



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare  
Inspection Summary Report:  
Evaluation of Care  
Coordination in Veterans  
Health Administration  
Facilities, Fiscal Year 2021



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Source: <https://www.gsa.gov/real-estate/gsa-properties/visiting-public-buildings/veterans-administration-building> (accessed June 24, 2021).

## Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
CI	confidence interval
OIG	Office of Inspector General
VHA	Veterans Health Administration



## Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected care coordination program requirements related to inter-facility patient transfers. The OIG initiated unannounced inspections at 45 VHA medical facilities from November 30, 2020, through August 23, 2021.<sup>1</sup> Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.<sup>2</sup>

## Inspection Results

The OIG found general compliance with some of the selected care coordination requirements. However, the OIG identified weaknesses with the

- existence of facility policies for inter-facility transfers,
- monitoring and evaluation of inter-facility transfers,
- transmission of patients' active medication lists and advance directives to the receiving facilities, and
- communication between nurses at sending and receiving facilities.

Improvement in these areas is critical for seamless care and patient safety.

## Conclusion

The OIG conducted detailed inspections at 45 VHA facilities to ensure the facilities implemented selected care coordination program processes. The OIG subsequently issued four recommendations for improvement to the Under Secretary for Health in conjunction with

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<sup>1</sup> The OIG performed a limited review at the VA Central Western Massachusetts Healthcare System (Leeds), but the results of the inspection were omitted from this report's analysis since the healthcare system ceased urgent care center operations on March 1, 2020.

<sup>2</sup> Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

Veterans Integrated Service Network directors and facility senior leaders. VHA leaders should use the results in this report to improve operations and clinical care at the facility level. The recommendations address findings that may prevent the delivery of quality health care.

## **VA Comments**

The Under Secretary for Health concurred or concurred in principle with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendix C, page 11, and the responses within the body of the report for the full text of the executive's comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.



JOHN D. DAIGH, JR., M.D.  
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## Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

The OIG selects and evaluates specific areas of focus on a rotating basis each year since the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.<sup>1</sup> These leaders are directly accountable for program integration and communication within their level of responsibility.

VHA's goal is to serve as the nation's leader in delivering high quality, safe, reliable, and veteran-centered care.<sup>2</sup> To meet this goal, VHA requires that its medical facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.<sup>3</sup> Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as those from The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, access, and patient experience."<sup>4</sup>

Inter-facility transfers are necessary to provide access to specific providers, services, or levels of care. While there are inherent risks in moving an acutely ill patient between facilities, there is also risk in not transferring a patient when his or her needs can be better managed at another facility.<sup>5</sup>

VHA medical facility directors are "responsible for ensuring that a written policy is in effect that ensures the safe, appropriate, orderly, and timely transfer of patients."<sup>6</sup> Further, VHA staff are

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<sup>1</sup> Caregivers and Veterans Omnibus Health Services Act of 2010, Pub. L. No. 111-163, § 505 (2010).

<sup>2</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

<sup>3</sup> VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

<sup>4</sup> Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*.

<sup>5</sup> VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.

<sup>6</sup> VHA Directive 1094.

required to use the VA *Inter-Facility Transfer Form* or a facility-defined equivalent note in the electronic health record to monitor and evaluate all transfers.<sup>7</sup>

The OIG assessed VHA facilities for their adherence to the following requirements:

- Existence of a facility policy for inter-facility transfers
- Monitoring and evaluation of inter-facility transfers
- Completion of all required elements of the *Inter-Facility Transfer Form* or facility-defined equivalent by the appropriate provider(s) prior to patient transfer
- Transmission of patients' active medication lists and advance directives to receiving facilities
- Communication between nurses at sending and receiving facilities

The OIG initiated unannounced inspections at 45 VHA medical facilities from November 30, 2020, through August 23, 2021.<sup>8</sup> The results in this report are a snapshot of VHA performance at the time of the fiscal year 2021 OIG inspections.<sup>9</sup> The findings may help VHA leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

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<sup>7</sup> A completed VA *Inter-Facility Transfer Form* or an equivalent note communicates critical information to facilitate and ensure safe, appropriate, and timely transfer. Critical elements include documentation of patients' informed consent, medical and/or behavioral stability, mode of transportation and appropriate level of care required, identification of transferring and receiving physicians, and proposed level of care after transfer. VHA Directive 1094.

<sup>8</sup> The OIG performed a limited review at the VA Central Western Massachusetts Healthcare System (Leeds), but the results of the inspection were omitted from this report's analysis since the healthcare system ceased urgent care center operations on March 1, 2020.

<sup>9</sup> Fiscal year 2021 began October 1, 2020, and ended September 30, 2021.

## Methodology

The OIG evaluated compliance with selected care coordination program requirements through comprehensive healthcare inspections during fiscal year 2021. The OIG randomly selected six Veterans Integrated Service Networks for review, and all facilities assigned to these networks were then inspected virtually. These 45 medical facilities represented a mix of size, affiliation, geographic location.

To determine whether VHA complied with OIG-selected inter-facility transfer requirements, the inspection teams reviewed relevant documents, interviewed key employees, and evaluated clinical and administrative processes. The teams also reviewed the electronic health records of 1,898 patients who were transferred from VA medical facilities due to urgent needs to a VA or non-VA facility from July 1, 2019, through June 30, 2020.

The OIG published individual CHIP reports for each facility. For this report, the OIG analyzed data from the individual facility reviews to identify system-wide trends and generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow up until VHA leaders complete corrective actions. The comments and action plans submitted by the Under Secretary for Health in response to the report recommendations appear within the report. The OIG accepted the action plans that the Under Secretary for Health developed based on the reasons for noncompliance.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.<sup>10</sup> The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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<sup>10</sup> Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

## Results and Recommendations

The OIG found general compliance with some of the selected care coordination requirements. However, across facilities inspected in fiscal year 2021, the OIG identified weaknesses with the

- existence of facility policies for inter-facility transfers,
- monitoring and evaluation of inter-facility transfers,
- transmission of patients' active medication lists and advance directives to the receiving facilities, and
- communication between nurses at sending and receiving facilities.

VHA requires medical facility directors to ensure that each VA facility has a written policy in place for “the safe, appropriate, orderly, and timely transfer of patients.”<sup>11</sup> The OIG found that 8 of 44 facilities (18 percent) did not have a current inter-facility transfer policy. Failure to maintain an inter-facility transfer policy could result in lack of coordination between facilities to provide seamless care for patients. Reasons for noncompliance included staff's lack of awareness of the requirement and inadequate oversight.

### Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures medical facility directors make certain that a written policy is in place and implemented for the safe, appropriate, orderly, and timely transfer of patients.

VHA concurred in principle.

Target date for completion: August 2023

Under Secretary for Health response: The Specialty Care Program Office is updating the national Inter-facility Transfer Policy and will publish it when completed. The Specialty Care Program Office will communicate responsibilities regarding local policy and policy implementation to Veterans Integrated Service Networks (VISNs) and facilities once the policy is published. VHA concurs in principle because VHA would not necessarily require each facility to create local policy when they can follow the national policy.

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<sup>11</sup> VHA Directive 1094.

VHA requires chiefs of staff and associate directors of patient care services to ensure “all transfers are monitored and evaluated as part of VHA’s Quality Management Program.”<sup>12</sup> The OIG reviewed meeting minutes from the committees responsible for oversight of the transfer process and did not find evidence that staff at 20 of 44 facilities (45 percent) monitored and evaluated transfers. Failure to monitor and evaluate patient transfers could inhibit medical facilities’ performance improvement activities. A typical reason for noncompliance was the staff’s general lack of awareness of the requirement.

## Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures chiefs of staff and associate directors of patient care services monitor and evaluate all transfers as part of Veterans Health Administration’s Quality Management Program.

VHA concurred in principle.

Target date for completion: August 2023

Under Secretary for Health response: VHA will convene a multidisciplinary team to include VHA Specialty Care Program Office, VHA Quality and Patient Safety and VHA Patient Care Services to assess the role and responsibilities of the appropriate personnel in implementation of the Inter-facility Transfer Policy. The multidisciplinary team will review current procedures that monitor and evaluate all inter-facility transfers. The multidisciplinary team will ensure VHA’s updated Inter-facility Transfer Policy contains clear standards for monitoring and evaluating transfers and establishes the appropriate reporting structure at the facility and VISN level. The multidisciplinary team will communicate responsibilities regarding local policy and policy implementation to VISNs and facility once the policy is published.

VHA requires transferring providers to “send all pertinent medical records available, including an active patient medication list and...documentation of the patient’s advance directive” to the receiving facility during inter-facility transfers.<sup>13</sup> The OIG did not find evidence that staff sent an active medication list to the receiving facility for an estimated 30 (95% CI: 19.0 to 39.6) percent of inter-facility transfers, which is statistically significantly above the OIG’s 10 percent deficiency benchmark.<sup>14</sup> Additionally, the OIG did not find evidence that staff provided a copy of the advance directive to the receiving facility for an estimated 72 (95% CI: 54.9 to 87.5)

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<sup>12</sup> VHA Directive 1094.

<sup>13</sup> VHA Directive 1094.

<sup>14</sup> A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

percent of inter-facility transfers, which is statistically significantly above the OIG's 10 percent deficiency benchmark. These deficiencies could have resulted in suboptimal treatment decisions that may have compromised patient safety. Reasons for noncompliance included staff's lack of awareness of requirements and failure to document that necessary information was sent with the patients when they were transferred.

### Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain chiefs of staff ensure that transferring providers send patients' active medication lists and copies of advance directives to receiving facilities during inter-facility transfers.

VHA concurred.

Target date for completion: August 2023

Under Secretary for Health response: The Specialty Care Program Office is updating the national Inter-facility Transfer Policy and will publish it when completed. The Specialty Care Office will ensure VHA's updated Inter-facility Transfer Policy contains clear standards for monitoring and evaluating transfers with respect to ensuring active medication lists and advance directives are transmitted to receiving facilities and establishes the appropriate reporting structure at the facility, VISN and national program office levels. The Specialty Care Program Office, in collaboration with appropriate VHA program offices, will communicate responsibilities regarding local policy and policy implementation to VISNs and facility once the policy is published.

VHA requires chiefs of staff and associate directors of patient care services to ensure nurse-to-nurse communication occurs during the inter-facility transfer process to allow for questions and answers from staff at both sending and receiving facilities.<sup>15</sup> The OIG did not find evidence of nurse-to-nurse communication for an estimated 20 (95% CI: 12.8 to 30.1) percent of inter-facility transfers, which is statistically significantly above the OIG's 10 percent deficiency benchmark. This could have resulted in staff at the receiving facility lacking the information needed to care for patients. Reasons for noncompliance included the staff's lack of awareness of the requirement and attention to detail and inconsistent documentation.

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<sup>15</sup> VHA Directive 1094.

## Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain chiefs of staff and associate directors of patient care services ensure nurse-to-nurse communication occurs during the inter-facility transfer process.

VHA concurred.

Target date for completion: August 2023

Under Secretary for Health response: The Specialty Care Program Office is updating the national Inter-facility Transfer Policy and will publish it when completed. The Specialty Care Office in collaboration with VHA's Office of Patient Care Services/Office of Nursing Services will ensure VHA's updated Inter-facility Transfer Policy contains clear standards regarding nurse-to-nurse communications during inter-facility transfers and clearly establishes oversight responsibilities for communication of critical patient care. The Specialty Care Program Office, in collaboration with VHA's Office of Patient Care Services, will communicate responsibilities regarding local policy and policy implementation to VISNs and facility once the policy is published.

## Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines four OIG recommendations aimed at reducing vulnerabilities that may lead to patient safety issues or adverse events. The recommendations are attributable to the Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders. The intent is for these leaders to use the recommendations to guide improvements in operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

**Table A.1. Summary Table of Recommendations**

Healthcare Processes	Review Elements	Critical Recommendations for Improvement	Recommendations for Improvement
Care Coordination: Inter-facility Transfers	<ul style="list-style-type: none"> <li>• Inter-facility transfer policy</li> <li>• Inter-facility transfer monitoring and evaluation</li> <li>• Inter-facility transfer form/facility-defined equivalent with all required elements completed by the appropriate provider(s) prior to patient transfer</li> <li>• Patient’s active medication list and advance directive sent to receiving facility</li> <li>• Communication between nurses at sending and receiving facilities</li> </ul>	<ul style="list-style-type: none"> <li>• Facility directors make certain that a written policy is in place and implemented for the safe, appropriate, orderly, and timely transfer of patients.</li> <li>• Chiefs of staff and associate directors of patient care services monitor and evaluate all transfers as part of Veterans Health Administration’s Quality Management Program.</li> <li>• Chiefs of staff ensure transferring providers send patients’ active medication lists and copies of advance directives to receiving facilities during inter-facility transfers.</li> <li>• Chiefs of staff and associate directors of patient care services ensure nurse-to-nurse communication occurs during the inter-facility transfer process.</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> </ul>

## Appendix B: Parent Facilities Inspected

**Table B.1. Parent Facilities Inspected  
 (October 1, 2020, through September 30, 2021)**

<b>Names</b>	<b>City</b>
Bay Pines VA Healthcare System	Bay Pines, FL
Beckley VA Medical Center	Beckley, WV
Charles George VA Medical Center	Asheville, NC
Cheyenne VA Medical Center	Cheyenne, WY
Durham VA Health Care System	Durham, NC
Eastern Oklahoma VA Health Care System	Muskogee, OK
Edith Nourse Rogers Memorial Veterans' Hospital	Bedford, MA
Fayetteville VA Coastal Health Care System	Fayetteville, NC
Hampton VA Medical Center	Hampton, VA
Herschel "Woody" Williams VA Medical Center	Huntington, WV
Hunter Holmes McGuire VA Medical Center	Richmond, VA
James A. Haley Veterans' Hospital	Tampa, FL
James J. Peters VA Medical Center	Bronx, NY
Louis A. Johnson VA Medical Center	Clarksburg, WV
Manchester VA Medical Center	Manchester NH
Martinsburg VA Medical Center	Martinsburg, WV
Miami VA Healthcare System	Miami, FL
Montana VA Health Care System	Fort Harrison, MT
North Florida/South Georgia Veterans Health System	Gainesville, FL
Northport VA Medical Center	Northport, NY
Oklahoma City VA Health Care System	Oklahoma City, OK
Orlando VA Medical Center	Orlando, FL
Providence VA Medical Center	Providence, RI
Salem VA Medical Center	Salem, VA
Samuel S. Stratton VA Medical Center	Albany, NY
Sheridan VA Medical Center	Sheridan, WY
Syracuse VA Medical Center	Syracuse, NY
VA Boston Healthcare System	Jamaica Plain, MA
VA Caribbean Healthcare System	San Juan, PR

Names	City
VA Central Western Massachusetts Healthcare System	Leeds, MA
VA Connecticut Healthcare System	West Haven, CT
VA Eastern Colorado Health Care System	Aurora, CO
VA Finger Lakes Healthcare System	Bath, NY
VA Hudson Valley Health Care System	Montrose, NY
VA Maine Healthcare System	Augusta, ME
VA Maryland Health Care System	Baltimore, MD
VA New Jersey Health Care System	East Orange, NJ
VA New York Harbor Healthcare System	New York, NY
VA Salt Lake City Health Care System	Salt Lake City, UT
VA Western Colorado Health Care System	Grand Junction, CO
VA Western New York Healthcare System	Buffalo, NY
W.G. (Bill) Hefner VA Medical Center	Salisbury, NC
Washington DC VA Medical Center	Washington, DC
West Palm Beach VA Medical Center	West Palm Beach, FL
White River Junction VA Medical Center	White River Junction, VT

*Source: VA OIG.*

## Appendix C: Under Secretary for Health Comments

### Department of Veterans Affairs Memorandum

Date: August 19, 2022

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report:  
Evaluation of Care Coordination in Veterans Health Administration Facilities,  
Fiscal Year 2021 (2022-00815-HI-1232) (VIEWS 8034385)

To: Office of Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report Comprehensive Healthcare Inspection Summary Report: Evaluation of Care Coordination in Veterans Health Administration Facilities, Fiscal Year 2021. The Veterans Health Administration (VHA) concurs with Recommendations 3 and 4, and concurs in principle with Recommendations 1 and 2. VHA provided an action plan in the attachment.
2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [VHA10BGOALACTION@va.gov](mailto:VHA10BGOALACTION@va.gov).

*(Original signed by:)*

Shereef Elnahal, M.D., MBA

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