Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00794-151

Healthcare Inspection

Delay of Care
Goshen Community Based Outpatient Clinic
Goshen, Indiana

March 24, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Congresswoman Jackie Walorski to assess care provided at the Goshen Community Based Outpatient Clinic, Goshen, IN, to a patient who died of complications related to metastatic lung cancer.

We determined that, although this patient's metastatic disease presentation was not typical, there was a delay in obtaining magnetic resonance imaging (MRI) after computed tomography (CT) results showed left rib involvement, and his quality of life could have been improved through an earlier diagnosis. We could not, however, determine that an earlier diagnosis would have changed his outcome. We also determined the patient and his wife were not aware of VA's Patient Advocacy Program.

We recommended that the VA Northern Indiana Health Care System Director ensure a review of the patient's care is conducted and Goshen Community Based Outpatient Clinic patients and their families are aware of VA's Patient Advocacy Program.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 7–9 for the Directors' comments.) We consider the recommendations closed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Congresswoman Jackie Walorski to assess care provided at the Goshen Community Based Outpatient Clinic (CBOC), Goshen, IN, to a patient who died of complications related to metastatic lung cancer.

Background

VA Northern Indiana Health Care System (VANIHCS) consists of two campuses, one located in Fort Wayne and the other in Marion, IN. It is part of Veterans Integrated Service Network (VISN) 11. The Fort Wayne campus offers primary and secondary medical care services, a 24-hour/7-day per week emergency department (ED), and a 16-bed inpatient medical unit with telemetry monitoring for all beds. Intensive care services were not offered during the period relevant to this review.[1] The Goshen CBOC is an urban, mid-size clinic.[2] It is one of four CBOCs under VANIHCS' oversight. VANIHCS contracts with an outside (non-VA) health care provider to deliver care at the Goshen CBOC.

The clinical presentation of lung cancer may vary widely, from patients with limited or no symptoms to those with diffuse physical problems throughout the body. Most lung cancers are diagnosed at a later stage, as symptoms increase as the cancer spreads. A significant finding of a lung tumor on chest x-ray with subsequent tissue biopsy would be typical of how lung cancers are found and diagnosed. Lung cancer with metastasis without having a well-defined tumor is possible, but not typical.[3] Technological advances have allowed identification of metastatic cancer cells that may help identify the primary tumor.

In spring 2014, a patient who had recently received primary care services at the CBOC and emergency services at the Fort Wayne campus died of complications related to metastatic lung cancer.

[1] OIG conducted reviews of the circumstances leading to the pause of intensive care services in 2012 and of service phase-in processes in 2014. See *Review of Circumstances Leading to a Pause in Providing Inpatient Care, VA Northern Indiana Health Care System, Fort Wayne, Indiana*, Report No. 13-00670-265, August 2, 2013; and *Follow Up of the Pause in Providing Inpatient Care, VA Northern Indiana Healthcare System, Fort Wayne, Indiana*, Report No. 13-00670-262, August 28, 2014.
[2] Based on the number of unique patients seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, the size of a CBOC facility is categorized as very large (> 10,000), large (5,000–10,000), mid-size (1,500–5,000), or small (< 1,500).
[3] Altman E, Cadman E. *An analysis of 1539 patients with cancer of unknown primary site*. Cancer. 1986 Jan 1: 120–4.

Scope and Methodology

We conducted a site visit at Fort Wayne on December 3, 2014. We interviewed the patient's wife and the VANIHCS Director, Chief of Staff, and Quality Manager. We also interviewed Radiology Department staff and an ED provider familiar with the case.

We reviewed the patient's VA electronic health record (EHR) and pertinent non-VA medical records, relevant policies, and Goshen CBOC providers' credentialing and privileging documentation. We reviewed Goshen CBOC Nurse Practitioner oversight data and Patient Advocate complaint data. We also reviewed Goshen CBOC peer review data.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The patient was a male in his early seventies with a medical history significant for chronic lymphocytic leukemia diagnosed more than 8 years ago and coronary artery disease with myocardial infarction and stent placement in 2013. He died in spring 2014. His death certificate listed metastatic lung cancer as the immediate cause of his death.

In fall 2013, the patient had an appointment with his VA oncologist at the Fort Wayne campus.[4] The patient denied having chest pain, shortness of breath, and fevers.

About 2 months later, the patient requested an unscheduled appointment at the CBOC and was examined the same day by Provider A. He complained of fevers, body aches, muscle cramps, back pain, and poor appetite. He denied shortness of breath or chest pain. Provider A ordered laboratory tests. In the following weeks, an Oncology Service staff member documented a phone call with the patient, who stated he was "back to normal," and Provider A noted that the patient denied fever, chest pain, or shortness of breath.

A few weeks after the above unscheduled CBOC appointment, the patient called the CBOC complaining of cold-like symptoms. He was advised to come to the CBOC to be evaluated, but he did not. In the following weeks, a CBOC nurse noted the patient stated that he was no longer having symptoms, and his non-VA cardiologist noted that he was doing well and had no complaints.

In early winter, the patient requested an unscheduled appointment at the CBOC and was examined the same day by Provider A for complaints of fever. He pointed to an area on his chest when asked if he had pain. Provider A diagnosed flu/viral illness and ordered blood tests, which were later noted as stable by the patient's oncologist.

In mid-winter, the patient requested an unscheduled appointment at the CBOC and was examined the same day by Provider B for complaints of right sided chest pain for 7 to 10 days, shortness of breath, and a non-productive cough. The patient stated he had loaded a large wood stove. An electrocardiogram was normal. Provider B diagnosed arthritis of the back with muscle strain and ordered chest and back x-rays. A radiologist noted that the chest x-ray showed no abnormalities and specifically noted, *"There is neither a lytic nor blastic lesion visualized."* The radiologist who reviewed the back x-ray noted arthritis and that magnetic resonance imaging (MRI) might be helpful if the patient's symptoms persisted.

A few weeks later, a CBOC staff noted, *"Pt [patient] stopped by writer's office. Was notified of recent CXR [chest x-ray] results per request. States he is feeling "98% better" at this time and does not feel an MRI is needed yet..."* However, 3 days after that interaction, the patient requested an unscheduled appointment at the CBOC and was examined the same day by Provider A for left chest wall pain for 3 weeks. The

[4] For treatment of his chronic lymphocytic leukemia.

patient stated that his pain was 10 out of 10 (on a 1 to 10 scale), there were no aggravating factors, and he was not sleeping well. Provider A noted a golf ball size bruise on the patient's chest, the pain was reproducible with palpation, his electrocardiogram was normal, his lung sounds were clear, and his breathing was easy and regular. Provider A prescribed ibuprofen, a muscle relaxer, and rest.

In late winter, the patient requested an unscheduled appointment at the CBOC and was examined the same day by Provider C for left chest pain. An electrocardiogram was normal. Provider C diagnosed the patient with pleurisy[5] and prescribed a narcotic pain reliever used to treat moderate to severe pain. Provider C noted that an exercise stress test (stress test)[6] would be ordered if the patient's symptoms worsened.

A week later, the patient presented to the CBOC for an unscheduled visit. He complained of left chest pain and requested an MRI. Provider C noted the patient's symptoms were more likely his heart than his spine and that he would have a stress test and an MRI could be set up if needed. The following day, the patient told the CBOC staff member who called to schedule the stress test that the pain was interfering with his ability to perform his daily activities. The stress test was ordered as routine and scheduled to occur 8 weeks later.

A week later, the patient went to a community non-VA ED where he received a computed tomography (CT) scan for worsening left-sided chest pain. The results of this scan showed a 6 millimeter left rib lesion and a 2.1 centimeter lesion to the liver. He received prescriptions for additional narcotic pain relievers and an antianxiety medication, and he was advised to follow up with his primary provider for further studies. The following day, Provider C called the patient to discuss the CT scan results. An MRI was ordered as routine and was scheduled to occur in 4 weeks.

Six days later, the patient's wife reported to CBOC staff that the patient's pain was 10 out of 10, and he was unable to dress himself due to the pain. The patient presented later that day to the Fort Wayne VA ED, and he was treated for constipation and over sedation from his prescribed pain medications. Two days after that, the patient's wife called the CBOC and stated he was in "excruciating" pain, she could no longer take care of him, he needed help "NOW," and she was "pleading" for an MRI. The MRI was rescheduled to be completed sooner, but the requested consult was not changed to urgent or emergent.

Three days later, the patient presented to a community non-VA ED and was admitted with intractable chest pain. A chest x-ray, ultrasound and CT of the abdomen, a liver biopsy, and MRI of the back were completed. His chest x-ray showed no defined tumor. The results of all his other studies were consistent with widespread metastatic disease from cancer involving the liver and spine. A liver biopsy showed cancer cells that originated from a cancerous process that typically is associated with lung cancer.

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[5] Pleurisy is an inflammation of the membrane (pleura) surrounding the lungs. http://www.mayoclinic.org/diseases-conditions/pleurisy/basics/definition/con-20022338. Accessed January 9, 2015.
[6] A test to determine how the heart responds to exertion.

The patient was discharged from the community non-VA hospital and transferred to a nursing home. He received chemotherapy but expired a few weeks later.

Inspection Results

Issue 1: Delay of Care

We determined that there was a delay in obtaining an MRI after CT results showed left rib involvement and that the patient's quality of life could have been improved through an earlier diagnosis; however, we could not determine that an earlier diagnosis would have changed his outcome.

We determined the patient's metastatic disease presentation was not typical in that his chest x-rays did not show a defined tumor and, although he complained to his care providers of rib pain and fever, he would often soon after verbalize that he was better and had no complaints when queried during follow-up calls with CBOC staff and/or scheduled health care appointments.

However, because the quality, frequency, and intensity of his complaints of rib pain changed in late winter, we determined there was a delay in diagnosing his metastatic disease:

1) The stress test that was ordered to determine if the patient's pain was cardiac related should have been ordered with an urgency greater than routine and scheduled sooner than 8 weeks in light of the patient's cardiac history.

2) The MRI should have been ordered with an urgency greater than routine when his CBOC provider learned a CT performed at the community non-VA ED revealed rib and liver lesions and because the patient was increasingly unable to perform activities of daily living due to his pain and inability to tolerate higher doses of narcotic medications.

3) The patient should have received an MRI emergently when his CBOC provider learned he required additional narcotic pain and antianxiety medication to treat his pain and his wife stated that his pain was "excruciating" and she could no longer care for him due to his reported pain.

Issue 2: Patient Advocacy

We determined that the patient and his wife were not aware they could have contacted a VA Patient Advocate to assist them when they had concerns regarding his care.

During an interview, the patient's wife told us she was not aware of VA's Patient Advocacy Program,[7] which is designed to facilitate resolutions when patients and/or their family members have care related concerns.

[7] http://www.va.gov/health/patientadvocate. Accessed December 19, 2014.

Conclusions

We determined that although this patient's metastatic disease presentation was not typical, there was a delay in obtaining an MRI after CT results showed left rib involvement and that his quality of life could have been improved through an earlier diagnosis; however, we could not determine that an earlier diagnosis would have changed his outcome. We also determined the patient and his wife were not aware of VA's Patient Advocacy Program.

Recommendations

1. We recommended that the VA Northern Indiana Health Care System Director ensure a review of this patient's care is conducted.

2. We recommended that the VA Northern Indiana Health Care System Director ensure Goshen Community Based Outpatient Clinic patients are aware of the process for contacting a VA Northern Indiana Health Care System Patient Advocate when concerns regarding provider communication or access to medical care arise.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 17, 2015

From: Acting Director, Veterans in Partnership (10N11)

Subj: **Draft Report**—Healthcare Inspection – Delay of Care, Goshen Community Based Outpatient Clinic, Goshen, Indiana

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I concur with the findings and recommendations for VA Northern Indiana Healthcare System.

2. If you have any questions or concerns, please contact me.

Thank you,

Robert P. McDivitt, FACHE/VHA-CM

Appendix B

System Director Comments

Department of Veterans Affairs

Memorandum

Date: February 13, 2015

From: Interim Director, VA Northern Indiana Health Care System (610A4/00)

Subj: **Draft Report**—Healthcare Inspection – Delay of Care, Goshen Community Based Outpatient Clinic, Goshen, Indiana

To: Director, Veterans in Partnership (10N11)

1. I have reviewed the recommendations made during the Office of Inspector General Review regarding the Goshen Community Based Outpatient Clinic. I concur with the responses to the recommendations.

2. We greatly appreciate the opportunity to work with the Office of Inspector General. If you have any questions, please do not hesitate to contact me at (260) 426-5431, extension 71504.

Thank you,

Himanshu S. Singh, M.D.

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the VA Northern Indiana Health Care System Director ensure a review of this patient's care is conducted.

Concur

Target date for completion: January 30, 2015

Facility response: A thorough review of the Veteran's record was conducted and the results of the review were shared with the Office of Inspector General on January 30, 2015.

Recommendation 2. We recommended that the VA Northern Indiana Health Care System Director ensure Goshen Community Based Outpatient Clinic patients are aware of the process for contacting a VA Northern Indiana Health Care System Patient Advocate when concerns regarding provider communication or access to medical care arise.

Concur

Target date for completion: February 12, 2015

Facility response: A Patient Advocate informational sign is prominently displayed in the Goshen Community Based Outpatient Clinic (CBOC) Waiting Room. The current sign has contact information for the CBOC Patient Advocate Liaison (PAL), who is an on-site staff member, and the Fort Wayne Campus Patient Advocate. In addition, the CBOC staff are aware of the contact information for the Patient Advocates and regularly provide this information to Veterans and caregivers.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Stephanie Hensel, RN Thomas Wong, DO

Appendix D

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