible for care at the facility who present to the emergency department are stabilized and then transferred to a community hospital if in need of admission. The acting COS told the OIG of approving admission of patients ineligible for care at the facility in circumstances when a patient cannot be transferred to a community hospital.[31]

In the spring of 2024, the patient presented to the facility's emergency department. The OIG learned through an interview and email correspondence that upon arrival, an emergency department MSA noted the patient as 8G, an ineligible priority group, on the emergency department display board. Emergency department providers told the OIG that the display board is used to become aware of a patient's eligibility. The emergency department provider did not recall seeing 8G on the display board that day, lacked knowledge of what the designation meant, and determined that the patient needed inpatient admission at the facility. The emergency department provider reported not considering that the patient could have been labeled as ineligible for care, as the patient had surgery at the facility approximately seven weeks prior and therefore, did not follow stated practice to transfer the patient to a community hospital or obtain COS approval for admission at the facility.

The OIG concluded that the emergency department provider was unaware that the patient was labeled as ineligible for care at the facility and therefore did not follow stated practice to transfer or obtain the COS's approval to admit the patient.

[30] 38 U.S.C. § 1784A (2016). The OIG recognizes that in some situations, patients may not require stabilization prior to transfer. These situations include, but are not limited to, when a patient (or a legally responsible person) requests transfer regardless of risk and a physician determines medical benefits of transfer reasonably outweigh the risks.

[31] The deputy COS reported being assigned to the acting COS role at the time of the OIG inspection and is referred to as the acting COS throughout this report.

Alleged Forced Discharge and Knowledge Deficits Related to Options for Care

The OIG did not substantiate that the podiatrist was forced to discharge the patient. However, the OIG determined that the podiatrist made the discharge decision without knowledge of the ability to seek COS approval to provide care at the facility and based on misinformation about the patient's ineligibility for transfer to a community hospital.

Option to Continue Care at the Facility

Providers are responsible for deciding if a patient is safe for discharge.[32] The acting COS and former COS told the OIG of having the ability to approve care at the facility for ineligible patients.

During OIG interviews, the podiatrist reported being informed by the social work supervisor that the patient was ineligible for care at the facility and needed to be discharged if medically stable and not in need of emergent surgery.[33] The podiatrist reported being unaware that not all veteran patients are eligible for care at the facility and having limited experience discharging patients.[34] The podiatrist perceived that the social work supervisor knew more about eligibility rules and adhered to the social work supervisor's instructions. However, the podiatrist clarified, "I didn't feel bullied by the social worker … [social work supervisor] was just very persistent in [reference to] the VA policy."

The podiatrist explained that alternatives to discharge were not explored due to feeling frustrated. The podiatrist reported being unaware that the COS had the discretion to approve the patient for continued care at the facility regardless of eligibility status. The podiatrist stated that in hindsight, instead of discharging the patient, the social work supervisor's instruction could have been disregarded, a supervisor could have been contacted for guidance, and a reason to maintain the patient's care at the facility could have been identified.[35]

[32] Facility, "Bylaws, Rules, and Regulations of the Medical Staff," March 13, 2024. The acting COS clarified that podiatrists at the facility have privileges for admitting and discharging patients.

[33] The OIG noted a discrepancy between report from the podiatrist and the social work supervisor. The social work supervisor told the OIG of informing the podiatrist that the patient needed to be discharged if stable as opposed to the podiatrist reporting the social work supervisor stated to discharge the patient if stable and not in need of emergent surgery.

[34] The podiatrist reported discharging patients approximately once every six weeks.

[35] An example of a reason the podiatrist identified for maintaining the patient's care within VA was the need to evaluate the patient's cultures results, which were pending.

Option to Transfer to Community Hospital

VHA and facility transfer policies outline the process for providers to follow when transferring patients and do not differentiate between the transfer of eligible and ineligible patients.[36] The acting COS explained to the OIG that when patients are ineligible for care at the facility, the provider should attempt to arrange transfer to a community hospital.

The OIG interviewed the podiatrist and learned that, due to lack of experience transferring patients, the podiatrist asked the social work supervisor if the patient could be transferred to a community hospital. The social work supervisor told the OIG of seeking information from the covering transfer coordinator and being told transfer was not an option due to the patient's ineligibility. During an OIG interview, the covering transfer coordinator acknowledged that the social work supervisor asked about transferring the patient, however, due to misinterpreting the question to be about *transportation*, responded that the patient was not eligible for transport.

The podiatrist told the OIG of being informed by the social work supervisor that transfer was not an option. Therefore, approximately five hours after admission, the podiatrist discharged the patient and antibiotic and wound vacuum treatments were discontinued. Additionally, the podiatrist told the OIG of a plan for the staff to call an ambulance for transport to a community hospital for evaluation. The podiatrist described the patient as stable and reported feeling "OK" about the patient's discharge because the patient was going to a community hospital.

The OIG concluded that the podiatrist was not forced to discharge the patient. However, the podiatrist made the decision to discharge based on a lack of knowledge that the COS could have approved the patient to have continued receiving care at the facility and misinformation relayed by the social work supervisor that the patient could not have been transferred to a community hospital.

Missed Step in Note Removal Process

The OIG did not substantiate that the removal of the podiatrist's note from the patient's EHR was inconsistent with VHA policy. However, the podiatrist and a document specialist did not follow facility policy prior to the note being removed.[37]

VHA requires EHR notes to be clinically relevant and include pertinent facts; information that is derogatory or critical in nature is prohibited in the EHR.[38] VHA also requires facilities to have a

[36] VHA Directive 1094(1), *Inter-facility Transfer Policy,* January 11, 2017, amended June 24, 2024. The June 2024 contains the same or similar language as the January 2017 directive related to the transfer process. Facility "Inter-Facility Transfer Policy;" "SOP ADPCS-16," effective July 2022.

[37] For the purposes of this report the term "note" includes an addendum to a note.

[38] VHA HIM, *Health Record Documentation Program Guide*, version 1.2, September 29, 2023.

process for correcting patient information in EHRs.[39] The facility policy requires the provider to write an addendum to notes written in error, instructing viewers to disregard the contents of the note entry. Health Information Management Service (HIMS) staff must not retract the note prior to the addendum being added.[40]

The podiatrist documented in the patient's EHR, "I have been instructed by social work that [the patient] must be discharged today without transport to another hospital due to being stable and not requiring emergent surgery. Therefore, I am forced to discharge this patient." The facility risk manager and acting chief of HIMS believed that the note contained inappropriate and unprofessional language that should be corrected.[41] The podiatrist told the OIG that the note was written out of frustration and of agreeing to remove and replace the note.

The podiatrist sent an email to the acting chief of HIMS to formally request an amendment or removal of the note. According to the acting chief of HIMS, the podiatrist did not enter an addendum to the note, instructing the viewer to disregard the contents, so the HIMS staff would know which note to address. The podiatrist told the OIG of being unaware that an addendum was required. After receiving the email, the acting chief of HIMS requested that the document specialist amend the note. The document specialist attempted to amend the note, but the computer software only allowed removal of the note. The document specialist notified the acting chief of HIMS that the system did not allow for amendment and the acting chief of HIMS responded to proceed with removal. After the document specialist removed the note, the podiatrist entered a new note.[42] The document specialist explained that the addendum was not requested from the podiatrist because the request came directly from the acting chief of HIMS. The acting chief of HIMS told the OIG that an addendum should have been included and acknowledged not contacting the provider to request that the required addendum be added to the note. The acting chief of HIMS explained that the missed step is important for ensuring that the correct note is removed. The OIG did not identify any negative impact resulting from the missed step in the process.

The OIG concluded that the acting chief of HIMS and the risk manager deemed the content of the note as critical in nature and the podiatrist agreed, making the note appropriate for removal

[39] VHA HIM, *Health Record Documentation Program Guide*.

[40] Facility Policy 136-3, *Electronic Documents Entered in Error*, January 28, 2020. VHA Directive 0999(1), *VHA Policy Management*, March 29, 2022. The OIG recognizes the facility policy is expired, however, facility policies "remain in effect until recertified or rescinded."

[41] The chief of HAS is also the acting chief of HIMS referenced in this report.

[42] The new note directed readers to the social work supervisor's note, as the podiatrist felt the social work supervisor's note accurately reflected the events regarding the discharge. Additionally, the note included the recommendation for the patient to follow up with a vascular surgeon at the local community hospital.

according to VHA guidance. However, the podiatrist and document specialist missed a step in the process to remove the note.

Inadequate Discharge Plan and Attempt to Escalate Concerns

The OIG substantiated that the medical team's discharge plan for the patient was inadequate. Specifically, the OIG determined that facility staff failed to ensure continuity of care. Facility staff did not identify a door-to-door transportation option, provide written discharge instructions to the patient, or communicate relevant medical information to the community hospital. In addition, facility staff left the patient alone on a bench to await ambulance transport, a safety risk. Although the patient's nurse was uncomfortable with the discharge plan, an attempt to escalate the concern was unsuccessful.

According to facility policy, prior to the patient leaving the facility, staff should make certain that the discharge plan ensures continuity of care and can be completed safely.[43]

Door-to-Door Transportation Option Not Identified and Patient Left on a Bench

During interviews, the Facility Director and acting COS stated that the facility had an obligation to arrange the patient's transportation to the community hospital. The acting COS indicated having the authority to approve transport to the community hospital. The chief of HAS told the OIG that the facility utilizes a contracted ambulance company when needed. The acting chief of social work informed the OIG that if an ineligible patient needs ambulance transport due to medical or functional limitations, HAS staff can inform the ambulance company, and the patient will be responsible for the cost.[44]

The social work supervisor told the OIG that the patient denied having personal resources (such as friends, family, or taxi fare) for transport to the community hospital. The social work supervisor also told the OIG of being unaware of other transportation options and sought information from the covering transfer coordinator.

The social work supervisor stated that the covering transfer coordinator indicated that there were no other transport options aside from 911; however, the information was inaccurate.[45] During an OIG interview, the covering transfer coordinator acknowledged providing the inaccurate information and being made aware later that other transport options were available. Based on the misinformation, the social work supervisor informed the nursing officer of the day (NOD) that

[43] Facility Memorandum 122-15; Facility, "Bylaws, Rules, and Regulations of the Medical Staff," March 13, 2024.

[44] The acting chief of social work was in the role of assistant chief of social work prior to May 1, 2024; however, the OIG will refer to this individual as the acting chief of social work in this report section.

[45] The covering transfer coordinator told the OIG of subsequently learning that the patient's transport could have been arranged utilizing the patient's insurance.

the patient was not eligible for transport and that 911 would need to be called for transport to the community hospital.

Both the patient's nurse and NOD indicated belief that the patient was not eligible for VA arranged transport. The patient's nurse and NOD reported escorting the patient to the main lobby and assisting the patient to call 911 on a facility phone to request transport to the community hospital.[46] The 911 dispatcher noted that the patient could not be picked up while at the facility and worked with the NOD to identify a location away from facility grounds.[47] Subsequently, the patient's nurse and NOD escorted the patient to a bench by wheelchair at the agreed upon location. The NOD told the OIG that, shortly after leaving the patient, a representative from the ambulance company called to confirm the patient was being transported to the community hospital. The OIG is concerned that staff's decision to leave the patient with an open wound, mobility deficiencies, and no cellular phone, on a bench presented a safety risk as the ambulance may have been delayed or unable to locate the patient.

Discharge Documents Not Provided

Facility policy requires that clinical staff ensure patients receive written discharge instructions upon discharge. Written discharge instructions are necessary to provide a reference for treatments received, medications, and posthospitalization follow-up needs.[48] During interviews with the OIG, the podiatrist and patient's nurse explained that typically a nurse provides the discharge documents to the patient.

The OIG reviewed the patient's EHR and found that the podiatrist documented discharge instructions prior to the discharge; however, the patient's nurse reported not providing the documents to the patient due to feeling rushed because the social work supervisor stated that the patient needed to be discharged quickly. The social work supervisor stated that the former chief of social work had indicated that the patient needed to be discharged that day.[49]

Lack of Communication with the Community Hospital

According to The Joint Commission, when a patient is discharged, facility staff should provide information about the patient's care, treatment, physical and psychosocial status, and reason for

[46] The NOD informed the OIG that ambulance service is used to transport patients in Albuquerque even if the patient is not experiencing an emergency.

[47] The ambulance dispatcher noted the inability to pick up a person from hospital grounds to transport to a community hospital as doing so would be a lower level of care from the point of origin (VA hospital) and is against standards.

[48] Facility Memorandum 122–15. Charisma DeSai, et al., "Empowering patients: simplifying discharge instructions," *BMJ Open Quality* (2021): 1–7, https://doi.org/10.1136/bmjoq-2021-001419.

[49] The social work supervisor reported being uncertain if the former chief of social work provided a reason the patient needed to be discharged that day.

discharge to clinicians who will provide ongoing care to the patient.[50] When "providers work together and share information, [a] patient's needs and preferences are known and communicated at the right time to the right people, and the information is used to provide safe, appropriate, and effective care."[51]

Multiple facility leaders told the OIG that facility staff should have called the community hospital to share information. Additionally, the acting deputy COS reported that the podiatrist should have provided copies of relevant medical information to the community hospital.[52]

The podiatrist told the OIG of having the belief that the patient would seek care immediately at the community hospital; however, no contact with the community hospital providers was made as it did not occur to the podiatrist to provide information. The podiatrist stated that the patient would be evaluated by doctors who could make a decision about the care upon arrival to the community hospital.

The OIG would have expected the podiatrist to share pertinent clinical information with the community hospital providers prior to the patient's arrival, such as

- surgical history related to the open foot wound;
- work-up performed such as imaging, blood tests, and wound and blood cultures;
- treatments, including antibiotics administered;
- planned wound care; and
- suggested non-weight-bearing status.

Nursing Officer of the Day Failed to Recognize an Escalation of Concerns

NOD duties at the facility include coordinating safe and effective patient care and demonstrating leadership regarding the management of complex situations. Clinical staff may escalate clinical concerns or patient safety issues through their chain of command.[53]

The OIG learned during an interview that the patient's nurse believed that the patient needed further care and felt uncomfortable with the plan to discharge. The patient's nurse escalated the concern to the nurse manager and the NOD. The nurse manager told the OIG, "We [nurse

[50] The Joint Commission, *Standards Manual E-dition*, PC.04.02.01, January 14, 2024.

[51] "Care Coordination" (web page), CMS.gov, accessed October 16, 2024, https://www.cms.gov/priorities/innovation/key-concepts/care-coordination.

[52] The acting deputy COS reported being detailed to the role since approximately May 2024, and was in the chief of surgical service role prior to being detailed.

[53] Pennsylvania Patient Safety Advisory, "Chain of Command: When Disruptive Behavior Affects Communication and Teamwork," *Pennsylvania Patient Safety Authority* 7, suppl. 2 (June 16, 2010): 4-13, https://patientsafety.pa.gov/ADVISORIES/Pages/2010sup2_04.aspx.

manager and the patient's nurse] both had concerns …. We didn't want to just simply discharge [the patient] and leave [the patient]." Both the nurse manager and the patient's nurse reported sharing concerns with the NOD. The nurse manager reported asking the NOD how the patient, who was labeled as ineligible, became admitted. The patient's nurse recalled telling the NOD the patient could not stay and did not qualify for transportation and that the NOD confirmed the patient had to leave and could be taken to the front of the building and have an ambulance called. However, the NOD reported being contacted by the patient's nurse to assist with informing the patient of the need to discharge due to ineligibility. The NOD relied on the podiatrist to make the determination that the patient was safe for discharge, and, therefore, did not elevate concerns to facility leaders. The NOD did not know that the patient's medical treatments, including the wound vacuum, had been discontinued and did not seek further information from staff or the patient's EHR. The NOD stated that, in hindsight, a discussion might have occurred with the podiatrist. The NOD supervisor was unable to determine if the NOD should have taken additional action and stated, "it's hard to say because I wasn't there." Due to conflicting accounts, the OIG was unable to determine the content of the communication between the patient's nurse, nurse manager, and NOD. The OIG would expect that the NOD, who demonstrates leadership for managing complex situations, would have been knowledgeable about transport options, gathered additional information about the situation, and recognized that discharging off facility grounds to call an ambulance for transport to a community hospital was an inadequate discharge plan.

The OIG concluded that due to lack of knowledge, social work and nursing staff failed to identify a nonemergent door-to-door transportation option and left the patient alone on a bench, a safety risk. Further, nursing staff did not ensure continuity of care as the patient was not given written discharge instructions, and the facility podiatrist did not communicate pertinent information to the community hospital providers.

Failures in Senior Leaders' Responses

The OIG determined that the interim Facility Director initiated a root cause analysis (RCA) to review the patient's discharge in the spring of 2024 but failed to uphold the integrity of the RCA. In addition, an RCA action plan was not implemented timely. Senior leaders primarily relied on the RCA and failed to effectively utilize High Reliability Organization (HRO) principles to identify and address issues related to the discharge.

Deficiencies with Root Cause Analysis and Implementation of the Action Plan

An RCA is a tool that may be used to identify root causes of an adverse event and action plans for correction. [54] Notably, RCAs are not required to address all causes of an event. Facility directors are responsible for chartering RCAs and concurring with RCA action plans prior to implementation. Staff directly involved in the event must be excluded from the RCA team to ensure objectivity and credibility.[55]

The interim Facility Director told the OIG of learning about the patient's discharge from a patient safety report. The interim Facility Director chartered an RCA the following week.[56] During the RCA team's presentation of findings, the interim Facility Director became aware of a staff member's involvement in the event. The interim Facility Director explained relying on the quality team to not include inappropriate staff members in the charter.

The care coordination manager reported recommending the staff member who had been involved in the patient's discharge despite having awareness of the staff member's involvement. The care coordination manager conveyed the inaccurate belief that the recommendation was appropriate due to the staff member's knowledge of discharge planning and transportation. The patient safety manager told the OIG of the incorrect belief that the staff member was not involved with the discharge, therefore having no concerns. The staff member explained being unaware of an issue with participating on the RCA team and thus did not self-recuse.

The interim Facility Director told the OIG of planning to charter a new RCA due to the staff member's inappropriate involvement and the belief that the RCA did not address concerns

[54] "Root Cause Analysis (RCA)," VA National Center for Patient Safety, accessed July 5, 2024, https://dvagov.sharepoint.com/sites/vhancps/SitePages/Root-Cause-Analysis.aspx. (This website is not publicly accessible.)

[55] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 14*, March 2024. This guide was subsequently updated. The January 2025 version of the guide contains the same or similar language as the March 2024 guide regarding RCA's not addressing all causes of an event, facility director responsibility, and the exclusion of staff involved in the event from the RCA team.

[56] The patient safety manager explained that RCA team members are identified by facility leaders who are educated to identify staff for participation who have not been involved in the event. The patient safety manager then prepares the root cause analysis charter, which is reviewed and signed by the Facility Director.

related to the patient's discharge. The interim Facility Director told the OIG of not concurring with the action plan and requesting a new charter during the presentation and further explained that the quality team did not provide the new charter prior to the interim Facility Director leaving the position. The patient safety manager informed the OIG that the request for a new charter was not communicated to the patient safety team and thus was not completed. Due to conflicting information, the OIG was unable to determine why a new RCA was not chartered.

The interim Facility Director reported vacating that role nine days after the RCA presentation. The Associate Director of Patient Care Services (ADPCS) told the OIG of being the acting Facility Director for two weeks during which time, a meeting was held with the VISN quality management and patient safety officers to discuss the lack of timeliness in completing the RCA. The ADPCS told the OIG of being unaware of the specific reasons why the interim Facility Director had concerns and concurring with the RCA action plan. The interim Facility Director reported the belief that the ADPCS was aware of the staff member's involvement in the event because the information was shared during the RCA presentation. However, the ADPCS told the OIG of not attending the RCA presentation and being unaware of the staff member's involvement.

The OIG reviewed the RCA action plan, which had two actions, and found that one of the actions was not completed by the planned implementation date. The OIG noted that the Associate Director was the senior leader supervising the staff member assigned to implement both RCA actions. The Associate Director told the OIG of being unaware of the status of the RCA actions and relying on the chief of HAS to provide updates.[57] The chief of HAS told the OIG of providing regular updates to the Associate Director but was unable to provide documentation due to the updates being informal.

The OIG concluded that the RCA lacked objectivity and credibility to address concerns related to the patient's spring discharge. Although the interim Facility Director planned to address concerns with the RCA by chartering a new RCA, a new RCA was not chartered. Further, the Associate Director, who was the senior leader responsible for overseeing implementation of the RCA actions, did not ensure the actions were implemented by the due date.

HRO Principles Not Utilized

In 2018, VHA started efforts to become an HRO with a culture that utilizes safety values and practices to "prevent harm and learn from mistakes." Leaders should be engaged, actively seek knowledge, and set the tone for facility culture by creating opportunities to interact with frontline

[57] The Associate Director was unable to explain the lack of awareness of some RCA actions despite receiving monthly updates.

staff and provide feedback for actions that were taken.[58] Also, leaders should commit to safeguarding a climate of bidirectional communication.

Senior leaders described the patient's discharge as, "unethical probably," "horrible," and "the care of the veteran was inappropriate, veteran always first." One leader stated, "I was shocked that we would have done that to a human being." Despite these descriptions, the OIG found that senior leaders' efforts to review and learn from the patient's discharge did not match the expressed sentiments. The OIG would have expected senior leaders to actively seek knowledge and ensure that feedback was provided to the staff who were involved. The senior leaders responsible for oversight of the staff involved in the deficiencies related to the patient's spring discharge included the COS, ADPCS, and Associate Director.[59]

The COS is responsible for oversight of the medical care and medical staff, including podiatrists, at the facility. The former COS told the OIG of requesting that the deputy COS, who became the acting COS approximately four weeks after the patient's discharge, review the event. The acting COS requested the completion of peer reviews and told the OIG that the chief of surgery and chief of podiatry spoke with the podiatrist about the patient's discharge.[60] However, the OIG conducted interviews approximately six months after the patient's discharge and found that the podiatrist continued to lack knowledge related to patient transfers and reported receiving no feedback related to the discharge. Also, the emergency department provider reported remaining unaware of the 8G eligibility priority group and not receiving training related to 8G. The former COS left the position approximately three weeks after the event, but acknowledged missing an opportunity to learn why the medical providers did not make contact regarding the discharge stating, "I wish I would have been a little more aggressive … to find out why did I not get a phone call." Neither the former nor acting COS ensured that the involved providers were given feedback related to the patient's admission, discharge, and coordination of care.

The ADPCS is responsible for the oversight of social work and nursing staff at the facility. The ADPCS reported requesting that the acting chief of social work review the patient's discharge. During an interview, the OIG learned that the acting chief of social work spoke with the social work supervisor about the discharge and told the social work supervisor that the patient's

[58] Gary L. Sculli and Robin Hemphill, "Culture of Safety and Just Culture," VHA National Center for Patient Safety, accessed May 31, 2024, https://uthscsa.edu/medicine/sites/medicine/files/2023-08/Culture%20of%20Safety%20and%20Just%20Culture.pdf; VHA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024. (This site is not publicly accessible.)

[59] The OIG analyzed senior leaders' response to the spring discharge, which was reported through a patient safety report.

[60] VHA policy defines a peer review for quality management as "a critical review of care performed by a peer" to include "identification of learning opportunities for practice improvement and any related improvement actions recommended." VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

discharge was unacceptable.[61] The OIG found that the ADPCS was unaware that the former chief of social work directed the social work supervisor to facilitate the patient's discharge, despite reporting speaking to the former social work chief about the discharge.

The OIG found that the ADPCS did not take adequate action to learn of nursing staff's involvement with the event, therefore missing an opportunity to address deficits outlined in this report. Specifically, the ADPCS told the OIG of not reviewing the patient's EHR and choosing not to discuss the event with frontline staff due to concern of appearing punitive. Notably, the ADPCS was unaware of which NOD was involved with the patient's discharge and if the staff contacted the transfer coordinator. The OIG concluded that the ADPCS's actions and statement contradicted HRO's principles of actively seeking knowledge and creating opportunities to interact with frontline staff and provide feedback.

The Associate Director is responsible for the oversight of enrollment and eligibility, MSAs, and HIMS staff at the facility. In response to learning about the discharge, the Associate Director reported the belief that the concerns in the patient safety report were primarily related to medical and social work staff and reported not having a role in addressing the concerns. The Associate Director told the OIG of speaking to the chief of HAS to ensure that providers are aware of eligibility requirements for patients to receive care at the facility. The Associate Director informed the OIG of being aware that the patient later became eligible to receive care at the facility but reported it was not the role of the Associate Director to know why or how the patient became eligible. As a result, the Associate Director was unable to identify and correct related process and knowledge deficiencies. The Associate Director reported not actively seeking further information but instead relying on the service chief to bring concerns forward. The Associate Director's statement to the OIG did not align with HRO's goals of creating an environment for bidirectional communication and actively seeking knowledge.

The OIG concluded that senior leaders did not effectively utilize HRO principles to identify and address the full scope of staff's process failures related to the patient's discharge.

Deficiencies in First-Year Podiatry Resident Supervision

The OIG determined that podiatry residents were not routinely supervised in accordance with VHA policy. Specifically, postgraduate year-1 (PGY-1) residents were providing patient care while on-call during nights, weekends, and holidays without on-site supervision by a more senior podiatry resident or attending podiatrist.[62]

[61] The acting chief of social work reported being in the role since May 1, 2024, and prior to, being in the assistant chief of social work role.

[62] VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents,* November 7, 2019.

According to VHA policy, PGY-1 residents must have on-site supervision, defined as the presence of a supervising practitioner or more senior resident within the VA medical facility.[63] The facility residency program director is responsible for monitoring the quality of the training program.[64]

The OIG interviewed the podiatrist, a podiatry resident, and the podiatry residency program director (also the chief of podiatry) who provided consistent responses regarding facility practices for the supervision of PGY-1 podiatry residents. From these interviews, the OIG learned that at the beginning of the PGY-1 year, residents are assigned a few weeks of "buddy call" with a senior resident, after which they begin taking on-call duties independently.[65] PGY-1 podiatry residents took on-call duties for nights, weekends, and holidays from home and managed some calls entirely by telephone, but other calls required them to return to the facility for evaluation of a patient. In situations that required a resident to return to the facility, patients were commonly assessed without on-site supervision and then discussed with the on-call podiatry attending over the phone. However, if patients were assessed to need emergent surgery, the attending podiatrist would always return to the facility.

During an interview with the OIG, the podiatry residency program director provided an explanation of not becoming familiar with VHA's supervision of medical residents directive until "recently" and was unsure if the supervision rule applied to emergency department consults. The Deputy National Podiatry Program Office leader responded to a related email inquiry from the podiatry residency program director with confirmation that PGY-1 podiatry residents should not evaluate an initial consult "alone" but instead should be accompanied by an attending or a more senior resident.[66]

[63] VHA Directive 1400.01. Residents are health care trainees and contribute to the care of patients under the supervision of designated members of the medical staff, while learning their specialty. However, a PGY-1 resident may fail to recognize and address significant patient conditions early and with the urgency of a more senior clinician and is therefore required by VHA to have on-site supervision during all patient encounters.

[64] VHA Directive 1400.01. A residency director (also known as a "program director") is a member of the facility or affiliated academic medical center's medical staff who is responsible for the clinical and didactic education of residents training in their specialty in medicine.

[65] Podiatry, dentistry, and individual medical specialties require completion of varying years of postgraduate training ("residency") to be considered board-eligible for their respective disciplines. After graduation from professional school in the spring, the typical "start" to a residency year is approximately July 1 and ends the following June 30. Each successive year of residency follows that calendar. "Buddy call" is when a more senior resident is on-call with a PGY-1 resident to prepare them for increased responsibility.

[66] VHA Directive 1400.01. Indirect supervision occurs when a supervising practitioner "is not physically present with the resident and patient during the patient encounter, procedure, or episode of care. In all such instances, the supervising practitioner … is on-call by telephonic, video-conferencing, or other electronic modalities for consultation." The podiatry residents involved with the patient's emergency department care were PGY-1 podiatry residents. However, the OIG determined that their method of supervision had no impact on this particular patient's care.

In the fall of 2024, the OIG learned from the podiatrist and the podiatry residency director that changes had been made to the facility's on-call system for PGY-1 podiatry residents to ensure compliance with VHA's resident supervision directive. In October 2024, the OIG reviewed the facility's updated residency program manual and confirmed alignment with PGY-1 supervision requirements as mandated by VHA's resident supervision directive.

The OIG concluded that PGY-1 podiatry residents were on-call without consistent on-site supervision, placing patients at risk. The OIG confirmed that subsequent changes implemented by the facility corrected the deficiency.

Conclusion

After the patient's transmetatarsal amputation in early 2024, outpatient services through the facility were planned, including a follow-up podiatry appointment, despite staff being aware that the patient was labeled as ineligible for care at the facility. As a result, the appointment was canceled, and the patient did not receive follow-up care.

In the spring of 2024, the emergency department provider was unaware that the patient was labeled as ineligible for care at the facility and, therefore, did not follow stated practice to transfer or obtain the COS's approval to admit the patient. In a meeting prior to the patient's discharge, the social work supervisor, former chief of social work, and enrollment and eligibility supervisor failed to discuss pertinent financial information that could have led to the patient becoming eligible. The podiatrist's lack of knowledge that care could have been continued at the facility and the covering transfer coordinator's inaccurate information about transferring and transporting the patient contributed to the decision to discharge the patient. Staff did not identify a door-to-door transportation option due to inaccurate information and instead had the patient call 911. Staff did not provide the patient with discharge paperwork or contact the providers at the community hospital to provide relevant information. The patient's nurse attempted to escalate concern about the discharge, but the NOD did not recognize the attempt or gather additional information. Instead, the NOD assisted with the discharge plan.

The OIG concluded that the patient's financial information could have been corrected in early 2024; however, due to the social work staff's knowledge deficits, the correction was not completed. The information was corrected approximately three months later; however, the delay and failure to follow processes for patients who are ineligible to receive care at the facility resulted in the patient's lack of postsurgical follow-up care and abrupt discharge to a bench to await 911 transport to a community hospital for care.

Facility leaders took steps to review the patient's spring 2024 discharge; however, the OIG identified deficiencies with the RCA process and failures to leverage HRO principles when addressing the event, which resulted in missed opportunities to identify mistakes, provide feedback to staff, and implement change to ensure nonrecurrence. In addition, PGY-1 podiatry

residents were on-call without consistent on-site supervision, placing patients at risk. The OIG confirmed that subsequent changes implemented by the facility corrected the deficiency.

Recommendations 1–15

1. The VA New Mexico Healthcare System Director ensures that social work staff are knowledgeable that 10-10EZR forms can be completed at any time to correct a patient's financial information and documents are not required to verify financial information.

2. The VA New Mexico Healthcare System Director reviews the ineffective communication, collaboration, and utilization of available sources of information by social work staff and the enrollment and eligibility supervisor and ensures the ongoing assessment of barriers that could affect patients' care.

3. The VA New Mexico Healthcare System Director identifies why postsurgical follow-up care was not coordinated for the patient and takes action as warranted.

4. The VA New Mexico Healthcare System Director educates emergency department providers on the expectation for identifying the eligibility of each patient who requires admission and the need to obtain Chief of Staff approval if an ineligible patient necessitates care at the facility.

5. The VA New Mexico Healthcare System Director ensures that inpatient providers are aware of the process to obtain Chief of Staff approval for an ineligible patient to continue care at the facility when clinically indicated.

6. The VA New Mexico Healthcare System Director reviews the process for note retractions and ensures providers and document specialists are trained on the process.

7. The VA New Mexico Healthcare System Director ensures that inpatient social workers, providers, transfer coordinators, and nurses are aware that ineligible patients can be transferred from the facility and provides education related to the processes required for approval and facilitation of the transfer.

8. The VA New Mexico Healthcare System Director monitors compliance with the requirement that discharge paperwork is provided to each patient who is discharged.

9. The VA New Mexico Healthcare System Director ensures that providers communicate relevant information to community healthcare providers as needed to ensure continuity of care.

10. The VA New Mexico Healthcare System Director evaluates that staff (inpatient social workers, providers, transfer coordinators, nurses, and the nursing officer of the day) are aware that ineligible patients can be transported from the facility and provides education related to the processes required for approval and facilitation of the transport.

11. The VA New Mexico Healthcare System Director educates staff on steps to take if attempts to escalate concerns to their supervisors are not adequately addressed.

12. The VA New Mexico Healthcare System Director reviews the facility's root cause analysis process, ensures that staff directly involved in an adverse event do not participate in root cause analysis of an event, and considers if another root cause analysis should be completed on this event.

13. The VA New Mexico Healthcare System Director makes certain that leaders are aware when assigned as responsible for root cause analysis action items and adhere to action plan due dates.

14. The VA New Mexico Healthcare System Director takes action to ensure that leaders understand and effectively utilize high reliability organization principles noted in this report to identify and correct deficiencies.

15. The VA New Mexico Healthcare System Director monitors the podiatry residency program for compliance with VHA Directive 1400.01 postgraduate year 1 resident supervision requirements.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 21, 2025

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Office of Inspector General (OIG) Draft Report, Healthcare Inspection—Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque

To: Director, Office of Healthcare Inspections (54HL10)
Executive Director, Office of Integrity and Compliance (10OIC)

1. Veterans Integrated Services Network (VISN) 22 appreciates the opportunity to work with the OIG's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the findings and recommendations 1-15. I have provided an action plan in the attachment.

2. Should you need further information, please contact the VISN 22 Quality Management Officer.

(*Original signed by:*)

Stephanie Young, MHA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on June 13, 2025.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 21, 2025

From: Director, VA New Mexico Healthcare System (501/00)

Subj: Office of Inspector General (OIG) Draft Report, Healthcare Inspection—Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Inspection – Failures Related to the Care and Discharge of a Patient and Leaders' Response at the VA New Mexico Healthcare System in Albuquerque. VA New Mexico Healthcare System concurs with the recommendations and will take appropriate action.

2. Should you need further information, please contact the Chief of Quality Management and Patient Safety.

(*Original signed by*:)

Breton M. Weintraub, M.D., FACP

[OIG comment: The OIG received the above memorandum from VHA on June 13, 2025.]

Facility Director Response

Recommendation 1

The VA New Mexico Healthcare System Director ensures that social work staff are knowledgeable that 10-10EZR forms can be completed at any time to correct a patient's financial information and documents are not required to verify financial information.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The Department of Veterans Affairs (VA) New Mexico Healthcare System Director will ensure that social workers are knowledgeable that VA Form 10-10EZR can be completed at any time to correct a patient's financial information and documents are not required to verify financial information.

On June 20, 2024, education was provided to the social work team by the inpatient Social Work Supervisor, about the VA Form 10-10EZR documentation and process. Continuing education is provided every 6 months and/or as new staff are hired. Additionally, since August 2024, the social work team in the Emergency Department and the inpatient medicine teams are completing the Assessing Circumstances and Offering Resources for Needs screening tool, which could trigger a Social Work initial assessment if concerns related to unmet health related social needs, including financial resources, housing, and transportation are identified.

To demonstrate compliance, the Chief of Health Administration Service (HAS) and the Chief of Social Work Services (SWS) will report monthly to the Quality Board. Compliance will be measured through monitoring of required staff who have received and completed education about VA Form 10-10EZR, with a goal of 90% compliance.

Recommendation 2

The VA New Mexico Healthcare System Director reviews the ineffective communication, collaboration, and utilization of available sources of information by social work staff and the enrollment and eligibility supervisor and ensures the ongoing assessment of barriers that could affect patients' care.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The VA New Mexico Healthcare System Director reviewed the ineffective communication, collaboration, and utilization of available sources of information by social work staff and the enrollment and eligibility supervisor and ensures the ongoing assessment of barriers that could affect patients' care.

On June 20, 2024, education was provided to the social work team by the inpatient SWS Supervisor, about VA Form 10-10EZR, documentation, and processes. Continuing education is provided to the social work team every 6 months and/or as new staff are hired. Collaboration occurs between HAS and SWS for patients who are deemed ineligible for care and ongoing communication for other enrollment criteria.

The HAS team collaborated with the SWS team to educate social workers at a bi-monthly new employee orientation (NEO) for social work staff beginning January 2024. Additional separate education is provided approximately every 6 months for the inpatient social workers and Emergency Department social workers, as they primarily treat any humanitarian patients.

To demonstrate compliance, the Chief of HAS and the Chief of SWS will report monthly to the Quality Board. Compliance will be measured through monitoring of required staff who have received and completed education about ineffective communication, collaboration, and utilization of available sources of information, with a goal of 90% compliance.

Recommendation 3

The VA New Mexico Healthcare System Director identifies why postsurgical follow-up care was not coordinated for the patient and takes action as warranted.

__X__Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The VA New Mexico Healthcare System Director identified why postsurgical follow-up care was not coordinated for the patient and is taking action as warranted.

The Veteran's post-operative wound care appointment was scheduled for February 21, 2024. The Advanced Medical Support Assistant cancelled the appointment because of misunderstandings in the report. The podiatry team was not notified of the cancellation. To prevent a reoccurrence of this situation, HAS will develop a process to communicate when ineligible Veteran appointments are cancelled to the ordering provider for appropriate follow-up. On July 24, 2024, the VA New Mexico Healthcare System conducted two protected peer reviews for quality management to

review and identify any clinical decision-making concerns. Postsurgical care was coordinated and subsequently canceled due to the patient's eligibility status.

To demonstrate compliance, the Chief of HAS will report monthly to the Quality Board. Compliance will be measured by monitoring required staff who have received and completed education on the developed process. The compliance goal is 90%. compliance.

Recommendation 4

The VA New Mexico Healthcare System Director educates emergency department providers on the expectation for identifying the eligibility of each patient who requires admission and the need to obtain Chief of Staff approval if an ineligible patient necessitates care at the facility.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The VA New Mexico Healthcare System Director will ensure education to the Emergency Department providers on the expectation for identifying the eligibility of each patient who requires admission and the need to obtain Chief of Staff approval if an ineligible patient necessitates care at the facility.

The HAS team provided education to administrative officers on duty and medical support assistants regarding eligibility requirements for patients presenting to the VA New Mexico Healthcare System for care. A standard operating procedure (SOP) titled "Management of Humanitarian Emergencies" was signed on March 31, 2025. The SOP outlines the standardized process for identifying ineligible Veterans on the Emergency Department integration software patient tracking board in the Emergency Department.

Between March and June 2024, multiple in-services were held with clinical staff to review Basic enrollment and eligibility education, to include topics such as how ineligible patients can be transferred from the facility; the processes required for approval; and the facilitation of the transfer. As new staff are hired, the HAS team will continue to provide education on basic enrollment and eligibility to Emergency Department providers.

To demonstrate compliance, the Chief of Emergency Medicine will report the Basic Enrollment and Eligibility training monthly to the Quality Board. Compliance will be measured through monitoring of required staff who have received and completed education on identifying the eligibility of each patient who requires admission and the need to obtain Chief of Staff's approval if an ineligible patient necessitates care at the facility. The compliance goal is 90%.

Recommendation 5

The VA New Mexico Healthcare System Director ensures that inpatient providers are aware of the process to obtain Chief of Staff approval for an ineligible patient to continue care at the facility when clinically indicated.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The VA New Mexico Healthcare System inpatient providers were educated on the process to obtain Chief of Staff approval for an ineligible patient to continue care at VA New Mexico Healthcare System when clinically indicated. On March 31, 2025, an SOP, Management of Humanitarian Emergencies, was published detailing the process for admitting humanitarian patients, to include seeking approval from the Chief of Staff or Medical Center Director. The VA New Mexico Healthcare System also communicated the need to escalate concerns to service line leadership or higher if needed. Inpatient providers will notify the Chief of Staff when an ineligible patient requires hospital admission.

Education regarding patient care eligibility has been provided to all providers and continues to be ongoing as new staff are hired during orientation.

Between March and June 2024, multiple in-services were held with clinical staff to review basic enrollment and eligibility education which includes how ineligible patients can be transferred from the facility, the processes required for approval, and facilitation of the transfer.

To demonstrate compliance, the Chief of Medicine will report monthly to the Quality Board. Compliance will be measured through monitoring of required staff who have received and completed education about obtaining Chief of Staff approval for an ineligible patient to continue care at the facility when clinically indicated. The compliance goal is 90%.

Recommendation 6

The VA New Mexico Healthcare System Director reviews the process for note retractions and ensures providers and document specialists are trained on the process.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The VA New Mexico Healthcare System Director will ensure a review of the process for note retractions and ensure providers and document specialists are trained on the process.

On April 10, 2025, the HAS Chief educated the Health Information Management Service staff and the Clinical Service Chiefs on the correct VA New Mexico Healthcare System policy for note retractions.

To demonstrate compliance, the Chief of HAS will report monthly to the Quality Board. Compliance will be by monitoring of required staff who have received and completed education on the process for note retractions. The compliance goal is 90%.

Recommendation 7

The VA New Mexico Healthcare System Director ensures that inpatient social workers, providers, transfer coordinators, and nurses are aware that ineligible patients can be transferred from the facility and provides education related to the processes required for approval and facilitation of the transfer.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The VA New Mexico Healthcare System Director will ensure that inpatient social workers, providers, transfer coordinators, and nurses are aware that ineligible patients can be transferred from the facility and provide education on the processes required for approval and facilitation of the transfer.

Between March and June 2024, multiple in-services were held to educate clinical staff on basic enrollment and eligibility requirements, to include that ineligible patients can be transferred from the facility; the processes required for approval; and the facilitation of patient transfers.

On June 21, 2024, the Chief of Staff provided training to all providers regarding the transfer of patients, which included guidance on the appropriate forms required for interfacility transfer.

To demonstrate compliance, the Chief of Social Work Services, Chief of Staff, and the Associate Director of Patient Care Service will report education and attendance monthly to the Quality Board. Compliance will be measured through monitoring of required staff who have received and completed education on the processes required for approval and facilitation of the transfer. The compliance goal is 90%.

Recommendation 8

The VA New Mexico Healthcare System Director monitors compliance with the requirement that discharge paperwork is provided to each patient who is discharged.

__X__Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The VA New Mexico Healthcare System Director will monitor compliance with the requirement that discharge paperwork is provided to each patient who is discharged.

Nursing staff are tasked with ensuring discharge paperwork is provided to each patient who is discharged. Education about providing discharge paperwork to patients at discharge will be developed by Nursing Education Services and incorporated into the Nursing New Employee Orientation. Nursing Service will coordinate with the Emergency Department nurse educator and nurse managers to provide the same instruction to the Emergency Department staff by June 30, 2025.

To demonstrate compliance, the Nursing Service will report monthly to the Quality Board. Compliance will be measured by monitoring required staff who have received and completed the education on the requirement that discharge paperwork is provided to each patient who is discharged. The compliance goal is 90%.

Recommendation 9

The VA New Mexico Healthcare System Director ensures that providers communicate relevant information to community healthcare providers as needed to ensure continuity of care.
__X__Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The VA New Mexico Healthcare System Director will ensure that providers communicate relevant information to community health care providers as needed to ensure continuity of care.

On June 21, 2024, the Chief of Staff provided education and instructions to all providers regarding the transfer of patients, which included guidance on the appropriate forms required for an interfacility transfer to ensure continuity of care.

To demonstrate compliance, the Transfer Coordinator will report monthly to the Quality Board. Compliance will be measured by monitoring the required staff who have received and completed education on providers communicating relevant information to community health care providers as needed to ensure continuity of care. The compliance goal is 90%.

Recommendation 10

The VA New Mexico Healthcare System Director evaluates that staff (inpatient social workers, providers, transfer coordinators, nurses, and the nursing officer of the day) are aware that ineligible patients can be transported from the facility and provides education related to the processes required for approval and facilitation of the transport.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The VA New Mexico Healthcare System Director will evaluate that staff (inpatient social workers, providers, transfer coordinators, nurses, and the nursing officer of the day) are aware that ineligible patients can be transported from the facility and provides education related to the processes required for approval and facilitation of the transport.

Education is provided to Social Workers on insurance transportation resources outside of VA for patients who do not have transportation benefits. Additionally, the Social Work Service (SWS) team is advised to work with the Transfer Coordinator if a patient needs additional care. Continuing education is provided to the SWS team every 6 months and/or as new staff are hired. A humanitarian group email (VHAABQ Humanitarian Admissions) was created to notify the group (consisting of HAS, Psychiatry Chief, Discharge Registered Nurse Planner, Chief of Staff, Deputy Chief of Staff, SWS Assistant Chief, SWS Chief, Associate Director of Patient Care Services, and Nursing Officer of the Day) upon check-in at the Emergency Department for continuity and communication throughout disciplines.

The HAS team started collaborating with the SWS team to instruct Social Workers on the Basic Enrollment and Eligibility policy at a bi-monthly New Employee Orientation for Social Work Services staff. Additionally, separate education sessions will be developed with a focus on transportation options for ineligible/humanitarian patients.

Between March and June 2024, multiple in-services were held with clinical staff to review basic enrollment and eligibility education, to include that ineligible patients can be transferred from the facility; the processes required for approval; and the facilitation of the patent transfer.

To demonstrate compliance, the Chief of SWS, Chief of Staff, and the Associate Director of Patient Care Service will report monthly to the Quality Board monthly. Compliance is measured by monitoring the required staff who received and completed education about how ineligible patients are transported from the facility; the processes required for approval of the transport; and the facilitation of the transport. The compliance goal is 90%.

Recommendation 11

The VA New Mexico Healthcare System Director educates staff on steps to take if attempts to escalate concerns to their supervisors are not adequately addressed.

__X__Concur

____Nonconcur

Target date for completion: September 2025

Director Comments

The VA New Mexico Healthcare System Director will educate staff on the steps to take if attempts to escalate concerns to their supervisors are not adequately addressed.

Between May and August 2024, multiple in-services were held with clinical staff by local and guest speakers to ensure staff understood the steps to take if attempts to escalate concerns to their supervisors are not adequately addressed.

The VA New Mexico Healthcare System Patient Safety Managers continued to provide Stop the Line and Culture of Safety presentations routinely in NEO, service line meetings, patient safety forums, daily huddles, and All Employee Town Hall meetings.

To demonstrate compliance, the VA New Mexico Healthcare System Chief of Quality and Patient Safety will report monthly to Quality Board monthly. Compliance will be measured through monitoring of required staff who have received and completed education on steps to take if attempts to escalate concerns to their supervisors are not adequately addressed, with a goal of 90% compliance.

Recommendation 12

The VA New Mexico Healthcare System Director reviews the facility's root cause analysis process, ensures that staff directly involved in an adverse event do not participate in root cause analysis of an event, and considers if another root cause analysis should be completed on this event.

__X__Concur

____Nonconcur

Target date for completion: June 2024

Director Comments

The VA New Mexico Healthcare System Director strictly follows the National Center for Patient Safety (NCPS) Guide to Performing Root Cause Analyses. RCA team members are not to be "directly involved in the event." We will take care to avoid similar circumstances in the future and commit to providing additional training to staff, thereby adhering to the best practices as recommended by the NCPS.

OIG Comments

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

Recommendation 13

The VA New Mexico Healthcare System Director makes certain that leaders are aware when assigned as responsible for root cause analysis action items and adhere to action plan due dates.

__X__Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The VA New Mexico Healthcare System Director concurs to ensure that leaders are aware when assigned as responsible for root cause analysis action items and adhere to action plan due dates. Beginning May 2024, the Patient Safety Managers implemented a memorandum for all RCA action plans, including due dates, that is signed by the Director. This signed memorandum is sent electronically to the individuals responsible for the action plan and associated Executive Leadership Team member.

To demonstrate compliance, Patient Safety will report total RCA action plans (actions and outcome measures) quarterly to the Quality Board. The numerator is the total number of RCA actions and outcome measures that are completed on time or early. The denominator is the total number of open RCA actions and outcome measures. Compliance will be measured through the monitoring of required staff who have received and completed education so that leaders are aware when assigned as responsible for root cause analysis action items and adhere to action plan due dates. The compliance goal is 90%.

Recommendation 14

The VA New Mexico Healthcare System Director takes action to ensure that leaders understand and effectively utilize high reliability organization principles noted in this report to identify and correct deficiencies.

__X__Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The VA New Mexico Healthcare System Director continued the journey towards high reliability through several means, including daily patient safety stories (Decision Management System Operations meeting), use of visual management systems, weekly leadership rounds by the executive leadership team (ELT) and service line leadership, continuous process improvement sponsored by, but not limited to, the Quality and Patient Safety department, and use of Just Culture principles. Additionally, presentations by local and guest speakers were provided throughout the facility to ensure leadership understanding on high reliability organization principles.

The VA New Mexico Healthcare System Patient Safety Managers continued to provide Stop the Line and Culture of Safety presentations routinely in NEO, service line meetings, patient safety forums, daily huddles, and All Employee Town Halls.

The VA New Mexico Healthcare System is also implementing an integrated tiered safety huddle structure supported by the visual management system across departments within the facility.

To monitor compliance, the high reliability organization (HRO) lead will report the HRO education and attendance monthly to the Quality Board. Compliance will be measured through monitoring of all staff, including newly hired staff, who have received and completed HRO training. The compliance goal is 90%.

In addition, the HRO lead will monitor the effectiveness of the VA New Mexico Healthcare System's high reliability organization principles and report compliance monthly to the Quality Board. The HRO lead will report the ELT leadership rounds schedule; attendance of the rounds by each ELT member; the risks or issues identified during the rounds; the resolution of risks through closed loop communication to the originating staff member(s); and the implementation of tiered safety huddles, supported by visual management systems and weekly leadership rounds, to ensure the effective utilization of HRO principles. The compliance goal is 90%.

Recommendation 15

The VA New Mexico Healthcare System Director monitors the podiatry residency program for compliance with VHA Directive 1400.01 postgraduate year 1 resident supervision requirements.

__X__Concur

____Nonconcur

Target date for completion: December 2025

Director Comments

The VA New Mexico Healthcare System Director will monitor the podiatry residency program for compliance with VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, for postgraduate year 1 (PGY-1) resident supervision requirements.

On June 14, 2024, the Acting Chief of Surgical Services informed all the Podiatry attendings of the supervision changes and provided them with the residency supervision policy. From June 14, 2024, to current, all PGY-1 residents are supervised per VHA Directive 1400.01. On June 28, 2024, this information was shared with all the new incoming residents at the Podiatry orientation.

To demonstrate compliance, the Surgical Chief will report monthly to the Quality Board. Compliance will be measured through monitoring of required staff who have received and completed education on VHA Directive 1400.01 for PGY-1 resident supervision requirements, with a goal of 90% compliance. Compliance will also be measured through audits of podiatry residency program call schedules to ensure attending supervision. The compliance goal is 90%.

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