



**Department of Veterans Affairs
Office of Inspector General**

Healthcare Inspection

**Quality of Care Issues
North Florida/South Georgia
Veterans Health System
Lake City, Florida**

**To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244**

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an evaluation in response to allegations that clinical practitioners disregarded a patient's cardiac complaints, did not refer him to Cardiology Service, and as a result, did not provide timely treatment relevant to his cardiac complaints at the North Florida/South Georgia Veterans Health System located in Lake City, FL.

We did not substantiate that medical center providers disregarded the patient's cardiac complaints and did not refer him to Cardiology Service. We also did not substantiate that as a result, the patient did not receive timely treatment relevant to his cardiac complaints. We found that each primary care provider appropriately treated the patient for his presenting symptoms and chronic conditions. In addition, we found no evidence that the patient complained about cardiac-specific issues to his primary care physicians. Medical record documentation and electrocardiogram testing between February 2005–February 2008 clearly reflects the patient's stable cardiac condition.

We made no recommendations.



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

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: Healthcare Inspection – Quality of Care Issues, North Florida/South Georgia Veterans Health System, Lake City, Florida

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an evaluation in response to a complaint that a veteran received inadequate care related to his cardiac complaints at the North Florida/South Georgia Veterans Health System (the system) located in Lake City, FL. The purpose of the review was to determine whether the allegations had merit.

Background

The system is comprised of the VA medical centers in Gainesville and Lake City; three large multi-specialty outpatient clinics in Daytona Beach, Jacksonville, and Tallahassee; and six community based outpatient clinics located in Lecanto, Leesburg, Ocala, St. Augustine, and The Villages in north Florida and Valdosta in south Georgia. It operates 285 inpatient hospital beds and 264 long-term care beds and provides medical, surgical, mental health, and long-term care services. The system is part of Veterans Integrated Service Network (VISN) 8.

On April 17, 2008, the OIG Hotline received a letter from the complainant alleging that between February 2005 and April 2008, Lake City VA Medical Center (referred to in this report as the medical center) clinical practitioners disregarded his cardiac complaints, did not refer him to Cardiology Service, and as a result, did not provide timely treatment relevant to his cardiac complaints.

Scope and Methodology

We conducted a site visit July 14–15, 2008. Prior to our visit, we interviewed the patient via telephone. During our site visit, we interviewed medical center practitioners with knowledge of the case. We reviewed the patient's Veterans Health Administration

(VHA) and private-sector medical records in addition to relevant medical center and VHA policies and documents. This review was performed in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case Summary

The patient is a male veteran in his early 60s with a history of coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD). In 1998, the patient had a coronary stent placed at a medical facility in California, and an April 2004 stress test and electrocardiogram¹ (ECG) completed at this same facility were normal. The patient then transferred his care to the medical center; his initial primary care appointment was in mid-February 2005. A routine ECG ordered on that day and performed a week later was normal.

The patient told us that after this appointment (in late February), he filed a formal complaint with the patient advocate because he needed to see a cardiologist. However, according to documentation, the patient first visited the patient advocate's office in mid-April 2005, requesting a change in his primary care provider (PCP) because he was not referred to a urologist.² Managers approved the request, and the patient received a new PCP and was scheduled for a urology appointment to discuss his concerns.

The second assigned PCP treated the patient in late July, mid-September, and early November 2005. Medical record documentation did not reflect any cardiac complaints during those visits. When this PCP transferred to the emergency department (ED) in 2006, the patient was reassigned to his third and current PCP.

The third PCP saw the patient in mid-July 2006 and noted a normal ECG and stable CAD. During the patient's annual physical examination in late-January 2007, the PCP documented stable CAD. The patient was seen twice in the ED, initially in mid-March 2007 with chest and sinus congestion, and then again in mid-January 2008 with shortness of breath diagnosed as viral upper respiratory illness and COPD.

In early February 2008, the patient kept routine clinic appointments with primary care and mental health (MH). During the patient's annual physical examination, the PCP documented that the patient suffered from shortness of breath on exertion related to COPD and also noted that the clinical pharmacist followed his diabetes. The patient's medical treatment plan was unchanged. The patient's MH provider, a nurse practitioner (NP), documented his MH medication plan. In early March, the NP added her February note, writing that the patient was scheduled for a diagnostic cardiac

¹ A test that checks for problems with the electrical activity of the heart.

² A physician who has specialized knowledge and skill regarding problems of the male and female urinary tract.

catheterization³ by a private cardiologist. There is no record that the NP alerted the PCP of the pending diagnostic cardiac catheterization scheduled for late March, nor is there any evidence that the patient told his PCP about the upcoming diagnostic procedure.

The patient underwent a diagnostic cardiac catheterization in late March 2008, which indicated a high-grade lesion⁴ in his circumflex.⁵ The patient was admitted to the private-sector hospital and a stent⁶ was inserted the following day. However, the stent did not achieve the desired effect, and the patient required a second cardiac catheterization with placement of three stents in the same artery on the day following placement of the original stent. The patient again had an abnormal ECG, and physicians performed a third cardiac catheterization 2 days later that reflected a stable cardiac condition. The patient was discharged in early April.

In early April, a week following discharge from the private hospital, the patient presented to the medical center for a scheduled MH appointment and voiced his concerns to the NP about the care he received at the medical center. In late April, the patient visited the patient advocate's office and requested payment for his late March–early April 2008 private-sector hospitalization. The patient advocate sent the request to the fee basis department for evaluation.

Also in late April, the patient's PCP documented his stable cardiac condition and wrote prescriptions for medications, including one prescribed by the private cardiologist for Coreg®.⁷ In early May, the patient called his PCP and stated he was short of breath, so the PCP discontinued the Coreg®.⁸ In mid-May, the patient called the PC nurse stating that he had continued to take Coreg® (even though it had been discontinued), and that he felt well and wished to continue taking this medication. The PCP agreed to reorder the Coreg®.

In early June, the patient told his MH NP that he experienced problems obtaining prescriptions through the medical center for medications prescribed by his private-sector cardiologist. The patient further voiced concerns that he had not been referred to a medical center or a fee basis cardiologist. The NP documented the concerns and sent an alert to the PCP. The PCP requested a cardiology consultation that same day; a medical center cardiologist evaluated the patient on 6 days later and documented no acute disease.

³ Diagnostic procedure to obtain information about the blood flow in the heart.

⁴ Blockage in a coronary artery.

⁵ Artery of the heart.

⁶ Tube inserted to ensure blood supply to the heart.

⁷ Medication that lowers blood pressure.

⁸ Some patients report shortness of breath when taking this medication.

Inspection Results and Conclusion

We did not substantiate the allegation that medical center clinical providers disregarded the patient's cardiac complaints and did not refer him to Cardiology Service. We also did not substantiate that as a result, the patient did not receive timely treatment relevant to his cardiac complaints.

We found that each PCP appropriately treated the patient for his presenting symptoms and chronic conditions. In addition, we found no evidence that the patient complained about cardiac-specific issues to his PCPs. The patient did present to the ED in mid-January 17, 2008, complaining of shortness of breath. Although this symptom could have been related to CAD, it was equally reasonable for the ED physician to diagnose upper respiratory infection and COPD, given the patient's medical history. While it is unclear what, if any, clinical indications prompted the initial private-sector cardiac catheterization, medical center documentation and ECG testing between February 2005–February 2008 clearly reflects the patient's stable cardiac condition. We therefore concluded that referral to Cardiology Service was discretionary rather than mandatory. When the patient expressed his concern to his NP in early June 2008 that he had not been referred to a medical center cardiologist, a consultation was promptly entered, and the patient was seen less than a week later. The consultation results were unremarkable. The VISN and medical center Directors agreed with our report. We made no recommendations.

(original signed by:)

JOHN D. DAIGH, JR., M.D.
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OIG Contact and Staff Acknowledgments

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