Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Delayed Cancer Diagnosis
VA Greater Los Angeles
Healthcare System
Los Angeles, California

Report No. 07-01305-177 **July 24, 2007**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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Executive Summary

The purpose of this inspection was to determine the validity of allegations that several patients experienced delays in their cancer diagnoses, and clinicians had not been fully informed about the procedures related to disclosing adverse events at the VA Greater Los Angeles Healthcare System.

We substantiated the allegation that one patient's colorectal cancer (CRC) diagnosis was delayed. This patient reported gastrointestinal symptoms in September 1999. However, these symptoms were not evaluated until December 2004 when he underwent a sigmoidoscopy procedure, and a small polyp near the anal canal was detected. Because the sigmoidoscopy revealed inadequate preparation, a colonoscopy procedure was recommended to obtain a definitive diagnosis. Ten months later, the colonoscopy revealed CRC. The healthcare system has taken full responsibility for failing to follow up on the initial referral in 1999 by disclosing the system failure and working with the patient to facilitate future care and monetary compensation.

We could not substantiate or refute the allegation that several other patients had delayed cancer diagnoses. The allegation was apparently based on events that had occurred over the past 7–10 years.

Managers had begun to implement actions to improve CRC prevention, diagnosis, and timely follow-up for high-risk patients. Planned actions included implementing a review process to identify at-risk patients and establishing a CRC registry to improve follow-up. The plan also included hiring a CRC Coordinator, who will case manage patients through their diagnostic and treatment processes. We determined that an assessment of the efficiency of the gastroenterology (GI) section's clerical processes and the adequacy of clerical support staff is warranted to ensure necessary procedures are accomplished.

We did not substantiate the allegation that clinicians had not been made fully aware of the requirements for disclosing adverse events. We recommended that the healthcare system implement all planned actions to improve CRC prevention, diagnosis, and timely follow-up. We also recommended that the healthcare system assess GI clerical efficiencies and staffing adequacy.

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

TO: VISN 22 Director

SUBJECT: Healthcare Inspection – Delayed Cancer Diagnosis, VA Greater Los Angeles Healthcare System, Los Angeles, California

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations that several patients experienced delays in their cancer diagnoses and clinicians had not been fully informed about the procedures related to disclosing adverse events at the VA Greater Los Angeles Healthcare System (the healthcare system). The purpose of this inspection was to determine the validity of the allegations.

Background

On December 15, 2006, a staff physician (secondary complainant)[1] sent an e-mail message to the healthcare system Chief of Staff (COS), with a courtesy copy to the healthcare system Director and two other physicians, including the primary complainant. In that e-mail, the secondary complainant revealed his concerns about delays in cancer diagnoses of some patients. The correspondence named a patient and referenced that this patient was 1 of 15 similar cases he had witnessed as an attending physician. In addition, he commented that clinical section chiefs should be made fully aware of the procedures for disclosing adverse events.

The primary complainant forwarded a copy of the secondary complainant's e-mail to the OIG Hotline without the secondary complainant's knowledge. We contacted the primary complainant for clarification and to obtain the identities of the 14 other patients referenced in the e-mail. However, the primary complainant had no specific information. Therefore, we contacted the secondary complainant to obtain more information, including the identities of the patients.

[1] For the purpose of this report, we will refer to the individual who contacted the OIG as the primary complainant and the individual who wrote the e-mail as the secondary complainant.

The secondary complainant told us that he also did not have specific information about the patients referenced in his e-mail. He stated that his comment about 14 other patients, who might have experienced similar delays, was based on cases he had witnessed over the past 7–10 years. He explained that his e-mail was intended as an internal dialogue with the COS and to support his colleagues. He was not aware that a copy was forwarded to the OIG and stated that he would probably reconsider sending similar e-mails in the future based on this experience. He also emphasized that his e-mail received timely and appropriate response from healthcare system management.

The healthcare system is a tertiary medical center with more than 900 beds and approximately 3,500 employees. It has an operating budget close to $500 million. The healthcare system is part of Veterans Integrated Service Network (VISN) 22.

Scope and Methodology

We conducted a site visit at the healthcare system on April 12, 2007, and interviewed the secondary complainant, clinical section chiefs, and healthcare system senior managers. We reviewed documents, including policies, medical records, and reports related to colorectal cancer management (CRC). The scope of our review was limited to the information described in the e-mail.

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

Inspection Results

Case Review

The patient is a 61-year-old male with a history of hypertension, severe right hip degeneration, and substance abuse. The patient had no prior or family history of cancer. He has received treatment at the healthcare system since 1998.

In September 1999, the patient reported to his primary care provider (PCP) that he had experienced rectal bleeding and diarrhea every few weeks for the past 3 years. The PCP requested a gastroenterology (GI) consultation and ordered a flexible sigmoidoscopy to screen for CRC. Between 1999 and 2004, we found several progress notes indicating that a sigmoidoscopy had been ordered. The PCP also noted that the patient missed a number of scheduled appointments during this timeframe. The patient had a sigmoidoscopy in December 2004, which revealed a 4-millimeter polyp near the anal canal. Clinicians recommended a colonoscopy and scheduled the patient for a pre-colonoscopy evaluation a month later. The patient canceled the appointment, and the evaluation did not take place until June 2005. In October 2005, the patient underwent a colonoscopy that revealed a colon mass, which was determined to be CRC.

Issue 1: Delayed Cancer Diagnosis

We substantiated the allegation that a patient's CRC diagnosis was delayed.

The Chief of Organizational and Performance Improvement told us that he requested an internal review of the care provided to the patient upon receipt of the e-mail message. This review identified several systemic issues, which are consistent with the system-wide issues OIG identified in a report about CRC detection and management.[2] The Chief also stated that he did not review the care of the other patients referenced in the e-mail because he had no specific information. He believed these might have been cases that have occurred over several years and had been previously reviewed.

The Chief of Medicine Service told us that he had begun to implement actions to improve CRC prevention and ensure that high-risk patients receive timely follow-up. High-risk patients are those with family histories of CRC, symptoms, and/or positive screening tests, such as fecal occult blood and sigmoidoscopy. Planned actions included implementing a retrospective review process to identify at-risk patients and establishing a CRC registry to capture high-risk patients. The Chief also indicated that the CRC registry will be managed by a coordinator, who will case manage high-risk patients through their diagnostic and treatment processes. He plans to recruit for the coordinator position once it is assigned the appropriate grade level by Human Resources Management staff.

The Chief of the GI Section confirmed that improvement actions have been initiated to address timeliness of CRC detection and follow-up for high-risk patients. He supported the plan for a dedicated CRC Coordinator. However, he stated that GI also needs a sufficient number of clerical support staff to ensure all patients are scheduled and contacted when they cancel or fail to show up. He was concerned that GI does not have sufficient clerical support to meet current demands. Other clinicians expressed the same concern. We agreed that an assessment of the efficiency of clerical processes and the adequacy of GI clerical support staff was warranted.

We concluded that the patient's CRC diagnosis was delayed. This patient should have been a higher priority and more effort should have been made to follow up with him, given his symptoms during his initial presentation and the subsequent positive sigmoidoscopy. This patient might have had a better outcome if the sigmoidoscopy and diagnostic colonoscopy procedures had occurred more expeditiously.

[2] VAOIG report, *Colorectal Cancer Detection and Management in Veterans Health Administration Facilities*, Report No. 05-00784-76, February 2, 2006.

Issue 2: Disclosing Adverse Events

We did not substantiate the allegation that clinicians had not been made fully aware of the requirements for disclosing adverse events. The healthcare system's policy is consistent with Veterans Health Administration guidance. The policy outlines the procedures and requirements for communicating adverse events to the patients and/or patients' families. We found documentation that the policy was discussed at the Medical Executive Committee meeting and at a training session in October 2005.

On April 11, 2007, clinicians met with the subject patient and appropriately disclosed the delayed diagnosis, including advising him of his right to file a tort claim and/or claim for increased benefits. The secondary complainant confirmed that he was present during this discussion.

We found evidence that other adverse events had also been appropriately disclosed. We concluded that managers had adequately disseminated information about disclosing adverse events.

Recommendations

Recommendation 1. We recommended that the VISN Director require the Healthcare System Director to implement all planned actions to improve CRC prevention, diagnosis, and timely follow-up, including the recruitment of a CRC Coordinator.

Recommendation 2. We recommended that the VISN Director require the Healthcare System Director to assess the efficiency of GI clerical processes and the adequacy of GI clerical staffing to ensure necessary procedures are accomplished.

Comments

The VISN and Healthcare System Directors concurred with our findings and recommendations with one minor clarification. The Healthcare System Director requested that all references made in the report related to the December 2004 flexible sigmoidoscopy should state that the procedure disclosed inadequate preparation and a 4-millimeter polyp near the anal canal. He further stated that had the preparation been adequate, the sigmoidoscopy may have been diagnostic to reveal the rectal cancer, which would have reduced the time delay in making a definitive diagnosis. He also commented that due to the failure of the healthcare system to follow up on the initial referral in 1999, the VA has taken full responsibility by disclosing the system failure to the patient.

The improvement actions submitted by the healthcare system met the intent of the recommendations. We will follow up on the planned actions until they are completed. (See Appendixes A and B, pages 6–8, for the full text of the Directors' comments.)

(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: May 10, 2007

From: Network Director, VA Desert Pacific Healthcare Network (10N/22)

Subject: **Healthcare Inspection—Delayed Cancer Diagnosis, VA Greater Los Angeles Healthcare System, Los Angeles, California**

To: Director, Los Angeles Regional Office of Healthcare Inspections, OIG

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

After a thorough review of the report and action taken and planned by the VA Greater Los Angeles Healthcare System, I concur with the report and amendment proposed.

(original signed by:)
Kenneth J. Clark, FACHE

Appendix B

Healthcare System Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 10, 2007

From: Director, VA Greater Los Angeles Healthcare System (691/00)

Subject: **Healthcare Inspection—Delayed Cancer Diagnosis, VA Greater Los Angeles Healthcare System, Los Angeles, California**

To: Director, Los Angeles Regional Office of Healthcare Inspections, OIG

After a thorough review of the report by myself and pertinent staff members at the VA Greater Los Angeles Healthcare System (GLA), I concur with the report with one minor clarification requested as follows:

All references to the report of the flexible sigmoidoscopy procedure performed in December 2004 should include "procedure disclosed an inadequate preparation and a 4-millimeter polyp near the anal canal."

It is significant to note that had the preparation been adequate in December, the flexible sigmoidoscopy may have been diagnostic to reveal the rectal cancer, which would have reduced the time delay in making a definitive diagnosis. However, due to the failure of GLA to follow up on the initial referral in 1999, the VA has taken full responsibility for this system failure and is working with the patient to facilitate appropriate action for future care and monetary compensation.

(original signed by:)
Charles M. Dorman, FACHE

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

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

OIG Recommendations:

Recommendation 1. We recommended that the VISN Director require the Healthcare System Director to implement all planned actions to improve CRC prevention, diagnosis, and timely follow-up, including the recruitment of a CRC Coordinator.

Concur **Target Completion Date**: August 1, 2007

The GLA Resources Board has approved the development of a Program Specialist position at the GS-9 target GS-11 level that will function as the CRC Coordinator. The position descriptions have been classified, and posting of the position is in process by the Human Resources Service.

Service agreements have been developed and are in the process of being implemented between Ambulatory and Primary Care and Gastroenterology Services which define hand off and follow-up communication processes.

Recommendation 2. We recommended that the VISN Director require the Healthcare System Director to assess the efficiency of GI clerical processes and the adequacy of GI clerical staffing to ensure necessary procedures are accomplished.

An assessment team was formed to evaluate and redesign clerical processes within the Gastroenterology Service. Several key changes have been implemented, including the development of a supervisory position and the consolidation of all clerical resources under one supervisor. The workflow has been redesigned, and a "command and control" consult, triage, and processing system has been implemented. The Program Specialist/CRC Coordinator will oversee the new system and "manage" patients through the entire process once they screen in for high risk.

Concur **Target Completion Date**: August 1, 2007

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Julie Watrous, Director Los Angeles Office of Healthcare Inspections (213) 253-2677 ext. 4936
	Daisy Arugay Jerome Herbers, M.D. Michelle Porter, RN

Appendix D

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