



# Department of Veterans Affairs Office of Inspector General

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## Healthcare Inspection

### Quality of Care Review Bob Stump VA Medical Center Prescott, Arizona

**Redacted**

**To Report Suspected Wrongdoing in VA Programs and Operations**

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## Executive Summary

The purpose of the review was to evaluate allegations related to quality of care in several services and the rating change of a peer review at the Bob Stump VA Medical Center (Prescott), Prescott, AZ. Allegations of untimely consultation services; denial of a prompt transfer in an emergent situation; delayed follow up due to miscommunication; delayed orthopedic care; delay in urologic care; and a rating change for a peer review at Prescott, were not substantiated. Although the allegations were not substantiated, the inspection revealed that Prescott lacked a mechanism for tracking their large number of fee basis consults. A physician with fee basis management experience was hired to manage the process. Additionally, during our review, we found a Prescott provider failed to inform leadership about an unacknowledged abnormal chest x-ray from the Southern Arizona VA Health Care System (Tucson). The Prescott Chief of Staff (COS) was made aware of the finding and notified Tucson's COS.

We recommended that the Prescott Director ensure compliance with Veterans Health Administration Directive 2008-002, *Disclosure of Adverse Events to Patients*, and that the Tucson Director review and take appropriate action for the failure to respond to an abnormal chest x-ray. Management agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on the planned actions until they are completed.



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

**TO:** Veterans Integrated Service Network Director (10N18)

**SUBJECT:** Healthcare Inspection – Quality of Care Review, Bob Stump VA Medical Center, Prescott, Arizona

## **Purpose**

VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations related to quality of care in several services and the rating change of a peer review at the Bob Stump VA Medical Center (Prescott), Prescott, AZ.

## **Background**

The Northern Arizona VA Health Care System includes the main medical facility, the Bob Stump VA Medical Center in Prescott, and five Community Based Outpatient Clinics (CBOCs) in Anthem, Kingman, Lake Havasu City, Bellemont and Cottonwood, AZ. Prescott provides inpatient and outpatient care and is part of Veterans Integrated Service Network (VISN) 18.

The complainant contacted the OIG Hotline Division with allegations related to quality of care in several services and the rating change of a confidential peer review. Specifically the complainant alleged:

- Untimely consultation services resulted in a delayed diagnosis.
- Denial of interfacility transfer in an emergent situation.
- Lack of communication prevented appropriate follow-up.
- Ongoing delays of orthopedic care.
- Delay in urologic care.
- Peer review rating change.

## **Scope and Methodology**

Documents were requested from Prescott prior to our site visit on April 14–17, 2009. A detailed review of patient medical records, policies and procedures, medical staff by-laws, and case related documents was completed. During the site visit, the

following staff were interviewed: Prescott Director, Chief of Staff, primary care physicians, nurse practitioner, various service chiefs, transfer coordinator, suicide prevention coordinator and risk manager. Additional documents were reviewed and the timeliness and quality of care was assessed for all patient cases.

The inspection was conducted in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

## **Inspection Results**

### **Issue 1: Alleged Delay in Consultation and Diagnosis**

#### **Issue 1 Case History**

The patient had a history of hypertension, hypercalcemia, gastroesophageal reflux disease, kidney stones, six beer/day alcohol use, and one pack/day tobacco use for 30 years. The patient arrived at the Prescott Emergency Department (ED) in April 2007 with complaints of vomiting blood and bloody stools 2 days prior. The patient was admitted overnight for laboratory and an upper gastrointestinal x-ray study. Laboratory studies completed revealed a hemoglobin of 11.6 (normal 14–18). The x-ray study revealed mucosal changes and minimal reflux with slight thickening of the lower esophageal folds. The patient completed 6 weeks of treatment with omeprazole (a medication to reduce stomach acid) and it was recommended that he undergo esophagogastroduodenoscopy (EGD).<sup>1</sup>

In June 2007, a previously scheduled screening colonoscopy was completed with normal results. The patient's primary care provider (PCP) saw the patient for one visit each in May, September, and December, and on each of these days the PCP submitted a request for fee basis consultation with a gastroenterology (GI) consultant for EGD. During our interview, the PCP reported that, although the patient exhibited no further symptoms, the patient was advised at each visit about the importance of scheduling the EGD. However, at each visit the PCP found that the patient had not scheduled the EGD with a provider in the community.

The patient was assessed by a GI consultant in January 2008 and reported the medication had helped with reflux symptoms. An EGD completed in February revealed poorly differentiated esophageal carcinoma. The PCP sent a consult to Phoenix VA Health Care System (Phoenix) in February for further management. The patient was seen at Phoenix 6 days later by GI and general surgery consultants. Analysis of tissue from the February EGD indicated stage III or IV carcinoma of the esophagus. A fee basis request for chemotherapy and radiation was submitted and approved in March. The patient

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<sup>1</sup> A procedure for examining the esophagus, stomach, and first portion of the small intestine by means of a scope inserted through the mouth.

underwent assessment by the fee basis radiation oncologist in April, followed by radiation and chemotherapy.

Another EGD in July showed that the esophageal mass had increased to 14 centimeters (cm) in diameter (from 10 cm as reported in March) despite treatment. The patient was not considered a surgical candidate and continued to deteriorate. Hospice was initiated in August and the patient died at home 5 days later.

### **Issue 1 Inspection Results**

The allegation that Prescott caused a delay in consultation or diagnosis of a patient was not substantiated. The patient was referred promptly and the consults were approved in a timely manner. When interviewed, the PCP stated discussion with the patient occurred at each clinic visit regarding recommended follow up with a gastroenterologist for additional diagnostic studies. The patient was considered competent and educated about his healthcare. The patient was provided the information and appropriate resources to obtain care, and the PCP made every effort to encourage the patient to seek further evaluation.

### **Issue 2: Alleged Delay in Interfacility Transfer**

#### **Issue 2 Case History**

The patient has a history of hyperlipidemia, peptic ulcer disease, diabetes mellitus, and one pack/day tobacco use. After undergoing a cholecystectomy (gall bladder resection) at Phoenix in August 2006, the patient had an unremarkable post operative course. At the patient's scheduled follow-up appointment 10 days later, the patient reported no pain or other concerns.

Approximately 4 months after the cholecystectomy, on what we will term day 1, the patient presented to the Prescott ED. At that time, the patient was complaining of abdominal and right flank pain increasing over the previous 3 weeks. Abdominal x-rays showed no abnormalities. Complete blood count, serum chemistries, and urinalysis were found to be within normal limits. No assessment was recorded. The patient was sent home on day 1 with instructions to follow up with the PCP.

On day 2, the patient saw the PCP who documented a continued complaint of right abdominal pain. The PCP also noted that the patient had a normal appetite and denied nausea, vomiting, and diarrhea. The PCP's examination revealed mild right upper quadrant abdominal tenderness. The PCP considered several diagnoses, including a viral syndrome, and instructed the patient to return if fever or increased abdominal pain occurred.

On day 6, the patient called the PCP and indicated that flank pain persisted. The PCP ordered laboratory studies, abdominal ultrasonography, and computed tomography (CT).

The ultrasound exam revealed a 5 x 8 cm lesion consistent with an abscess near the liver involving the abdominal wall, and the patient was sent to the ED.

The patient was noted to have a temperature of 100.6° F; laboratory studies were within normal limits. Intravenous antibiotics were initiated and the plan was to admit the patient until transfer to Phoenix could be arranged. Therefore, at 1950 hours on day 6 the patient was admitted; by 2122 hours, the attending physician had discussed the patient with Phoenix staff. During our interview, the admitting physician indicated that immediate transfer was denied and that Phoenix staff recommended continued intravenous antibiotics and overnight observation.

On day 7, a different attending physician contacted Phoenix at 1130 hours. After review of the CT scan, the patient was transferred to Phoenix general surgery unit at 1519 hours for possible abscess drainage. The patient's vital signs and laboratory results remained normal. He underwent abscess drainage by interventional radiology on day 8 and was discharged on day 9.

## **Issue 2 Inspection Results**

The allegation that the patient had a delay in transfer was not substantiated. The patient was admitted to Prescott for observation and intravenous antibiotics. The attending physician contacted Phoenix to complete an interfacility transfer.

The Prescott interfacility transfer policy states that non-emergency case transfers should be planned 24 hours in advance when feasible. The patient was considered to be stable by the ED physician at the time of admission to Prescott. The patient remained stable and an attending physician was able to arrange transfer for the patient to Phoenix within 24 hours of admission.

## **Issue 3: Inadequate Follow-Up of an Abnormal Chest X-Ray**

### **Issue 3 Case History**

The patient (now deceased) had a history of chronic back pain, diabetes mellitus, hypertension, and kidney stones. The patient was diagnosed with metastatic lung cancer in August 2008.

In November 2007, the patient presented to the patient's PCP with complaints of worsening back pain. A routine urinalysis showed blood in the urine. A CT scan of the lower abdomen revealed a stone in the urinary bladder. The PCP documented a weak urine stream and urinary frequency at night and requested urology consultation. The patient was evaluated in the urology clinic and referred for cystoscopy<sup>2</sup> with a

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<sup>2</sup> Examination of the interior of the bladder by means of a lighted tube.

transurethral resection of the prostate (TURP)<sup>3</sup> at Southern Arizona VA Health Care System (Tucson) in Tucson.

A pre-operative chest x-ray in Tucson in May 2008 revealed an “asymmetric density in the left peri-hilar<sup>4</sup> region,” and further x-rays were recommended. There is no documentation of notification by the radiologist or review of the chest x-ray by the surgeons involved in the case in Tucson. The cystoscopy and TURP completed in July were uneventful, and the patient was instructed to return to the PCP at Prescott for further care.

In late August, the patient was assessed at Prescott for exacerbation of chronic back pain by the Physical Medicine and Rehabilitation service. Magnetic resonance imaging (MRI) of the lumbar spine performed a week later showed multiple lytic skeletal lesions.<sup>5</sup> A subsequent CT scan of the abdomen and chest completed revealed suspicious lung lesions and multiple bone lesions consistent with bronchogenic carcinoma with metastases. Later in August, the patient was admitted to Prescott for pain control and evaluations by hematology/oncology and respiratory services.

The admitting provider at Prescott disclosed to the patient the findings from the May 2008 pre-operative chest x-ray completed at Tucson, along with the findings from the CT scan completed in August. Staff at Tucson remained unaware of the incidental pre-operative chest x-ray findings and they were not notified by Prescott.

In early September, the patient was transferred to Phoenix for bronchoscopy with biopsy to confirm the diagnosis of lung cancer. Consults for fee basis radiation and medical oncology treatment close to home were approved and the patient was discharged two days later.

Four days after the discharge from Phoenix, the patient was re-admitted to Prescott for confusion and back pain. Two days after admission to Prescott, the patient was discharged home with hospice care; he died 12 days later.

### **Issue 3 Inspection Results**

The allegation that Prescott failed to follow-up on the patient’s abnormal chest x-ray was not substantiated. The chest x-ray was performed at Tucson, where the patient had been referred for surgery. There was no documentation of notification or awareness of the results at Tucson. However, when the patient’s worsening back pain was evaluated at Prescott approximately 3 months later, the abnormality was discovered and the patient was promptly diagnosed, referred, and treated. The admitting provider at Prescott disclosed the abnormal finding from Tucson to the patient, but neither the PCP nor the

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<sup>3</sup> A surgical procedure to relieve obstruction to urinary flow by removing prostate tissue.

<sup>4</sup> An area in the central chest where the main bronchi and blood vessels enter and exit the lung.

<sup>5</sup> Destruction of bony tissue due to a disease process, such as cancer.



admitting provider notified Prescott leadership. During our visit, the COS was made aware of the incidental finding and took immediate action to notify Tucson.

#### **Issue 4: Alleged Delay in Orthopedic Care**

##### **Issue 4 Case History**

The patient has a history of hypertension, chronic obstructive pulmonary disease, osteoarthritis, and one pack/day tobacco use for 40 years. He was first referred to Phoenix in 2003 for orthopedic care due to knee and shoulder pain. He had undergone a left total knee arthroplasty (TKA) in 1995 and in 2000 his right knee was injected with Synvisc<sup>®</sup>.<sup>6</sup>

The patient returned in May 2002 requesting further Synvisc<sup>®</sup> injections, which had provided relief for his knee pain. However, at that time Synvisc<sup>®</sup> was no longer available at the clinic, and the patient was offered an equivalent injection, surgery, or a brace. The patient declined all offers and said that he would seek care at an outside orthopedic clinic for the desired Synvisc<sup>®</sup> injection.

The patient returned to Phoenix orthopedic clinic in June 2003 with a complaint of right shoulder pain. He was offered a total shoulder arthroplasty (TSA), with the understanding that the benefit would be pain relief without improved function. The patient received an injection to relieve the shoulder pain and agreed to contact the clinic if surgery was desired.

The patient had no further contact with the orthopedic clinic until May 2004, when he returned with a complaint of right knee pain. The patient accepted the treatment plan of a right TKA and was advised that he would have to wait 10 months for surgery. Orders for physical therapy to strengthen leg muscles prior to surgery and a brace were provided. The patient declined an injection for pain and agreed to return to the PCP for pain management prior to surgery. The patient underwent a right TKA in February 2005.

At the 6 month follow-up appointment after the TKA, in August 2005, the patient again complained of right shoulder pain. The shoulder was injected for pain relief and follow-up in 3 months was recommended. The patient did not return to the orthopedic clinic until July 2006. His shoulder was again injected with 3 month follow-up advised.

The patient returned to the orthopedic clinic in October 2006, but at that time, services were restricted to patients receiving primary care at Phoenix. Because it was determined that the patient would benefit from a TSA, he was referred back to Prescott.

The patient's PCP saw the patient once in January, twice in June, and once in December 2007. During our interview, the PCP reported having discussions with the patient during

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<sup>6</sup> A proprietary fluid similar to the fluid found in normal, healthy knees.

each of the visit regarding his options for surgery. Although Prescott did not allow for non-service connected (NSC) orthopedic care through fee basis, the patient was eligible for state-funded care.

In early February 2008, the PCP provided medical clearance for the TSA to be performed by a community orthopedic surgeon. In April the PCP noted that the patient was looking for a surgeon for the TSA, and in May and again in August the PCP documented pre-operative clearances.

In September 2008, the patient returned to the PCP and reported the surgery had not been scheduled. The PCP sent a request to the newly contracted orthopedic consultant at Prescott. The patient saw the orthopedic consultant at Prescott in October and was referred again to Phoenix.

In November 2008, the patient was seen at Phoenix by the orthopedics service chief for evaluation. During a return visit in January 2009, medical work up had not been completed. At that time, the patient was requiring oxygen and was made aware that multiple medical problems could preclude surgery.

In early March 2009, the patient was counseled to quit smoking and an anesthesiologist considered his surgical risk to be high. In late March at a follow-up visit with orthopedics, the patient was noted to still be smoking and using oxygen. Nicotine patches were ordered to assist with smoking cessation and a follow-up appointment scheduled for re-evaluation.

#### **Issue 4 Inspection Results**

The allegation that the patient had a delay in orthopedic care was not substantiated. The patient had been followed for orthopedic care at Phoenix since 1995. Phoenix was unable to provide joint surgery for this patient in 2006, but referred the patient back to Prescott for assistance with fee basis care. At the same time, Prescott did not provide non-service connected (NSC) fee basis care.

The PCP described having discussions with the patient regarding options for orthopedic care. The patient had Arizona state-provided health care benefits that covered 100 percent of the cost for surgery. However, the patient did not have surgery outside the VA and returned to Phoenix in November of 2008. At that time, his risk for elective surgery was considered to be high by the anesthesiologist.

## **Issue 5: Delay in Urologic Surgery**

### **Issue 5 Case History**

The patient (now deceased) had a history of hypertension, multiple sclerosis, metastatic bladder cancer, and 1 pack/day tobacco use for over 20 years. He presented to Prescott in December 2006 with complaints of blood in the urine, low back pain, and frequent urination. The patient was ambulatory and in no acute distress. The CT scan revealed probable stones in the left proximal ureter. The patient was treated with pain medication and instructed to follow up with his PCP.

In March 2007, the PCP saw the patient and requested a urology consultation for continued blood in the urine. Laboratory studies for hemoglobin and hematocrit remained within normal limits. In early May, the patient was assessed by a urologist who performed cystoscopy and found a 2 cm bladder tumor. The patient was referred to Tucson for further evaluation and treatment, but cancelled the late May appointment and was re-scheduled for early June.

A Tucson urology consultant assessed the patient and recommended repeat cystoscopy and possible TURBT (transurethral resection of a bladder tumor). The patient cancelled the scheduled pre-operative appointments in July and August 2007. In October the patient underwent TURBT at Tucson, and the pathology report indicated a high grade muscle invasive tumor. The patient followed up with the urologist at Prescott in late October and had a repeat TURBT in early January 2008.

Seven days after the repeat TURBT, a Tucson urologist informed the patient that the most recent biopsy revealed a high grade tumor invading the muscle wall and recommended a radical cystoprostatectomy (removal of the urinary bladder and prostate). In late February, the patient underwent surgery at Tucson; he was discharged home on 8 days later with plans for follow-up with Prescott urology. In late March, the Prescott urologist requested fee basis consultation for oncology, and 4 days later the consultant assessed the patient and recommended radiation and chemotherapy.

In early April, based on the consultant recommendations, the Prescott urologist documented that the patient would start radiation and chemotherapy after regaining some strength. In late April, the PCP submitted a fee basis request for oncology services to initiate chemotherapy. However, the patient continued to feel weak and did not wish to begin the treatment.

The patient was admitted on in late May to the Prescott palliative care unit with severe pain, weakness, and bowel incontinence. Two days later, the patient requested to be “do not resuscitate” and continued to receive intravenous pain medication. The registered nurse documented good pain control at 2300 hours. Three days after admission, the patient was noted to be sleeping at 0200 hours and at 0300 hours was found without pulse

or respirations. The patient was pronounced dead at 0310 hours. An autopsy was declined.

### **Issue 5 Inspection Results**

The allegation that a delay in urologic care led to the patient's death was not substantiated. The patient was seen by a urologist at Prescott and referred to Tucson for specialized care.

### **Issue 6: Peer Review Rating Change**

#### **Issue 6 Case History**

A peer review was conducted at Prescott; an allegation was made that the rating on that peer review was changed. The content of peer reviews is protected information under Title 38 United States Code (U.S.C.) § 5705, entitled *Confidentiality of Medical Quality-Assurance Records*, and its implementing regulations. Protected Peer Review is intended to promote confidential and systematic processes that contribute to quality management efforts, within a non-punitive context. Because of this we cannot further discuss the details of our review.

#### **Issue 6 Inspection Results**

We reviewed the peer review process and concluded that the allegation that the peer review rating was changed was not substantiated.

### **Issue 7: Fee Basis Consultation Tracking**

Fee basis consultative services were utilized in five of the six cases reviewed for this inspection, but during the course of our review, we found that requests for community provided services were difficult to track.

#### **Issue 7 Inspection Results**

For fee basis consultation, patients are given a letter of approval and instructions for scheduling an appointment with a community provider of their choice. Following the consultation, patients return to their VA provider, who determines the plan of care based on recommendations. The medical center had no established process to determine whether a patient received the requested care.

## Conclusions

The complainant's allegations were not substantiated. However, this inspection revealed that Prescott lacked a mechanism for tracking consultations with community providers. This is an important issue because a large number of fee basis consultations are required since there are limited specialty services at Prescott. Recently, a physician with fee basis management experience was hired to redesign and manage the process. In addition, we found that a Prescott provider failed to inform leadership about an unacknowledged abnormal x-ray from Tucson. The Prescott COS was made aware of the finding and notified Tucson's COS.

## Recommendations

**Recommendation 1:** The VISN Director ensure that the Prescott Director ensure that clinical staff comply with VHA Directive 2008-002, *Disclosure of Adverse Events to Patients*.

**Recommendation 2:** The VISN Director ensure that the Tucson Director review the failure to respond to an abnormal chest x-ray and take appropriate action.

## Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable improvement plans. (See Appendixes A, B and C, pages 11–16 for the full text of their comments.) We will follow up on the planned actions until they are completed.

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

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 12, 2009  
**From:** Director, VA Southwest Health Care Network (10N18)  
**Subject:** Healthcare Inspection – Quality of Care Review, Bob Stump  
VA Medical Center, Prescott, Arizona  
**To:** Director, Dallas Regional Office of Healthcare Inspections  
(54DA)  
**Thru:** Director, Management Review Service (10B5)

We have reviewed and concur with the findings and recommendations presented in the Health Inspection - Quality of Care Review, Bob Stump VA Medical Center report. Prescott's follow up actions have been completed and Tucson's actions are partially complete, with full completion and documentation of same targeted for August 31, 2009. The work of the inspection team is appreciated.



Susan P. Bowers

## Prescott Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 12, 2009  
**From:** Director, NAVAHCS (649/00)  
**Subject:** Healthcare Inspection – Quality of Care Review, Bob Stump  
VA Medical Center, Prescott, Arizona  
**To:** Director, VA Southwest Health Care Network (10N18)

I concur with the findings and recommendation presented in the Health Inspection - Quality of Care Review, Bob Stump VA Medical Center report. Actions taken as a result of these findings are attached.



Susan A. Angell, MSW, PhD

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

**OIG Recommendation**

**Recommendation 1:** The VISN Director ensure that the Prescott Director ensure that clinical staff comply with VHA Directive 2008-002, Disclosure of Adverse Events to Patients.

Concur: **Target Completion Date:** Completed

During the time of this inspection, when the Chief of Staff was made aware of the finding that a provider failed to inform leadership about an unacknowledged abnormal x-ray from Tucson, he immediately notified Tucson's Chief of Staff. He also discussed with the provider the importance of informing leadership and communicating with the facility/provider who ordered the studies, any unacknowledged abnormal findings to assure appropriate patient treatment. This case was also used as an opportunity to reinforce education to the medical staff regarding the disclosure of adverse events and documentation. A memo was distributed to all medical staff on August 11, 2009, regarding the disclosure process, and it was discussed during the Medical Executive Board meeting on August 12, 2009.



## Tucson Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** August 10, 2009  
**From:** Director, SAVAHCS (678/00)  
**Subject:** Healthcare Inspection – Quality of Care Review, Bob Stump  
VA Medical Center, Prescott, Arizona  
**To:** Director, VA Southwest Health Care Network (10N18)

1. On July 27, 2009, I was notified by the Office of the Inspector General to review Recommendation 2 on the failure to respond to an abnormal chest x-ray and take appropriate action. The Chief of Staffs office was instructed to review and investigate the facts and circumstances associated with this recommendation.
2. Appendix D contains the findings of our report. This confirms my review of SAVAHCS failure to respond to an abnormal chest x-ray and appropriate action has been taken.
3. Please contact Julianne French, RN, Administrative Assistant to the Chief of Staff at (520) 629-1815 or [Julianne.French@va.gov](mailto:Julianne.French@va.gov) should you have any follow-up questions.



Jonathan H. Gardner, MPA, FACHE

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

**OIG Recommendation**

Recommendation 2: The VISN Director ensure that the Tucson Director review the failure to respond to an abnormal chest x-ray and take appropriate action.

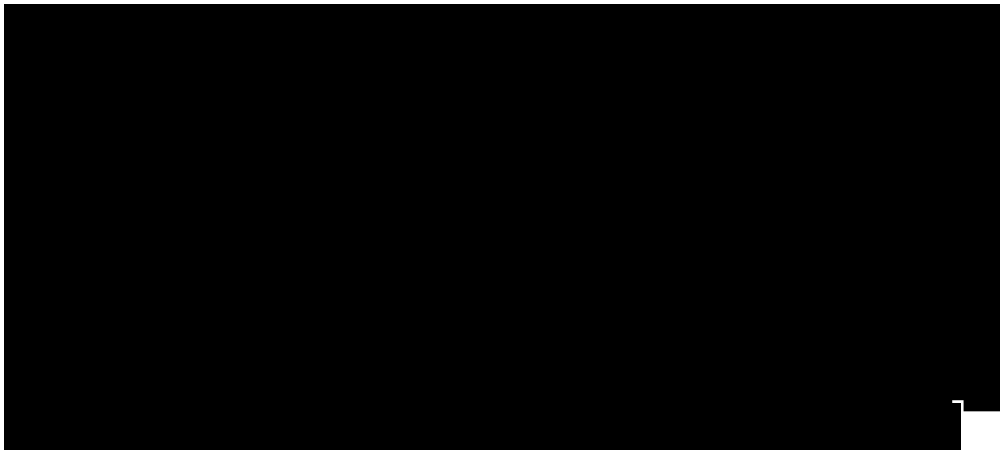
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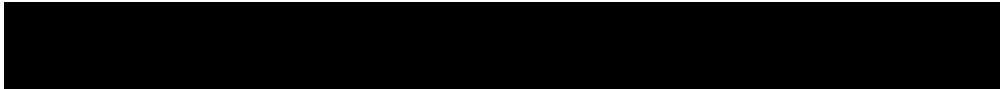
**Target Completion Date:** Aug 31, 2009

On April 16, 2009 the Chief of Staff, Tucson VAMC was informed by the Chief of Staff, Prescott of an alleged failure to diagnose a lung cancer.

The Tucson COS instructed that a peer review be performed.  (b)(3)



 (b)(3)





(b)(3)

All involved providers have been reminded of the process for processing alerts. A meeting with all staff Surgical Care Line providers has been scheduled for August 27, 2009, to review the process for alerts and provider expectations.

## OIG Contact and Staff Acknowledgments

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OIG Contact	Wilma Reyes Dallas Office of Healthcare Inspections (214) 253-3334
Acknowledgments	Cathleen King George Wesley, MD Jerome Herbers, MD

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