10-12393

HL-810

Administrative Closure
Alleged Patient Care and Contracting Issues
VA Maryland Health Care System, Baltimore, MD
Loch Raven Community Living Center
(2009-03066-HI-0178)

I. Purpose and Objectives

The purpose of the inspection was to determine the validity of four allegations related to quality of patient care, contracting for respite services, access to hospice and acute rehabilitation services, and the role of a clinical manager at the VA Maryland Health Care System (the system).

II. Background

On July 28, 2009, an anonymous complainant faxed a letter to the OIG's Hotline Division and made several allegations about the system and, in particular, the Loch Raven Community Living Center (CLC). The complainant alleged that:

- Delays in transferring three patients from the CLC resulted in poor patient outcomes, including the deaths of two patients and a preventable heart attack for a third patient.
- The system inappropriately contracted for respite care services.
- Bed shortages in the CLC's hospice and acute rehabilitation services resulted in delayed admissions.
- He/she did not understand the role of a clinical manager at the CLC.

In the faxed letter, the complainant provided only the last names of patients; however, based on the issues described by the complainant, system staff were able to identify the patients and their dates of service.

III. Scope and Methodology

- We discussed the allegations with system managers and requested that they conduct an investigation to determine the validity of the allegations and provide us with the results.
- We reviewed the system's investigation to determine if they sufficiently addressed the allegations.
- We also reviewed medical records for the three patients identified by the complainant to better understand the patient care issues and to evaluate the sufficiency of the system's peer reviews.

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IV. Inspection Objectives and Results

At our request, system management investigated the complainant's allegations and concluded that none of the allegations were substantiated. The system's investigation included:

- Reviews of patient census data and waiting lists for the CLC, acute rehabilitation, and hospice.
- Internal peer reviews (by three physicians) of two cases identified by the complainant.
- Review of patient complaint data, including complaints to the Patient Advocate.
- Review of credentialing and privileging and performance data for the physician identified by the complainant.

We reviewed the results of the system's investigation and concluded that system management conducted a thorough review of the allegations. We also reviewed the patient medical records and determined the peer reviews were sufficient, and we considered the peer reviews to be acceptable physician level reviews.

Issue 1: Determine if delays in transferring three patients from the CLC resulted in poor patient outcomes, including the deaths of two patients and a preventable heart attack for a third patient. System management did not substantiate this allegation.

Patient 1—The complainant alleged that the patient died in an acute medical unit while awaiting transfer to the CLC for hospice care. Although the patient did die in an acute medical unit while awaiting hospice care, the system did not substantiate that there was a delay in transferring the patient to the CLC. System staff informed the patient and his family of various hospice options, and they offered inpatient hospice to the patient, which the patient declined in favor of home hospice. However, the patient died prior to his family making home hospice arrangements.

Patient 2—The complainant alleged that a delay in transferring the patient from the CLC to acute medical care after his condition deteriorated resulted in the patient dying in the intensive care unit. The system peer review addressed this issue and (b)(3): 38 U.S.C. 5705 (b)(3): 38 U.S.C. 5705.

Patient 3—The complainant alleged that a delay in locating an available physician to evaluate a CLC patient's worsening condition and a delay in transferring the patient to acute medical care resulted in a preventable heart attack. The system peer review addressed this issue and (b)(3): 38 U.S.C. 5705.

Issue 2: Determine if the system inappropriately contracted for respite care services.

System management did not substantiate this allegation. Although the system did contract for respite care services so as to accommodate veterans' and caregivers'

preferences, VHA Handbook 1140.02, "Respite Care," dated November 10, 2008, permits facilities to contract for such services.

Issue 3: Determine if bed shortages in the CLC's hospice and acute rehabilitation services resulted in delayed admissions.

System management did not substantiate this allegation. They reviewed the patient waiting lists for CLC hospice services for fiscal years (FY) 2007 through 2009. The data showed that there were eight patients in FY 2007, six patients in FY 2008, and nine patients in FY 2009 on the waiting lists for at least 1 day. However, they determined that patient or family preference for CLC locations was the most common reason patients were on waiting lists. The system's hospice medical director could not identify any patients who died in acute medical care while awaiting placement in the CLC. In addition, the Comprehensive Integrated Inpatient Rehabilitation Program (CIIRP) has 10 beds, and it had an average daily census of 8 patients in FY 2009. Admissions and discharges to the CIIRP is coordinated and monitored closely by an attending physician. System management reported that they had not received any verbal or written concerns regarding delays in hospice or CIIRP admissions.

Issue 4: Determine if there were communication issues that resulted in the complainant not understanding the role of a clinical manager at the CLC.

System management did not substantiate this allegation. Understanding the role of a clinical manager or other staff person is subjective. System management will continue to monitor this and take corrective action as necessary.

V. Conclusion

At our request, system management reviewed the four allegations related to quality of patient care, contracting for respite services, access to hospice and acute rehabilitation services, and the role of a clinical manager at the VA Maryland Health Care System and concluded that none of the allegations were substantiated. We reviewed the investigation performed by system management and concluded that it was thorough and sufficiently addressed the concerns. Therefore, we are closing this case.

Nelson Miranda, Director
Baltimore Office of Healthcare Inspections

Date