Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Access to Care, Diagnosis, and Treatment at Community Based Outpatient Clinics in Smyrna and Rome, Georgia

Report No. 09-02985-46 **Decenber 10, 2009**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time, Monday through Friday, excluding Federal holidays

E-Mail: vaoighotline@va.gov

Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections reviewed allegations that a veteran was denied access to care at a community based outpatient clinic (CBOC) and that CBOC providers failed to diagnose and treat two serious medical conditions for that veteran. The complainant made the following allegations regarding the veteran's care:

- A veteran at the Rome CBOC complained of feeling like he was dizzy or "about to pass out" during a visit for blood work, asked to see a doctor, was denied access to medical care, and no alternative treatment was provided.

- At the Smyrna CBOC, a provider examined a sore on the veteran's lip and treated it with cream. This condition was diagnosed by a private-sector physician as cancer 2 years later.

- A Rome CBOC provider did not diagnose, and therefore did not treat, the veteran for decreased renal function. The veteran and his family were not informed of this condition until it had worsened and was identified by a private-sector physician.

Although we confirmed that the veteran notified the Rome CBOC staff of feeling dizzy while at the clinic, we did not substantiate that the veteran was denied access to care. We did not substantiate that a Smyrna CBOC Primary Care Provider (PCP) failed to diagnose and treat a lip cancer. The veteran's medical records show that the veteran was referred to a fee basis provider who treated the lip sore. We did not substantiate that a Rome CBOC PCP failed to diagnose and treat the veteran's decreased renal function. We made no recommendations and plan no further actions. The VISN and Medical Center Directors concurred with our findings.

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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Access to Care, Diagnosis, and Treatment at Community Based Outpatient Clinics in Smyrna and Rome, Georgia

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations that a veteran was denied access to care at a CBOC and that CBOC providers failed to diagnose and treat two serious medical conditions for the same veteran. The purpose of the review was to determine whether the allegations had merit.

Background

The Atlanta VA Medical Center (VAMC) is located east of Atlanta in Decatur, GA, and operates CBOCs in Lawrenceville, Oakwood, Rome, Smyrna, East Point, and Stockbridge, GA. The Rome and Smyrna CBOCs, which are the subject of this complaint, are located northwest of Atlanta. The Rome CBOC is approximately 70 miles from the VAMC and the Smyrna CBOC is approximately 20 miles from the VAMC. The VAMC is part of Veterans Integrated System Network (VISN) 7.

A complainant contacted the OIG Hotline Division in July 2009 with the following allegations:

- In May 2009, a veteran at the Rome CBOC complained of feeling like he was "about to pass out" during a visit for blood work and asked to see a doctor. Staff denied the veteran medical care three times because he did not have an appointment. No alternative treatments were provided. The veteran was admitted to a private hospital later that day with chronic obstructive pulmonary disease (COPD) and coronary artery blockage.

- At the Smyrna CBOC, a provider examined a sore on the veteran's lip and treated it with cream. This condition was diagnosed as cancer 2 years later after "one look" by a private-sector physician.

- A Rome CBOC provider did not diagnose and therefore did not treat the veteran for decreased renal function. The veteran and his family were not informed of this condition until it had worsened and was identified by a private-sector physician. The veteran currently has 50 percent renal function.

Scope and Methodology

We interviewed the complainant via telephone on September 9, 2009. We reviewed the veteran's medical records for January 2003–August 2009. We conducted a site visit on September 14–17, 2009, to interview the Rome and Smyrna CBOCs' senior managers and staff involved in the veteran's care. Additionally, we reviewed policies and procedures applicable to these issues during this time period.

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

Case Information

The veteran was in his late 70s, with a history of atrial fibrillation, diabetes, hypertension, COPD, stroke, and coronary artery disease. Due to a change of residence in the past 4 years, the veteran had been seen at Atlanta VA Medical Center and two CBOCs in VISN 7. The veteran was seen in the Smyrna CBOC from 2005 to 2007. When the Rome CBOC opened in 2007, the veteran requested to change to that CBOC. During the period of 2007 through 2009 the veteran had multiple hospital admissions at a private sector hospital. The veteran's spouse was present at all VA medical appointments.

Issue 1: Access to Care

While we confirmed that the veteran notified the Rome CBOC staff of feeling dizzy while having blood drawn in May 2009, we did not substantiate that the veteran was denied access to care. Staff members recalled the veteran did report feeling dizzy, but also complained that his continuous positive airway pressure (CPAP) facemask did not fit properly and that his motorized scooter did not function properly.

The veteran was seen by two registered nurses (RNs, referred to here as RN-1 and RN-2). The medical record shows that RN-1 entered a request for a CPAP facemask replacement, and also recorded the veteran's pulse oximetry (the amount of oxygen in the blood) at 98 percent (the normal range is 95-100 percent). RN-2 observed the veteran and offered a same day appointment with a pulmonologist. However, the veteran only wanted to see his PCP, who was overbooked and unable to see the veteran at that time. The veteran declined the pulmonary appointment and left the CBOC accompanied by his spouse.

Records indicate that later the same day the veteran had difficulty breathing at home and was admitted to a private-sector hospital for 9 days. Four days after discharge, the veteran was readmitted to the private-sector hospital for exacerbation of COPD; he remained there for 12 days.

Issue 2: Diagnosis and Treatment

We did not substantiate that a PCP at the Smyrna CBOC failed to diagnose and treat a lip cancer. The veteran's medical records from January 2003 to August 2007 show no documentation of a lip sore. Medical record documentation shows that the patient's lip sore was first documented in mid-August 2007. While no topical medications were ordered for the veteran's lip, a dermatology consultation was requested, with subsequent fee basis referral to a private-sector physician. Twenty days later, In September 2007, a malignant cancer was removed from the veteran's lip.

We did not substantiate that a PCP at the Rome CBOC failed to diagnose and therefore treat the veteran's decreased renal function. Medical records show that blood work drawn in July 2008 indicated normal renal function. The veteran was admitted to a private hospital for pulmonary and cardiac problems in December 2008 and was diagnosed by his private physicians with decreased renal function. Following the private hospital admission, the veteran saw his PCP in January 2009 at the Rome CBOC. Blood work was drawn and indicated decreased renal function. A letter describing the decreased renal function was sent to the veteran in February and again in April 2009 by the Rome CBOC. A private-sector physician continued to see the veteran for decreased renal function. Although medical records were requested from the veteran by the PCP, no records were provided to the VA. The veteran had several private hospital admissions and therefore missed clinical appointments from January through May 2009. His PCP initiated consults related to renal function in June 2009 and the veteran was seen within 45 days.

Conclusions

Although we confirmed that the veteran reported feeling dizzy and requested care at the Rome CBOC in May 2009, we did not substantiate that he was denied care. Nursing staff observed the veteran's condition and offered a same-day pulmonary appointment, which he declined. The veteran was stable and in no acute distress when he left the CBOC.

We did not substantiate allegations that CBOC providers failed to diagnosis and treat a lip cancer and decreased renal function. The first documented identification of the lip sore resulted in a dermatology referral and treatment within 1 month. Additionally, medical records indicate the veteran had normal renal function in July 2008, and the decreased renal function was diagnosed after the veteran was admitted to a private

hospital in December 2008. The PCP reviewed appropriate blood work and initiated consults related to the decreased renal function.

We did not substantiate the complainant's allegations in this hotline; therefore, we made no recommendations.

Comments

The VISN and VAMC Directors concurred with our conclusions (see Appendixes A–B, pages 5–6, for the full text of their 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: Oct 30, 2009

From: Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection – Access to Care, Diagnosis, and Treatment at Community Based Outpatient Clinics in Smyrna and Rome, Georgia**

To: Assistant Inspector General for Health Care Inspections

I have reviewed and concur with the response from the Atlanta VA Medical Center.

(original signed by:)

Lawrence A. Biro

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 26, 2009

From: Director, Atlanta VA Medical Center (508/00)

Subject: **Healthcare Inspection – Access to Care, Diagnosis, and Treatment at Community Based Outpatient Clinics in Smyrna and Rome, Georgia**

To: Director, VA Southeast Network (10N7)

I concur with the conclusions presented in the Healthcare Inspection report. The allegations were not substantiated and therefore no actions recommended.

(original signed by:)

James Clark, MPA

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Linda DeLong, Director Dallas Office of Healthcare Inspections (214) 253-3331
Acknowledgments	Warren Porter Karen Moore Laura Dulcie Michael L. Shepherd, MD

Appendix D

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