Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Evaluation of Patient Prostate Care
Tennessee Valley Healthcare System
Nashville, Tennessee

Report No. 11-00181-153

April 28, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections evaluated the validity of an allegation that the Chattanooga, TN, Community Based Outpatient Clinic (CBOC) did not provide appropriate medical follow-up for elevated prostate-specific antigen (PSA) levels.[1]

We did not substantiate the allegation. The patient's CBOC providers routinely measured PSA levels and communicated results to the patient. The patient told his VA provider that he received routine urology care from community providers that included prescribing medications and performing examinations, biopsies, and surgery.

The VISN and facility Directors agreed with our findings. We made no recommendations.

[1] PSA is a protein produced by the prostate gland. PSA is present in small quantities in the serum of individuals with healthy prostates but may be elevated in the presence of prostate cancer and in other prostate disorders.

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

TO: Director, VA Mid South Healthcare Network (10N9)

SUBJECT: Healthcare Inspection – Evaluation of Patient Prostate Care, Tennessee Valley Healthcare System, Nashville, Tennessee

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated the validity of the allegation that primary care providers (PCPs) at the Chattanooga, TN, Community Based Outpatient Clinic (CBOC) did not follow-up on elevated prostate-specific antigen (PSA) levels.[2] The purpose of the inspection was to determine if the allegation had merit.

Background

The CBOC provides outpatient primary care services to approximately 14,000 unique veterans. The CBOC is part of the Tennessee Valley Healthcare System (facility). The facility provides inpatient and outpatient services at the Alvin C. York VA Medical Center, Murfreesboro, TN; the Nashville VA Medical Center, Nashville, TN; and 13 community based outpatient clinics located in Tennessee and Kentucky. The facility is part of Veterans Integrated Service Network (VISN) 9.

In October 2010, a complainant contacted the OIG Hotline Division regarding medical follow-up of a patient. Specifically, the complainant alleged that a patient had elevated PSA levels that were not appropriately addressed.

Scope and Methodology

We conducted telephone interviews with the patient, available PCPs, and CBOC leadership. We reviewed the patient's medical record, the records from the community urology provider, relevant facility policies, and Veterans Health Administration directives.

[2] PSA is a protein produced by the prostate gland. PSA is present in small quantities in the serum of individuals with healthy prostates but may be elevated in the presence of prostate cancer and in other prostate disorders.

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.

Case Summary

The patient has a history of hypertension, diabetes, anxiety disorder, post-traumatic stress disorder, and benign prostatic hyperplasia.[3] The patient first visited the CBOC in May 1999 and returned after relocating to the area in October 2004. There is documentation by his VA PCPs that community primary care and urology providers were seeing the patient.

In October 2005, the patient had an elevated PSA level of 5.1 ng/ml.[4] The PCP treated the patient with antibiotics and 3 months later the PSA level was 3.0 ng/ml. In May 2006, the patient's PSA level was 4.0 ng/ml, and the PCP requested urology consultation. The urologist cancelled the consult and recommended that the patient be treated with antibiotics for 45 days, with repeat PSA. The PCP was to refer the patient back to urology if the PSA level did not decrease or if the patient developed an abnormal prostate exam. At the patient's next CBOC appointment in June 2006, the patient reported that a prostate exam performed 2 months earlier by a community provider was normal, and that a prostate biopsy done 2 years earlier was normal. The patient had a PSA drawn three times over the next 2 years, with levels of 4.3, 4.8, and 4.3 ng/ml, all only slightly above the upper limits of normal and with no rising trend.

In April 2010, the patient's PSA level was 6.5 ng/ml with a free PSA[5] of 13.7 percent. At the next appointment in June 2010, the PCP noted the elevated PSA. The patient refused a prostate exam and was to return to the CBOC in 6 months with a PSA drawn prior to the appointment. The patient did not return to the CBOC.

We reviewed the medical records from the community urologist dating back to 2004. The community urologist saw the patient on a regular basis and monitored PSA levels. In 2004, the patient had a PSA level of 10.5 ng/ml and a negative prostate biopsy. Between 2004 and 2010, the urologist monitored the patient's PSA levels. In July 2010, the PSA level was 10.4 ng/ml and a prostate biopsy in August 2010 revealed cancer. The patient underwent a prostatectomy in September 2010 by a community provider.

[3] Benign prostatic hyperplasia refers to the increase in size of the prostate gland.
[4] The optimal range for PSA is less than 4 ng/ml.
[5] A free PSA level below 15 percent suggests an increased probability of prostate cancer.

Inspection Results

Issue: Medical Follow-Up of Elevated PSA Levels

We did not substantiate the allegation that the CBOC PCPs communicated elevated PSA levels to a patient without further medical follow-up. The CBOC PCPs routinely ordered PSA levels. The PCP treated the patient's first elevated PSA level with antibiotics and a follow-up PSA level was normal. The CBOC PCPs documented that the patient either reported a recent normal prostate examination by a community provider or refused prostate examination. They also documented that the patient reported that a prostate biopsy in 2006 was normal. The CBOC nursing staff documented the provision of prostate screening education on three occasions.

During our interviews, PCPs stated that the patient reported receiving care from community providers. PCPs requested that the patient provide documentation of visits with community providers, but none were provided. The patient preferred to see the community provider for urology care. The PCPs continued to order PSA levels as part of the CBOC routine prevention screening.

Conclusion

We did not substantiate that the CBOC PCPs did not follow-up on elevated PSA levels. The patient chose to receive primary care and urology care from community providers.

Recommendation

We made no recommendations.

Comments

The VISN and System Directors concurred with our findings. See Appendixes A and B, pages 4–5 for the full text of their comments.

(original signed by:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 7, 2011

From: Director, VA Mid South Healthcare Network (10N9),

Subject: **Healthcare Inspection – Evaluation of Patient Prostate Care, Tennessee Valley Healthcare System, Nashville, Tennessee**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, Management Review Service (10B5)

1. I concur with the report and have no comments.

2. Should you need additional information, please contact Tammy Williams, VISN 9 Continuous Readiness Coordinator at (615) 695-2200.

(*original signed by*:)
John Dandridge, Jr.
Director, VA Mid South Healthcare Network (10N9)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 7, 2011

From: Director, Tennessee Valley Healthcare System (626/00)

Subject: **Healthcare Inspection – Evaluation of Patient Prostate Care, Tennessee Valley Healthcare System, Nashville, Tennessee**

To: Director, VA Mid South Healthcare Network (10N9)

I concur with the subject Office of Inspector General's inspection report and have no comments.

(*original signed by*:)
Juan A. Morales, RN, MSN
Director, Tennessee Valley Healthcare System (626/00)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Cathleen King, Project Leader Gayle Karamanos Maureen Washburn Monika Gottlieb Misti Kincaid

Appendix D

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