



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Discharge, Travel, and Treatment Issues Harry S. Truman Memorial Veterans' Hospital Columbia, MO

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections evaluated allegations of premature discharge, excessively long travel distance, and unsuccessful treatment in a patient with end stage liver disease. These complaints related to two episodes of care at a St. Louis area private-sector hospital (SLAH). Providers at the Harry S. Truman Memorial Veterans' Hospital (the facility), Columbia, MO, referred the patient to the SLAH for this care, and the facility authorized payment for the care.

We did not substantiate that “someone dropped the ball” in the care of this patient. Medical record documentation showed that the patient was referred to a qualified private-sector specialist for a transjugular intrahepatic portosystemic shunt (TIPS) procedure, and that the wife was aware of the rationale for the procedure, location of the SLAH where the procedure was performed, and the potential complications. The patient was discharged in stable condition after his two hospitalizations at the SLAH. The medical record reflects adequate communication between facility, SLAH, and community hospital emergency room staff members to ensure continuity of care. We made no recommendations.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Discharge, Travel, and Treatment Issues, Harry S. Truman Memorial Veterans’ Hospital, Columbia, Missouri

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) evaluated allegations of premature discharge, excessively long travel distance, and unsuccessful treatment in a patient with end stage liver disease (ESLD). These complaints related to two episodes of care at a private-sector hospital to which providers at the Harry S. Truman Memorial Veterans’ Hospital (the facility), Columbia, MO, referred the patient for this care, and the facility authorized payment for the care. The purpose of our review was to determine whether the allegations had merit.

Background

The facility, part of VA Heartland Network 15, provides a broad range of inpatient and outpatient medical, surgical, and specialty care. Its Hepatology Clinic treats patients with liver-related diseases and conditions.

ESLD is diagnosed when the harmful effects of liver disease can no longer be managed medically. ESLD is considered terminal unless the patient receives a liver transplant. Specialists use the Model for End-stage Liver Disease (MELD) score to prioritize patients for transplantation; those with the fewest remaining years of life may be moved up on the transplant waiting list. MELD scores range from 6 (lowest 3-month mortality rate) to 40 (highest 3-month mortality rate). They are calculated using the patient's bilirubin level (a measure of how well the liver is excreting the breakdown products of normal metabolism), prothrombin time (a measure of whether the liver is producing adequate amounts of clotting factors) and creatinine level (a measure of kidney function).¹ The life expectancy for a patient with ESLD who does not receive a transplant ranges from weeks to months.

¹ http://www.liverdisease.com/meld_hepatitis.html. Accessed December 19, 2011.

Ascites (excessive fluid accumulation in the abdomen) is a common finding with liver disease and is typically treated with diuretics (medications to help rid the body of excess water) and frequent paracentesis (a procedure using a thin needle to withdraw fluid from the abdomen). Patients sometimes become less responsive to these interventions and may then require a transjugular intrahepatic portosystemic shunt (TIPS) procedure. The TIPS procedure creates a new path for blood to flow through the liver, thereby helping relieve congestion and fluid accumulation. Paracentesis and TIPS procedures are considered palliative measures for managing fluid overload and other complications as chronic liver disease progresses. TIPS procedures are typically successful in 80-90 percent of cases.²

On August 16, 2011, OIG received a complaint regarding a patient with ESLD who had been treated at the facility since August 2009. The complainant described the last 10 days of the patient's life, from the time of his TIPS procedure on July 2, 2010, to his death on July 12. The complaint letter included allegations that:

- Fee basis providers at a St. Louis area private-sector hospital (referred to as SLAH in the remainder of this report) prematurely discharged the patient in unstable condition on two occasions.
- The patient was too ill to travel the 225 miles from SLAH to his rural home, and arrangements for continued hospitalization were not made.
- The TIPS procedure performed at SLAH made the patient worse, not better.

The complainant asked OIG to investigate why everyone “dropped the ball” in relation to this episode of the patient's care.

Scope and Methodology

We interviewed several individuals, including the complainant. We also conducted a site visit during November 1–2, 2011. Prior to our visit, we reviewed the patient's facility and available fee basis medical records, along with relevant policies and procedures. While onsite, we interviewed staff involved in the patient's care at the facility. Our review was limited to medical documentation available to us through the facility. Thus, we were able to review only the SLAH medical documents that were received and scanned as required for fee basis payment. We did not interview any SLAH staff.

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

² <http://www.nlm.nih.gov/medlineplus/ency/article/007210.htm>. Accessed December 19, 2011.

Case Summary

The patient was a man in his early 60s who had a history of hypertension, peripheral vascular disease, and chronic liver disease related to the hepatitis C virus (HCV). The patient initially received treatment for HCV at a private clinic and enrolled for VA care in June 2009. The patient received treatment at the VA medical centers in St. Cloud and Minneapolis, MN through August 2009.

In September 2009, the patient began receiving care at the facility. The patient saw providers in the Hepatology Clinic nine times during October 2009–June 2010. Due to advanced liver disease, the patient had weight gain and ascites. His treatment consisted of fluid management with diuretics and paracentesis.

In June 2010, a clinical nurse specialist (CNS) noted that the patient was requiring more frequent paracenteses for ascites and might benefit from placement of a TIPS. Because the facility did not perform TIPS procedures, the patient was evaluated at SLAH, a referral center with expertise in the management of patients with liver disease. The procedure was performed at SLAH on July 2 and the patient was discharged home the following day with instructions to return to SLAH in 1 month. Three days after discharge, the patient was transported by ambulance to a local community hospital emergency room (located 36 miles from his home) because of decreased responsiveness. The patient was noted to be combative and confused, and had a total bilirubin of 12.8 mg/dL (normal .2–1 mg/dL), and an ammonia level of 272 mcg/dL (normal 11–30 mcg/dL).

The community hospital was unable to provide the necessary level of care so the emergency room physician contacted the facility's hepatology CNS to assist with transfer to a more appropriate care setting. However, because there were no intensive care beds available at the facility, the CNS arranged for transport to the SLAH that same day. The community hospital emergency room physician and the SLAH liver specialist discussed the patient's status and the patient's wife was contacted to inform her of the plans for transfer to SLAH. After being hospitalized at SLAH for 2 days, the patient was discharged home on July 8.

On July 11, the patient's wife took him back to the local community hospital's emergency room for decreased responsiveness. The patient was found to have markedly abnormal liver function tests (ammonia >1000 mcg/dL) and a physician arranged for the patient to be transferred to the facility. Upon arrival at the facility, the patient was minimally responsive. The patient was admitted to the intensive care unit, intubated, and treated with intravenous fluids and medications. However, his condition continued to deteriorate and he expired early on July 12.

Inspection Results

Issue 1: Alleged Premature Discharges

We did not substantiate the allegation that the veteran was prematurely discharged from the SLAH in unstable condition on two occasions. The patient had a TIPS procedure on July 2 and was discharged on July 3. We evaluated the patient's SLAH discharge summary which reflected that he was stable at the time of discharge and that he no longer required hospitalization. He also received detailed discharge instructions regarding at-home management, potential complications, and emergency contact information.

The patient was hospitalized a second time at SLAH on July 6 for 2 days. The SLAH liver specialist told the patient and his wife that there were no more treatment options and that he needed to have a liver transplant. On July 8, the CNS entered a consultation request for the patient to be evaluated for liver transplant; his MELD score at that time was 24. The SLAH liver specialist documented that the patient was in no acute distress at the time of discharge and was to follow up in 2 weeks at SLAH.

The patient was medically stable for discharge on both July 3 and July 8.

Issue 2: Alleged Travel Issues

We could not confirm or refute the allegation that the patient was too weak and ill to travel 4½ hours by car to his home, necessitating overnight hotel stays on both occasions. Given the patient's deteriorating medical condition, he may have felt weak and ill, and the car ride may have added to his discomfort. However, these symptoms were not sufficient reasons to keep the patient hospitalized at SLAH or transfer him to another inpatient hospital setting.

Issue 3: Alleged Unsuccessful TIPS Procedure

We could not confirm or refute the allegation implying that the TIPS procedure made the patient worse, not better. While the procedure is usually successful, approximately 25 percent of patients develop hepatic encephalopathy, which is the occurrence of confusion, altered level of consciousness, and coma. The patient's wife told us she was aware of the potential complications.

The patient had a life-threatening illness and his condition had been deteriorating over several months as evidenced by increased frequency of paracenteses and need for the TIPS. The TIPS procedure was appropriately initiated as a palliative measure, and medical record documentation showed that the next step, evaluation for liver transplant, was being pursued.

Conclusions

We did not substantiate that “someone dropped the ball” in the care of this patient. Medical record documentation showed that the patient was referred to a qualified specialist for the TIPS, and that the patient’s wife was aware of the rationale for the procedure, location of SLAH, and the potential complications. The patient was discharged in stable condition after his two hospitalizations at SLAH. The medical record reflects adequate communication between facility, SLAH, and community hospital staff members to ensure continuity of care. We made no recommendations.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the report. No further action required.

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D." in a cursive script.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 3, 2012

From: Director, VA Heartland Network (10N15)

Subject: **Healthcare Inspection – Discharge, Travel, and Treatment Issues, Harry S. Truman Memorial Veterans’ Hospital, Columbia, Missouri**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Service (10B5)

Thank you for the opportunity to review the report as a process to ensure that we continue to provide exceptional care to our Veterans.

Concur with report of non substantiated allegations.

(original signed by:)

JAMES R. FLOYD, FACHE
Director, VA Heartland Network (10N15)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 30, 2011

From: Director, Harry S. Truman Memorial Veterans' Hospital
(589/A4)

Subject: **Healthcare Inspection – Discharge, Travel, and Treatment
Issues, Harry S. Truman Memorial Veterans' Hospital,
Columbia, Missouri**

To: Network Director, VA Heartland Network, Kansas City, MO
(10N15)

1. Though no recommendations were found, Truman VA appreciates the opportunity for the review as a continuing process to improve care for our Veterans.
2. Thank you for your comments and input. Concur with report of non substantiated allegations.

Sallie Houser-Hanfelder, FACHE

SALLIE HOUSER-HANFELDER, FACHE
Director, Harry S. Truman Memorial Veterans' Hospital

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
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