Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Poor Quality of Patient Care
Marion VA Medical Center
Marion, Illinois

Report No. 10-03080-124

March 16, 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 conducted a review to determine the validity of allegations that six patients received poor care at the Marion VA Medical Center (the facility). Complainants reported these allegations to Senator Richard Durbin.

We interviewed complainants, family members, managers, clinicians, and administrative staff, and consulted with a board-certified radiologist. We also reviewed Veterans Health Administration (VHA) directives, medical records, policies, procedures, and documentation of fee basis care.

For three patients we identified no lapses in quality of care. However, for the remaining three patients we identified deficiencies. For one patient the diagnosis of lung cancer was delayed due to the misinterpretation of chest x-ray findings. A second patient had poor coordination of diabetes care and the facility had insufficient procedures established for operation of its telephone call center. The third patient had poor management of pain during and after a visit to the facility emergency room (ER); however, we did not substantiate an allegation that there was mismanagement of a hip fracture.

We recommended that the facility Director: 1) obtain a peer review assessment of the care provided by radiologists interpreting chest x-rays for the patient with lung cancer; 2) monitor hospital discharges to ensure that patients have ongoing coordination of care; 3) establish telephone call center procedures in accordance with VHA policy; and 4) monitor ER pain management to ensure compliance with VHA policy. The VISN and facility Directors agreed with our findings and recommendations. The actions taken are acceptable.

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

TO: Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Alleged Poor Quality of Patient Care, Marion VA Medical Center, Marion, IL

Purpose

Senator Richard Durbin's office requested that the VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conduct a review to determine the validity of allegations that patients received poor medical care at the Marion VA Medical Center (the facility). Complainants had contacted Senator Durbin alleging poor care at the facility.

Background

The facility provides services to about 44,000 Veterans residing in southern Illinois, southwestern Indiana, and northwestern Kentucky. Part of Veterans Integrated Service Network (VISN) 15, the facility has 55 acute care beds and a 60 bed community living center.

In June and August 2010, OHI received the following separate allegations addressed to Senator Durbin regarding concerns about medical care at the facility:

1. Delay in diagnosis of lung cancer due to a change in primary care providers, absence of clinical oversight for a year, and failure to send primary care appointment letters
2. Inadequate management of a nose lesion and mismanagement of chest pain that required coronary stent placement
3. Poor coordination of care for diabetes
4. Poor pain management and mismanagement of a broken hip
5. Immediate death after discharge from the facility
6. Missed diagnosis of pulmonary embolism

Two additional allegations were received but not addressed in this report. One involved a human resources issue for a non-veteran employee. The other allegation was previously

evaluated by the Veterans Health Administration (VHA) Office of the Medical Inspector and several lapses in quality of care were substantiated.

Scope and Methodology

We conducted a site visit August 24–26, 2010, interviewed complainants, family members, managers, clinicians, and administrative staff, and consulted with a board-certified radiologist. We reviewed VHA directives, medical records, policies, procedures, and fee basis care documentation.

This review was performed in accordance with *Quality Standards for Inspection and Evaluation* published by the President's Council on Integrity and Efficiency.

Inspection Results

Patient 1

Case Review

The patient had chronic obstructive pulmonary disease **(**COPD) and post-traumatic stress disorder. At primary care encounters from August 2006 through May 2008, a primary care physician found his medical condition to be stable. The physician recommended follow-up appointments every 6 months. A nurse practitioner (NP) assumed care of the patient after the physician transferred to a different clinical service. In late October 2008, the NP documented that the patient denied increased shortness of breath and cough, and recommended continued follow-up appointments every 6 months.

In April 2009, primary care administrative staff mailed the patient three letters reminding him to schedule a follow-up appointment. The patient did not respond, and in June staff ordered a chest x-ray and scheduled an appointment for July. The chest x-ray, completed in late-July, showed stable COPD and was felt to reveal no new abnormalities.

In mid-August, a different primary care physician assessed the patient. The physician documented that the patient complained of back pain and that they discussed results of the recent chest x-ray. The physician recommended follow-up in 6 months.

In late October, the patient presented to the primary care clinic for an unscheduled visit. A provider documented that he was complaining of "cough for 2 weeks, sometimes productive of yellow sputum" and prescribed an antibiotic and cough syrup. A chest x-ray was interpreted as showing "chronic changes with questionable minimal interval progression of interstitial infiltrative disease in left upper lobe."

In early December, the patient presented to the emergency room (ER) with productive cough and fever. A diagnosis of pneumonia was made and he was discharged home with an antibiotic and instructions to be re-evaluated in 1–2 weeks. A chest x-ray was interpreted as showing persistence of "bilateral asymmetric interstitial and nodular infiltrate/lung markings."

Seventeen days later, during follow-up evaluation in the primary care clinic, a physician ordered a computerized tomography (CT) scan of the chest. The CT scan, completed three weeks later, showed a large mass encasing the left pulmonary artery. CT-guided biopsy of the left upper lobe performed at a local hospital in early February2010 revealed squamous cell carcinoma. Magnetic resonance imaging showed brain metastasis and an abdominal CT scan showed mass lesions in the kidneys. One month later, palliative radiation therapy was initiated. The patient died 2 months later.

Issue 1: Delay in cancer diagnosis

Although three chest x-rays over a 5-month period were interpreted as showing no significant changes from previous studies, we found that in fact x-ray evidence of cancer was present on the second of those studies. We noted that interpreting radiologists compared diagnostic images only to the most recent previous images, thereby increasing the probability that gradual changes over time would not be appreciated. On the second study during the 5-month period, however, the chest x-ray was clearly abnormal and should have prompted definitive management. When extensive disease was discovered on a CT scan 10 weeks later, appropriate care was initiated. We were unable to determine the impact of this delay on the patient's clinical course.

Issue 2: Lack of clinical oversight and failure to send appointment reminder letters

We did not substantiate these allegations. Except for one 10-month period, the patient had clinic appointments at 6-month intervals. Providers from the same primary care team evaluated the patient and documented that his condition appeared to be stable.

Facility staff provided documentation that three letters were mailed reminding him to schedule an appointment. When the patient did not respond, staff mailed a letter with an appointment date. Because the patient came to the primary care clinic for this appointment and also had scheduled visits at other clinics, we concluded that the patient was receiving care.

Patient 2

Case Review

The patient has a history of gastroesophageal reflux disease, hyperlipidemia,[1] and hypertension. He has been treated by a private physician in the community, visiting the facility for limited care and for medications.

In mid-July 2009, the patient presented to the primary care clinic for an "area [on] his nose he wants looked at." A physician documented, "no lesion detected." Two months later, staff documented receiving medical records indicating that a non-VA dermatologist had evaluated the patient and applied liquid nitrogen to the nose for actinic keratosis.[2]

In late October, the patient had a scheduled appointment with a new physician. The physician documented that the patient reported no chest pain, palpitations, or dizziness. The physician noted that the cardiac exam was normal and recommended follow-up in 1 year.

Two months later, clinic staff documented receiving medical records from the patient's private physician stating that the patient had undergone a percutaneous coronary intervention with stent placement at a private medical facility.

Issue 1: Inadequate management of a nose lesion

We neither substantiated nor refuted this allegation. In mid-July 2009, the patient presented to the primary care clinic with a complaint of a nose lesion. The provider examined the patient's nose and felt that no abnormality was present. Approximately 6 weeks later, a non-VA dermatologist treated the patient for a precancerous nose lesion.

Issue 2: Mismanagement of chest pain that resulted in surgical stent placement

We neither substantiated nor refuted this allegation. The patient received care in the private sector and came to the facility for medications. The patient told us that during a primary care visit for medications, he told a physician that he was having exertion-related chest pain. The patient said that he felt the physician did not listen to his complaints. The physician documented that the patient denied having chest pain and that the cardiac assessment was normal.

[1] High lipid (fat) levels in the blood.

[2] Rough, scaly patches of skin caused by sun exposure and considered to be precancerous.

Patient 3

Case Review

The patient had a history of diabetes and coronary artery disease. He had undergone coronary artery bypass surgery in 2008.

In mid-March 2009, the patient was admitted to the facility with poorly-controlled diabetes and an infection involving his left foot. After treatment with an intravenous (IV) antibiotic, he was discharged home three days later with arrangements for daily dressing changes by a community home health (HH) care agency. On the day of discharge, the patient's last recorded blood glucose was 400 milligrams per deciliter (mg/dl).[3] Several hours after discharge, the patient's mother called the inpatient medical unit and reported that the patient's blood glucose was in the 30–40 mg/dl range. A staff nurse advised the mother to take the patient to the nearest ER.

The next day, HH staff completed an initial home visit and two days later the VA community health nurse documented that HH agency goals for the patient were to improve diabetes compliance, decrease smoking, and initiate a home exercise program. The next day, the facility community health nurse approved 15 home visits.

Six days after discharge, a caregiver contacted the facility's telephone call center and reported that the patient's blood glucose ranged from 78 to 400 and that he was having episodes of dizziness and sweating. The call center nurse advised the caregiver about using insulin to treat this patient and recommended that the patient eat every 3–4 hours. Based on a computerized clinical decision support tool, the call center nurse characterized the patient's condition as "urgent" and recommended follow-up care in the clinic. The nurse's note indicates that the caregiver declined for the patient to return to the facility at that time. The nurse sent the call center note to two physicians with a request for receipt acknowledgement.

On the next day (7 days after discharge), HH staff completed a second visit and discharged the patient from care because of non-compliance. Facility staff were unaware that HH visits were not continuing. The patient died 2 days later.

Issue 1: Poor coordination of diabetes care

We substantiated this allegation. The patient was discharged with marked hyperglycemia. The facility approved 15 HH visits, but after 2 visits HH care was discontinued due to patient noncompliance. VA staff were unaware that HH had discontinued care. The HH agency documented that the patient was discharged from care

[3] The normal range for blood glucose is 70–100 mg/dl.

on the seventh day after he was discharged from the facility, but the VA community health nurse documented on the tenth day after discharge that HH care was ongoing.

A patient caregiver called the facility with concerns about unstable blood glucose values. The call center nurse recommended follow-up care at the facility, but the caregiver declined.

Issue 2: Lack of standard procedures in telephone call center

We assessed processes in the telephone call center, noting that VHA policy[4] requires an annual review of clinical decision support tools used in call centers. We found that the facility had no established procedure for determining how soon 'urgent' patients need to be evaluated and did not specify the expected level of involvement of primary care providers.

Patient 4

Case Review

The patient is an elderly man with COPD, hypertension, and Alzheimer's dementia.

In late May 2009, the patient fell at home and his family drove him to the facility's ER. The patient was noted to be in severe pain (10/10[5]), but an x-ray of the left hip showed no fracture. Staff instructed the patient to use a walker and take acetaminophen as needed for pain.

On the following day, the patient's family drove him back to the ER because of persistent severe pain. The patient's wife reported that he complained of knee, not hip, pain and that he was unable to stand. She said that she could not take care of him and requested nursing home placement. The ER staff documented that the patient was alert and oriented and that the intensity of his pain was 8 out of 10. An x-ray of the left knee showed no fracture or dislocation. The patient was admitted for pain management and nursing home placement. During the 4-day inpatient stay, staff documented that the patient moved all extremities well and ambulated 70 feet with a walker and assistance. At the time of transfer to a local nursing home, the patient denied pain.

Eight days after discharge, a private medical center reported that the patient had presented to its ER with right hip pain and was found to have a right hip fracture. The medical center's staff informed facility utilization review staff that the patient's wife reported that he had several recent falls.

[4] VHA Directive 2007-033, *Telephone Service for Clinical Care,* October 11, 2007.
[5] 0 = no pain. 10 = worst imaginable pain.

Issue 1: Poor pain management

We substantiated this allegation. During his initial ER evaluation, the patient had severe pain, but was discharged to home and treated with only acetaminophen. When he returned to the ER on the following day, he was admitted for management of severe pain and for nursing home placement.

Issue 2: Inadequate management of hip fracture

We did not substantiate this allegation. At initial presentation, the patient had left leg pain, but x-rays showed no fracture. While hospitalized, he moved all extremities well and was able to walk with assistance, and he denied pain at the time of discharge. The facility was notified 8 days after discharge that the patient had presented to a private hospital with right hip pain and was found to have a right hip fracture.

Patient 5

Case Review

The patient had a history of hypertension, diabetes, coronary artery disease, aortic stenosis, and congestive heart failure (CHF). He had undergone coronary bypass surgery approximately 15 years earlier.

The patient was hospitalized at the facility in late 2005 for management of abdominal pain. Four months prior to admission, echocardiography had shown severe aortic stenosis and markedly depressed left ventricular function. Ultrasonography of the upper abdomen showed no significant abnormalities of the gallbladder or liver. He was treated with diuretics to reduce fluid retention attributed to CHF and gradually improved. However, generalized weakness continued and he was able to walk only short distances. Short-term nursing home placement was declined.

On hospital day 11, the patient denied abdominal pain, reported feeling better, and was discharged to the care of his son. The discharging physician assessed the patient to be medically stable. Eleven days after discharge, staff documented that the son had called to report that the patient died soon after arriving home on the day of discharge.

Issue: Immediate death after discharge

We found no evidence that poor quality of care led to the patient's death soon after discharge from the facility. The patient had multiple medical problems, including severe aortic stenosis and CHF. Because the patient's heart disease caused marked generalized weakness, nursing home placement was recommended. However, the patient's son

requested to take him home. The son told us that the patient collapsed and died soon after arriving home.

Patient 6

Case Review

The patient is an elderly man with COPD and a remote history of colon cancer.

He presented to the ER with complaints of shortness of breath on exertion, productive cough, and mid-back pain that occurred with coughing, deep breathing, and movement. He had no fever, but did have an elevated white blood cell count and oxygen saturation by pulse oximetry of 92 percent while breathing room air. A chest x-ray showed chronic changes consistent with COPD. He was admitted to the medical unit with a diagnosis of COPD exacerbation with bronchitis and treated with IV antibiotics. On admission his oxygen saturation was 96 percent with the use of supplemental oxygen.

While hospitalized, the patient was treated with anticoagulants for the prevention of venous thromboembolism. A non-contrast chest CT scan showed only COPD; blood cultures had no growth after 5 days. His condition gradually improved and he was discharged home after 8 days with oxygen saturation 97 percent on room air.

Seventeen days after discharge, the patient presented to the ER with rectal bleeding and recurrent shortness of breath. A physician documented that the patient had a respiratory rate of 18, normal heart and lung examinations, and oxygen saturation 96 percent on room air. The chest x-ray showed no new abnormalities. The patient received IV fluids and was given a referral for gastroenterology consultation. He was discharged home with an antibiotic and instructions to rest and increase fluid intake.

Three days later the patient presented to a private medical facility where he was hospitalized and CT angiography revealed pulmonary embolism (PE).[6]

Issue: Missed diagnosis of PE

We did not substantiate this allegation. The patient was admitted to the hospital for an exacerbation of COPD and gradually improved on antibiotics. While hospitalized, he received anticoagulants for prevention of venous thromboembolism. Providers told us that on both occasions when he presented to the ER, he was not considered to be at increased risk for PE because of the absence of typical signs, symptoms, or risk factors. Providers reported that CT angiography for the possibility of PE was not done because

[6] Pulmonary embolism is the obstruction of blood vessels in the lungs by material travelling from elsewhere in the circulatory system, most commonly from blood clots in the legs.

the patient had impaired kidney function,[7] but this consideration was not mentioned in documentation by any provider.

This patient's care might have been improved if physicians had chosen to pursue the diagnosis of PE at initial presentation, including the option to perform lower extremity ultrasonography for possible deep vein thrombosis.[8] However, the absence of typical findings (risk factors, signs and symptoms, and persistent or marked oxygen desaturation) suggests that providers acted within the range of acceptable clinical practice.

Conclusions

Patient 1 had regular visits in the same primary care clinic and had numerous chest x-rays that were stable. When the patient had persistent symptoms, clinicians ordered a CT scan which revealed cancer. Review of the patient's x-rays revealed that the cancer had been evident on a chest x-ray 10 weeks before the CT scan.

Patient 2 visited a facility primary care physician complaining of a nose lesion. The physician examined the patient and judged that no abnormality was present. Although a non-VA dermatologist subsequently treated the patient for a precancerous lesion, we could not evaluate the appropriateness of that treatment. We were unable to determine whether this patient reported chest pain symptoms to physicians or that there was any delay in treatment of his heart disease.

Patient 3 had poor coordination of his diabetes care and the facility had insufficient procedures established for operation of its telephone call center.

Patient 4 had poor management of pain during and after his initial ER visit. He rated his pain as 10/10 (the worst possible pain), but received no effective treatment for pain and was discharged to home. However, we did not substantiate an allegation that there was mismanagement of a hip fracture.

Patient 5 was hospitalized with severe cardiovascular disease. He died within hours of discharge from the facility, but we identified no lapses in quality of care.

Patient 6 was found to have pulmonary embolism when he presented to a private hospital 3 days after evaluation at the facility. We found that care provided at the facility was within the range of acceptable clinical practice.

[7] Angiography requires the use of IV contrast material, which can damage the kidneys and is avoided when possible in patients with compromised kidney function.

[8] In most cases, PE arises from deep vein thrombosis (blood clots) in the legs. Detection of these clots would support the diagnosis of PE and prompt treatment with long-term anticoagulation at doses higher than what is used for prevention.

Recommendations

Recommendation 1. We recommend that the VISN Director require that the facility Director obtains a peer review assessment of the care provided by radiologists interpreting chest x-rays for Patient 1.

Recommendation 2. We recommended that VISN Director require that the facility Director monitors hospital discharges to ensure that patients have ongoing coordination of care.

Recommendation 3. We recommended that the VISN Director require that the facility Director establish telephone call center procedures in accordance with VHA policy.

Recommendation 4. We recommended that the VISN Director require that the facility Director monitor ER pain management to ensure compliance with VHA policy.

Comments

The VISN and facility Directors concurred with the inspection results (see Appendixes A and B, pages 12–14, for the full text of their comments and completed actions). We consider Recommendation 1 closed. We will follow up on the planned actions for Recommendations 2–4 until they 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: March 2, 2011

From: Director, VA Heartland Network (10N15)

Subject: Healthcare Inspection – Alleged Poor Quality of Patient Care, Marion VA Medical Center, Marion, IL

To: Director, Kansas City Office of Healthcare Inspections

Thru: Director, Management Review Service (10B5)

I have reviewed this report and the recommendations. First, I would like to thank the Kansas City Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) team for the time and attention they took to review these events, that occurred, in some cases two or three years ago. Retroactive reviews such as this present unique challenges and the efforts of the OIG/OHI team to be thorough and fair in their review deserves recognition.

Second, I want to emphasize the efforts that the Medical Center took proactively to address the issues since 2009 and also highlight actions that have been taken more recently in response to the report recommendations.

The OIG report indicates that the diagnosis of lung cancer in one patient may have been delayed because of a possible misinterpretation of chest x-ray findings. It is important to note that prior to the OIG review the Medical Center determined the situation warranted an independent peer review assessment of the care provided by radiologists interpreting chest x-rays. The peer review process has been completed with the determination that the appropriate standard of care was met.

In April 2009, the Medical Center implemented an Inpatient Case Management program to address; difficulties with monitoring hospital discharges, and coordination of care.

To address the issues identified by the OIG team regarding the hand-off process between the call center and the Primary Care Provider, the Medical Center is updating its procedures and expects to implement these no later than March 2011.

The event related to management of pain in the Emergency Room occurred in May 2009. In October 2009, the Medical Center implemented additional monitoring to assess if pain was being assessed in the Emergency Department and if treatment of the pain was initiated in the Emergency Department. The facility has been regularly monitoring pain management in the Emergency Department since that time.

Reviewing prior situations is important to inform future actions. Accordingly, we concur with the report recommendations and will continue to ensure that the Medical Center addresses these concerns.

JAMES R. FLOYD, FACHE

Appendix B

Facility Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 3, 2011

From: Director, Marion VA Medical Center, Marion, IL (657A5/00)

Subject: **Healthcare Inspection –** Alleged Poor Quality of Patient Care, Marion VA Medical Center, Marion, IL

To: Director, VA Heartland Network 15 (10N15)

An OIG visit was conducted August 24–26, 2010, in response to six Veteran's concerns. Enclosed is the response to the recommendations.

Paul Bockelman

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

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

OIG Recommendations

Recommendation 1. We recommend that the VISN Director require that the facillity Director obtain a peer review assessment of the care provided by radiologists interpreting chest x-rays for Patient 1.

Concur **Target Completion Date:** Closed

Prior to the OIG review, leadership at the VAMC Marion determined that an independent peer review assessment of the care provided by radiologists interpreting the chest x-rays for Patient 1 was warranted. Leadership then convened a review. The results of the review indicated that the standards of care had been met, and this review has been shared with the OIG.

Leadership at VAMC continues to pursue effective utilization of the peer review process to improve care for Veterans. The peer review process and requirements for the facility are stated in Medical Center Memorandum (MCM) 00-00QM-10-587 Peer Review Program. This MCM is based on the VHA Directive 2010-025, Peer Review for Quality Management. A monitor related to peer reviews conducted at VAMC Marion is in place so that leadership can continuously evaluate the volume and results of peer reviews as well as analyze the data for trends.

Recommendation 2. We recommended that the VISN Director require that the facility Director monitor hospital discharges to ensure that patients have ongoing coordination of care.

Concur **Target Completion Date:** Closed

This event occurred in March 2009 and was addressed by the Medical Center in April 2009 with the implementation of an inpatient case management program. This program included the hiring of three Registered Nurse (RN) Discharge Planning Case Managers and an increase in Community Health Nurses from one to six full-time positions in January 2010.

A Standard Operating Procedure has been developed and implemented outlining the process used by the Inpatient Case Managers to facilitate the coordination of care with the Primary Care Clinic Staff during the discharge process. In addition, a monitoring tool has been implemented to assess effectiveness of this process improvement.

Recommendation 3. We recommended that the VISN Director require that the facility Director establish telephone call center procedures in accordance with VHA policy.

Concur **Target Completion Date:** Closed

While the Medical Center had established specific telephone call center procedures, the report points out where improvements can be made. The Medical Center has established a more effective hand-off process between the call center and Primary Care providers. The process includes reviews to monitor effectiveness.

Recommendation 4. We recommended that the VISN Director require that the facility Director monitor ER pain management to ensure compliance with VHA policy.

Concur **Target Completion Date:** Closed

This event related to management of pain in the emergency room occurred in May of 2009. In November 2009, the Medical Center implemented an Emergency Department process for monitoring the completion of pain assessments with subsequent initiation of treatment in appropriate clinical situations. This process has been reviewed regularly. Effective January 24, 2011, an additional monitor has been added to assess the effectiveness of pain treatment initiated in the Emergency Department.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Dorothy Duncan, RN Director, Kansas City Office of Healthcare Inspections
Acknowledgments	James Seitz, RN Team Leader Jerome Herbers, MD Reba B. Ransom, RN Jennifer Whitehead

Appendix D

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