Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Delay in Diagnosis and Communication Issues, Chattanooga Community Based Outpatient Clinic, Tennessee Valley Healthcare System Nashville, Tennessee

Report No. 11-00599-186 **June 8, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to allegations of a delay in diagnosis and communication issues at the community based outpatient clinic (CBOC) located in Chattanooga, TN. The CBOC is part of the Tennessee Valley Healthcare System (the system), Nashville, TN.

A complainant contacted the OIG in November 2010 alleging delay in diagnosis related to a patient having a magnetic resonance image (MRI) in September 2008 that detected a right hip cystic mass, for which the reviewing radiologist recommended a computed tomography (CT) scan. However, the patient allegedly never received the results of the MRI, nor the recommended follow-up, and was later diagnosed with cancer located in the same area identified in the 2008 MRI. She also alleged that the CBOC primary care physician (PCP) did not adequately communicate with the patient and his TRICARE provider, and the patient was not allowed to change his PCP. We also reviewed the additional allegation that the patient had difficulty getting an appointment at the CBOC.

We substantiated the allegation of a delay in diagnosis. We found no evidence that the patient's PCP reviewed the MRI results, notified the patient of the abnormal results, or ensured follow-up care. We determined that current local policy does not delineate responsibility for the follow up of fee basis provider recommendations to ensure continuity of care.

We could not substantiate or refute the allegations that the PCP did not communicate adequately with the TRICARE provider, that the CBOC staff did not allow the patient to change providers, or that the patient had difficulty getting appointments at the CBOC.

We recommended that the Facility Director:

- require that ordering providers inform patients of abnormal test results and arrange for appropriate follow up according to local policy.
- conduct a peer review of this case, and if care is determined to be deficient, consult with Regional Counsel to determine if disclosure is warranted.
- review the local consult policy for fee basis care and make changes, as appropriate, to ensure continuity of care.

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

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

SUBJECT: Healthcare Inspection – Alleged Delay in Diagnosis and Communication Issues, Chattanooga Community Based Outpatient Clinic, Tennessee Valley Healthcare System, Nashville, Tennessee

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to allegations of a delay in diagnosis and communication issues at the Chattanooga, TN, community based outpatient clinic (CBOC) of the Tennessee Valley Healthcare System (the system). The purpose of the review was to determine whether the allegations had merit.

Background

The system is comprised of the Nashville and Alvin C. York (Murfreesboro) medical centers and nine CBOCs, and is part of Veterans Integrated Service Network (VISN) 9. The Chattanooga CBOC, which is the subject of the allegations, serves veterans of 21 counties in Tennessee, north Georgia, and northwest Alabama. The CBOC provides primary care, mental health, pharmacy, dental, audiology, and imaging services.

A complainant contacted the OIG in November 2010, alleging that:

- A delay in diagnosis in that a magnetic resonance image (MRI)[1] completed in September 2008 detected a cystic right hip mass and that the reviewing radiologist recommended a computed tomography (CT)[2] scan for further evaluation. However, the patient never received the results of the MRI or the recommended follow up. In January 2010, he was diagnosed with cancer located in the same area identified in the 2008 MRI.

[1] MRI uses a magnetic field, radio frequency pulses, and computers to produce detailed pictures of organs, soft tissue, bone, and all other internal body structures. www.radiologyinfo.org, accessed February 8, 2011.
[2] A CT scan uses special x-ray equipment with computers to produce cross-sectional images of internal organs, bones, soft tissue, and blood vessels. www.radiologyinfo.org, accessed February 8, 2011.

- The CBOC primary care physician (PCP) did not adequately communicate with the patient and his TRICARE[3] provider.
- The patient was not allowed to change his PCP.

We also evaluated an additional allegation that the patient had difficulty getting an appointment at the CBOC.

Scope and Methodology

We interviewed the complainant, the PCP, and the fee basis[4] orthopedic surgeon who recommended the MRI. We reviewed the patient's VA computerized patient record system (CPRS)[5] and non-VA hospital medical records, diagnostic images, and death certificate; local and Veterans Health Administration (VHA) policies, procedures, and directives; and patient advocate reports. We also reviewed correspondence from the Chief of the Business Office, the CBOC's Chief Medical Officer, and the Patient Advocate's Office.

We conducted the review 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 had multiple service-connected disabilities. His medical history included diabetes, coronary artery disease, coronary artery bypass graft,[6] and radical prostatectomy[7] due to prostate cancer. The patient saw his PCP an average of twice per year starting in 1997, intermittently saw a registered nurse, and called to request medication refills. The patient also received routine care from a private TRICARE provider.

In September 2005, the patient called the CBOC to request an appointment and indicated he wanted to give his recent TRICARE records to his PCP. The patient told the CBOC staff that his TRICARE provider found elevated blood glucose levels and had changed his diabetic medications. The PCP ordered blood work, and 2 days later, a clinic licensed practical nurse (LPN) notified the patient that his blood glucose level was normal, his

[3] TRICARE is the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, survivors, and certain spouses worldwide.
[4] These are services by a VA paid private provider for veterans who do not live near a VA facility or who need specialized treatment, unavailable at the local VA, 38USC Sec.1703, http://uscode.house.gov, accessed on February 9, 2011.
[5] An electronic medical record application used to enter orders and manage all information connected to any patient in the VA healthcare system.
[6] A coronary artery bypass graft is a type of surgery that improves blood flow to the heart.
[7] The surgical removal of all or part of the prostate gland.

HgA1c[8] was pending, and that he should resume the previously prescribed diabetic medication. The PCP wrote for the LPN to remind the patient that if he had concerns about his health, he could call the clinic for an appointment at any time; he did not have to wait for his next scheduled visit. The PCP also asked that the patient have his blood glucose levels checked at the CBOC instead of through TRICARE if he wanted to continue follow up at the VA. Records indicate that the LPN called and relayed the PCP's comments that same day.

In December 2005, the patient filed a complaint with the patient advocate requesting to change PCPs because he did not feel he could see his assigned PCP when needed. He also claimed that he did not get a return phone call regarding the elevated blood glucose levels noted by his TRICARE provider. The patient did not see his PCP on this date, nor did he have any scheduled appointments with him between September and December. The patient next had blood work in early March 2006, and saw the PCP for a routine visit the following month.

The patient saw his PCP once during 2007 for regular follow-up and called the telephone care line to request medication refills.

In May 2008, the patient saw his PCP and complained of new low back and right hip pain. He reported that the back pain was sometimes associated with left lower leg numbness. The PCP ordered x-rays and submitted an orthopedic consult for further evaluation of "persistent right hip and low back pain." The Orthopedic Clinic was not able to see the patient, so they forwarded the consult for fee basis approval.

In mid-June 2008, a fee basis orthopedic surgeon evaluated the patient and recommended an MRI of the lumbar spine and blood work, and he advised the patient to return in 10–14 days or as needed. Four days later, a program support assistant (PSA) forwarded the fee basis consultant's report to the PCP. One month later, in July, the PCP requested that the PSA contact the patient to schedule an MRI and blood work.

The patient had an MRI of the lumbar spine in early September 2008, and the radiologist verified the MRI findings the same day. The MRI showed an "expansile lesion involving the right iliac bone" and a "4.6 cm circumscribed cystic mass in the right iliac fossa."[9] The MRI report listed the diagnostic codes as "4-Abnormality Attn. Needed" and "13-Abnormal-Attn. Needed/Recommendations." The reviewing radiologist recommended a CT scan for a more complete evaluation. One day later, the PCP had his staff fax the MRI report to the fee basis orthopedic surgeon; however, he did not read the report himself.

[8] This is a test measuring a person's average blood glucose over the past 2–3 months.
[9] The right iliac bone and right iliac fossa are located in the right hip and right pelvic regions respectively. The term expansile lesion refers to a mass that is causing the underlying structure to expand beyond its usual perimeter.

The patient did not see the PCP again until late February 2009. On this visit, the PCP noted the patient underwent a coronary artery bypass graft and recorded medication changes made by the patient's TRICARE physician. The PCP's progress note did not reflect discussion of the patient's previously noted hip and back pain or the MRI results. He ordered blood work to be completed in 3 months, but the patient did not keep this appointment.

The patient did not see the PCP between February 2009 and January 2010. However, his appointment history shows "cancelled by clinic" appointments with the primary care registered nurse in March, April, and May 2009. The patient also called the telephone care line to request medication refills in June and September 2009.

In late January 2010, the patient went to a non-VA emergency department complaining of difficulty in walking. An MRI report of the cervical, thoracic, and lumbar spine noted "abnormalities…consistent with metastases" at multiple levels of the spine and "a large mass involving the posterior right pelvis" measuring at least 7 x 10 cm. The patient required emergency surgery because of spinal cord compression from tumor metastasis. Biopsies at the time of surgery showed multiple myeloma.[10] The patient received rehabilitation, chemotherapy, and subsequent surgeries at non-VA facilities. The patient died in September 2010, of complications from multiple myeloma.

Inspection Results

Issue 1: Delay in Diagnosis

We substantiated the allegation of a delay in diagnosis. Local policy states that ordering providers are responsible for initiating appropriate clinical actions and following up on the results of any orders they have placed. VHA policy requires that ordering providers relay test results to patients in a timely manner.[11, 12] We found no evidence that the patient's PCP reviewed the MRI results, notified the patient of the abnormal results, or ensured follow up.

VHA and local policy follow the guidelines set by the American College of Radiology (ACR) for non-routine communications in the "ACR Practice Guideline for Communication of Diagnostic Imaging Findings."[13] The guidelines state that the interpreting radiologist should communicate adverse findings to the ordering provider in a manner that reasonably ensures timely receipt of the findings, and that the radiologist document the communication, including the time and method of communication. The

[10] Type of cancer that begins in plasma cells (white blood cells that produce antibodies), http://www.cancer.gov/cancertopics/types/myeloma, accessed on March 25, 2011.
[11] VHA Directive 2003-043, *Ordering and Reporting Test Results*, August 6, 2003 (rescinded).
[12] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.
[13] American College of Radiology website, http://www.acr.org/SecondaryMainMenuCategories/quality_safety/guidelines/dx/comm_comm_diag_rad.aspx, accessed March 7, 2011.

ACR defines adverse findings as those that "may be seriously adverse to the patient's health and are unexpected by the treating or referring physician: these cases may not require immediate attention but, if not acted on, may worsen over time and possibly result in an adverse patient outcome." The radiologist documented "4-Abnormality Attn. Needed" and "13-Abnormal-Attn. Needed/Recommendations" in the MRI report, which automatically generated a "view alert" for the ordering physician (the PCP). However, the "view alert" automatically deleted once viewed by the PCP, so there was no permanent record of this communication. The PCP told us that he did not read the MRI report prior to forwarding it to the orthopedic surgeon.

The fee basis orthopedic surgeon confirmed that he received the MRI results. He reported that the patient did not keep a scheduled follow-up appointment with him and the appointment was not rescheduled. Due to the lapse in time, we were unable to determine what efforts, if any, were made to reschedule the appointment.

At the time of the patient's fee basis orthopedic surgery consult, the system's process for fee basis consults did not include a tracking system to ensure consult follow up and continuity of care. We also determined that current local policy does not delineate responsibility for follow up of fee basis provider recommendations to ensure continuity of care.

Issue 2: Communication with TRICARE Provider

We could not substantiate or refute the allegation that the PCP did not communicate adequately with the TRICARE provider. The complainant alleged that the PCP did not return calls from the TRICARE provider. We found no evidence that the TRICARE provider called or left messages for the PCP. We did find evidence that the PCP asked the patient about visits with outside providers and changes in medications. We made no recommendations in this area.

Issue 3: Request to Change Providers

We could not substantiate or refute that CBOC staff did not allow the patient to change providers after two different requests. The PCP recalled being "surprised" after receiving the patient's 2005 change in PCP request. He told us that he thought they "got along very well for several years." Contrary to the allegation, we noted that the patient's medical record reflected the PCP responded in a timely manner to the patient's request for follow up of his elevated blood glucose. However, the Patient Advocate Office staff confirmed that there was no follow-up documentation regarding the 2005 complaint.

The complainant told us that sometime after getting the MRI, the patient spoke to someone at the CBOC about his desire to change his PCP. Due to a lack of specifics, we were unable to identify the staff member in question. The patient continued to see the

PCP after both complaints. As Patient Advocate Office staff were able to explain the established process for changing PCPs, we made no recommendations in this area.

Issue 4: Appointment Scheduling

We could neither substantiate nor refute the allegation that the patient had difficulty getting appointments at the CBOC. CPRS notes did not reflect that the patient requested appointments but could not be accommodated.

The patient saw the PCP an average of twice per year between 1997 and 2009. The medical record indicated the patient was aware that he could walk-in for an appointment and had done so in the past. The PCP and CBOC staff documented on several occasions that they encouraged the patient to call and request earlier appointments, if needed. We made no recommendations in this area.

Conclusions

We concluded that the diagnosis of multiple myeloma was delayed. In February 2010, the patient was diagnosed at a non-VA facility with clinical stage III multiple myeloma, which included a large mass in the same area originally identified in the September 2008 MRI. Once diagnosed with multiple myeloma, patients typically undergo evaluation to determine the extent of the disease and the appropriate therapy.

We further concluded that local policy did not delineate responsibility for follow up of fee basis provider recommendations and continuity of care.

We could neither substantiate or refute the allegations that the PCP did not communicate adequately with the TRICARE provider, that the CBOC staff did not allow the patient to change providers, or that the patient had difficulty getting appointments at the CBOC.

Recommendations

Recommendation 1. We recommended that the Facility Director require that ordering providers inform patients of abnormal test results and arrange for appropriate follow up according to local policy.

Recommendation 2. We recommended that the Facility Director conduct a peer review of this case, and if care is determined to be deficient, consult with Regional Counsel to determine if disclosure is warranted.

Recommendation 3. We recommended that the Facility Director review the consult policy for fee basis care and make changes, as appropriate, to ensure continuity of care.

Comments

The VISN and Facility Directors agreed with the findings and recommendations and provided acceptable action plans. The Facility Director will ensure all providers are educated according to local policy regarding informing patients of abnormal test results and arranging for appropriate follow-up. Peer reviews of Primary Care and Radiology have been initiated and the Peer Review Committee and Chief of Staff will consult Regional Counsel if disclosure is warranted. The Facility Director will also ensure the fee basis consult policy is reviewed and that all Chattanooga CBOC providers are educated on the policy. We will follow up until the planned actions are completed.

(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: May 9, 2011

From: Network Director (10N9), VA Mid South Healthcare Network (VISN 9)

Subject: **Healthcare Inspection – Alleged Delay in Diagnosis and Communication Issues, Chattanooga CBOC, Tennessee Valley Healthcare System, Nashville, TN**

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

Thru: Director (10B5), Management Review Service

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.
Network Director (10N9), VA Mid South Healthcare

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 6, 2011

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

Subject: **Healthcare Inspection – Alleged Delay in Diagnosis and Communication Issues, Chattanooga CBOC, Tennessee Valley Healthcare System, Nashville, TN**

To: Network Director (10N9), VA Mid South Healthcare Network (VISN 9)

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)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director require that ordering providers inform patients of abnormal test results and arrange for appropriate follow up according to local policy.

Concur **Target Completion Date:** June 30, 2011

Facility's Response:

The Chief of Staff concurs with this recommendation and will ensure all providers are educated according to local policy regarding informing patients of abnormal test results and arranging for appropriate follow up. Chattanooga Providers will be educated regarding these issues.

Status: OPEN

Recommendation 2. We recommended that the Facility Director conduct a peer review of this case, and if care is determined to be deficient, consult with Regional Counsel to determine if disclosure is warranted.

Concur **Target Completion Date:** June 30, 2011

Facility's Response:

Peer reviews of Primary Care and Radiology have been initiated. Once they have been completed, they will be formally reviewed by the TVHS Peer Review Committee. In conjunction with the Chief of Staff, if they determine that the care of this patient was deficient and institutional disclosure is warranted, Regional Counsel will be consulted. If Regional Counsel concurs with their recommendation, institutional disclosure will immediately be done by TVHS.

Status: OPEN

Recommendation 3. We recommended that the Facility Director review the consult policy for fee basis care and make changes, as appropriate, to ensure continuity of care.

Concur **Target Completion Date:** Aug 31, 2011

Facility's Response:

The Chief of Staff concurs with this recommendation and will ensure an appropriate review is conducted regarding the consult policy for Fee basis care and to ensure continuity of care is provided to veterans. In addition, all providers in Chattanooga will be educated on the consult policy for Fee Basis and ensuring continuity of care.

Status: OPEN

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information on this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Tishanna McCutchen, NP, Project Manager Monika Gottlieb, MD Victoria Coates, LICSW

Appendix D

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