Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Mammography, Cardiology, and Colonoscopy Management Jack C. Montgomery VA Medical Center Muskogee, Oklahoma

Report No. 08-01866-62 February 2, 2009
VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The purpose of the review was to determine the validity of allegations regarding delays in mammography services, cardiology consult responses, and scheduling colonoscopy procedures at the Jack C. Montgomery VA Medical Center (medical center), Muskogee, OK.

We determined that in 2007 patients did not consistently receive mammograms in a timely manner as required by Veterans Health Administration (VHA) and local policy.

We concluded that a subject cardiac patient had not been contacted regarding the results of his cardiac imaging, cardiac catheterization, and echocardiogram in a timely manner. We further concluded that cardiology consultation requests were not always scheduled within the required timeframe.

We substantiated that a subject colonoscopy patient did not receive a screening colonoscopy as requested by the primary care provider (PCP) and that a diagnostic colonoscopy, ordered one year later, was not scheduled within 60 days of the request. We concluded waiting times for scheduling colonoscopies were excessive.

We could not substantiate or refute whether PCPs were notified regarding the status of mammogram requests, cardiology consults, and colonoscopy appointments.

Prior to our visit, management had already implemented initiatives to correct the issues regarding delays in mammography services, cardiology consults, and scheduling colonoscopy procedures. We confirmed that the number of delays to schedule consultations and procedures for the three services decreased in the last quarter of fiscal year 2008.

We recommended that the Veteran Integrated Service Network Director ensure that the Medical Center Director discusses the subject patient colonoscopy concern with Regional Counsel to determine whether this case meets disclosure requirements, and if it does, the disclosure is communicated and documented in accordance with VHA standards. The Regional Counsel reviewed this case and concluded that it did not meet disclosure requirements. Therefore, we consider this case closed.

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

TO: Director, Veterans Integrated Service Network (10N16)

SUBJECT: Healthcare Inspection – Mammography, Cardiology, and Colonoscopy Management, Jack C. Montgomery VA Medical Center, Muskogee, Oklahoma

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection at the request of Senator James M. Inhofe to determine the validity of allegations regarding delays in mammography services, cardiology consult responses, and scheduling colonoscopy procedures at the Jack C. Montgomery VA Medical Center (medical center), Muskogee, OK.

Background

The medical center provides primary and secondary levels of inpatient medical and surgical care, and primary and consultative care at three community based outpatient clinics that include medicine, surgery, and mental health. The medical center provides services for more than 45,000 enrolled veterans and operates an outpatient clinic in Tulsa, OK. Additional services are provided by fee basis specialists. The medical center is part of Veterans Integrated Service Network (VISN) 16.

A confidential complainant contacted the VA OIG Hotline Division with allegations regarding mammography services, cardiology consults, and scheduling colonoscopies. Specifically the complainant alleged that:

> In 2007, the medical center failed to achieve a timely diagnosis for 219 male and female patients who had mammograms ordered through primary care services. Forty-four of the requests were for diagnostic purposes to follow up on known cancers or previous suspicious mammograms, and the remaining 175 were for screening purposes. Some patients waited 14 months or longer for mammograms. Further, PCPs [primary care providers] are not notified when mammogram requests are canceled. The Acting Chief of Staff was aware of this but did not take action.

A cardiologist ended his employment at the medical center in March 2008, and management did not initiate a plan to address pending consults. The PCPs who ordered cardiology consults were unaware of the status of their requests. The complainant cited a case where a patient underwent a cardiac imaging test without being notified of the results and plans for follow up.

Colonoscopy requests are associated with delays in scheduling. Some colonoscopies are performed at the medical center and others are fee based to the community. PCPs who order colonoscopies are not aware when or if the test is performed. The complainant again cited a case where a screening colonoscopy was ordered based on age criteria and never completed. The patient returned with symptoms a year later, a diagnostic colonoscopy was completed, and colon cancer was identified.

Scope and Methodology

On August 18, 2008, we conducted a telephone interview with the complainant. On September 22–25, we conducted a site visit and interviewed medical center management and staff involved with mammography, cardiology, and colonoscopy services. We reviewed patient referrals, medical records, policies, and other relevant documents. We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Delays in Scheduling Screening and Diagnostic Mammograms

We substantiated that in calendar year 2007 the medical center failed to provide timely mammography services for several patients who had mammograms requested by their PCPs. We could not substantiate or refute that PCPs were not notified when mammography requests were canceled.

Veterans Health Administration (VHA) policy[1] requires that veterans with service-connected ratings of 50 percent or greater and veterans with less than 50 percent requiring care for service-connected disabilities be scheduled within 30 days of desired appointment dates. All other veterans must be scheduled for care within 120 days of the desired dates. The directive requires that requests for appointments be acted on by the medical facility staff as soon as possible, but no later than 7 calendar days from the date of request. To act on appointment requests means to schedule, complete, cancel, discontinue, or place the veteran on the Electronic Wait List (EWL). The EWL provides medical facilities with a standard tool to capture and track information about veterans

[1] VHA Directive 2006-055, *VHA Outpatient Scheduling Processes and Procedures*, October 11, 2006.

waiting for medical appointments and procedure requests. The scheduling coordinator is responsible for maintaining the EWL.

Medical center managers provided a list of 865 patients for whom PCPs had requested mammography studies in 2007. Of these 865 patients, 141 patients never had their requested mammograms.

By March 2008, when the Chief of Medicine was made aware of a backlog for mammography studies, the backlog list contained 200 requests. By April, 140 of the 200 patients were scheduled and received mammograms on a fee basis. The remaining 60 mammogram requests were closed out because patients did not respond to efforts to schedule the tests, patients failed to report for the scheduled appointments, or the requests were duplicate orders.

We could not substantiate or refute whether PCPs were notified regarding the status of mammogram requests. When consults are initiated, it is the receiving service's responsibility to act on the consult and to document the actions taken. The requesting provider is to be alerted of these actions. The Veterans Health Information System & Technological Architecture (VistA) scheduling software can be set to automatically alert the requesting providers when any actions are taken on consults. During our interviews, providers told us that the alert function in the VistA software had been disabled due to the high volume of inappropriate orders. However, managers told us that the alerts were working and demonstrated the alerts while we were onsite. Due to conflicting statements, we were unable to determine whether or not the alerts were active during calendar year 2007.

Issue 2: Pending Cardiology Consults

We substantiated that the subject patient had not been contacted in a timely manner regarding results of cardiac imaging, cardiac catheterization, and an echocardiogram. We also substantiated that cardiology consult requests were not always scheduled within the required timeframes. We did not substantiate that managers did not appropriately plan for cardiology consults after the departure of a staff cardiologist. We could not substantiate or refute that PCPs were unaware of the status of consult requests.

Case Study

This is a patient in his late 40s with a history of dyslipidemia, hypertension, rheumatoid arthritis, and chest pain with exertion. The patient underwent a stress myocardial scan in mid-March 2008, indicative of positive multi-vessel myocardial ischemia (coronary artery disease). The PCP prescribed isosorbide mononitrate and nitroglycerin sublingual (under the tongue) for chest pain management.

The following day, a Nuclear Imaging Service staff requested a cardiology consult for the patient. The request was placed on the EWL and was noted, "semi-urgent (within two

weeks).” Approximately 5 weeks later, the patient was seen by a rheumatologist who documented in the electronic medical record that the patient continued to experience chest pain with exertion. The rheumatologist also documented that the patient was not aware of his mid-March cardiac stress test results, and was waiting to see a cardiologist. That same day, the rheumatologist consulted with the Chief of Medicine about the case, and shortly thereafter, the Chief of Medicine instructed the PCP to contact the patient. The patient was notified to continue isosorbide mononitrate daily and wait for notification of a cardiology appointment. Later that day, the patient was notified that a heart catheterization had been scheduled for early May and the cardiology consult request had been canceled.

In early May, the patient had a cardiac catheterization at the Oklahoma City VA Medical Center (VAMC). The test revealed a normal heart catheterization with borderline slow flow. Documentation in the electronic medical record shows that discharge instructions, including follow up with the PCP, were discussed with the patient. However, there is no indication that the results of the heart catheterization were discussed with the patient.

In late August, the patient was seen by the PCP with complaints of chest pain without shortness of breath. The patient told the PCP that he had been non-compliant with his medication regime since April. The patient stated his chest pain increased with activity, but said he could walk half a mile without stopping. The treatment plan was to restart his current cardiac medications, add metoprolol to manage his blood pressure, add a daily ‘baby’ aspirin, and he was given a return appointment.

Two days later, an echocardiogram was performed that revealed no evidence of significant pericardial effusion. Comparison with a previous 2007 study indicated only minor changes. Documentation in the electronic medical record shows that the patient called the medical center in mid-September and asked about the results of the study which were then provided over the phone.

Finding

The patient was not told the results of his mid-March cardiac stress test until late April when he asked about the results during a clinic appointment. There is no indication in the medical record that the patient was ever given the results of his early May heart catheterization. Further, the patient was not aware of his late August echocardiogram results until mid-September when he called the medical center and requested the results.

Between March and June 2008, the medical center had only one full-time cardiologist on staff. To manage the workload during that period, managers made arrangements to send complicated and urgent consult requests to the Oklahoma City VAMC. While some routine consult appointments were less timely (ranging from 30 to 120 days of the requests) during this period, cardiology service continued to provide all requested

services. In June managers hired a full-time contract cardiologist and are currently recruiting for full-time staff cardiologists.

As discussed in Issue 1, due to conflicting statements regarding the VistA software alert function, we could not substantiate or refute whether PCPs were notified when cardiac consults were completed or canceled.

Issue 3: Delays in Scheduling Colonoscopies

We substantiated that a patient did not receive a requested age criteria screening colonoscopy, returned a year later with blood in his stool, and was diagnosed with cancer. We also substantiated excessive waiting times for requested colonoscopies. We could not substantiate or refute that the PCPs did not receive notification when colonoscopies were completed.

Case Study

This is a patient in his early 60s with a history of hypertension, depression, osteoarthritis, and a benign tumor of the salivary gland. In mid-September 2006, the patient presented to the clinic for a yearly follow up with a chief complaint of leg cramps after walking. The PCP requested a consult for a screening colonoscopy for age specific criteria.

A year later, in mid-September 2007, the patient presented to the clinic with indigestion, melena (blood in the stool), and wrist pain. The PCP requested a diagnostic colonoscopy. A month later, in mid-October, the nurse educated the patient on the procedure and provided a colon cleansing kit with instructions. The procedure was scheduled for late December and later canceled by the clinic due to physician absence. In early January 2008, the colonoscopy was completed with pathology results consistent with a grade II adenocarcinoma extending through the muscular wall into the overlying serosa (the outer lining).

In early February 2008, the patient underwent a low anterior rectal resection with pathology results identifying 2 of 32 positive nodes for metastatic disease. He was discharged home on a week later. The patient completed radiation and chemotherapy regimens in September and a follow-up colonoscopy was requested in early November.

Findings

The patient never had the screening colonoscopy the PCP requested during a September 2006 appointment. A year later, the patient complained of bloody stools during a clinic appointment. A diagnostic colonoscopy ordered in mid-September 2007, the day of the appointment, was scheduled for late December, more than 90 days after the request was submitted. VHA policy[2] states a veteran of any age with signs or symptoms must be

[2] VHA Directive 2007-004, *Colorectal Cancer Screening,* January 12, 2007.

immediately offered an appropriate diagnostic evaluation. The directive also states a diagnostic colonoscopy must be performed within 60 calendar days of the request.

We received a patient list of colonoscopies scheduled from August 2007 through August 2008. Due to the large volume of data provided, we selected 3 months for our review. Of the 522 colonoscopies completed during that 3 month period, 287 were diagnostic and 235 were for screening. We found 112 (39 percent) of 287 diagnostic colonoscopies were not completed within 60 days of the request as required. Of the screening colonoscopies, 71 (30 percent) of 235 were not completed within required timeframes.

As discussed in Issue 1 and 2, due to conflicting statements regarding the VistA software alert function, we could not substantiate or refute whether PCPs were notified when colonoscopies were completed or canceled.

Conclusions

We determined that in 2007 patients did not consistently receive mammograms in a timely manner as required by VHA and local policy.

We concluded that the subject cardiac patient had not been contacted regarding the results of his cardiac imaging, cardiac catheterization, and echocardiogram in a timely manner. We further concluded that cardiology consultation requests were not always scheduled within the required timeframe.

We substantiated that the subject colonoscopy patient did not receive a screening colonoscopy as requested by the PCP and that a diagnostic colonoscopy, ordered one year later, was not scheduled within 60 days of the request. We concluded waiting times for scheduling colonoscopies was excessive.

We could not substantiate or refute that PCPs were notified regarding the status of mammogram requests, cardiology consults, and colonoscopy appointments.

Management Actions

Management agreed there were delays in mammography services, cardiology consults, and scheduling colonoscopies. We were informed of initiatives that management had implemented, such as clearing the EWL for mammograms by fee basing to more providers and replacing the cardiologist with another full-time contract cardiologist in addition to recruiting for two more cardiologists. Further, they created a Performance Improvement Team to review and improve the colonoscopy ordering process. We confirmed during our site visit that the number of delays to schedule consultations and procedures for the three services decreased in the last quarter of FY 2008.

Recommendation:

Recommendation. We recommended that the VISN Director ensure that the Medical Center Director discusses the patient case in issue 3 with Regional Counsel to determine whether it meets disclosure requirements, and if it does, the disclosure be communicated and documented in accordance with VHA and local policy.[3]

Comments

The VISN and Medical Center Directors concurred with the finding and recommendation of this inspection and appropriate actions have to been taken. (See Appendixes A and B, pages 8−10, for the full text of the Directors' comments.) We consider the recommendation closed.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

[3] VHA Directive 2008-002, *Disclosure of Adverse Events to Patients,* January 18, 2008.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 8, 2009

From: Director, Veterans Integrated Service Network (10N16)

Subject: **Mammography, Cardiology, and Colonoscopy Management, Jack C. Montgomery VAMC, Muskogee, OK**

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

Director, Management Review Office (10B5)

I have reviewed the report and concur with the response to the recommendation.

(original signed by:)

George H. Gray, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 8, 2009

From: Director, Jack C. Montgomery VA Medical Center (623/00)

Subject: **Mammography, Cardiology, and Colonoscopy Management, Jack C. Montgomery VAMC, Muskogee, OK**

To: Director, Veterans Integrated Service Network (10N16)

In response to the OIG Draft Report, the Jack C. Montgomery VA Medical Center concurs with the report. Response to the recommendation is also submitted.

(original signed by:)

Adam C. Walmus,
Medical Center Director

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

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

OIG Recommendation(s)

Recommendation. We recommended that the VISN Director ensure that the Medical Center Director discusses the patient case in issue 3 with Regional Counsel to determine whether it meets disclosure requirements, and if it does, the disclosure be communicated and documented in accordance with VHA and local policy.

Concur **Target Completion Date:** December 19, 2008

Action taken: On 12/19/08 this review was completed by COS and Regional Counsel. They concluded: "This patient was screened appropriately for colorectal cancer by annual fecal occult blood testing from June 2002 through September 2006. All tests were negative. The request for screening colonoscopy submitted in September, 2006 was not acted upon timely, but did not result in lack of screening. Regional counsel agrees that this does not meet criteria for either clinical or institutional disclosure." Laboratory medical record documentation shows the patient was screened on 06/02/02, 10/21/03, 10/8/04, 10/12/05, and 9/25/06.

Recommend this recommendation be closed.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Marilyn Walls, Healthcare Inspector Dallas Office of Healthcare Inspections (214) 253-3335
Acknowledgments	Shirley Carlile Wilma I. Reyes George Wesley, M.D.

Appendix D

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