



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Delay in Cancer Diagnosis Iowa City VA Medical Center Iowa City, Iowa

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: <http://www.va.gov/oig/contacts/hotline.asp>)

Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding a delay in cancer diagnosis and treatment, and quality of care issues at the Iowa City VA Medical Center (the medical center) in Iowa City, Iowa.

Family members of a veteran alleged that physicians failed to order appropriate tests in response to the veteran's symptoms, resulting in delayed diagnosis and treatment of pancreatic cancer. The family also alleged that managers refused a request for chemotherapy treatment near the veteran's home and provided incorrect information regarding pay for travel to Omaha, Nebraska, for a second opinion at the VA Nebraska-Western Iowa Health Care System.

We substantiated that 52 days elapsed from the time the patient's initial computed tomography scan showed an abnormality to the biopsy which showed pancreatic cancer, and also substantiated that the patient was misinformed regarding non-VA care and reimbursement for travel.

We recommended that the Acting Veterans Integrated Service Network (VISN) Director ensure that the Acting Medical Center Director monitors reporting of abnormal tests and makes provisions for staff to refer patients to the appropriate administrative support offices when there are questions related to eligibility and travel pay. The Acting VISN and Acting Medical Center Directors concurred with the recommendations.



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

TO: Acting Director, VA Midwest Health Care Network (10N23)

SUBJECT: Healthcare Inspection – Delay in Cancer Diagnosis, Iowa City VA Medical Center, Iowa City, Iowa

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations that treatment for cancer was delayed for a veteran at the Iowa City VA Medical Center (the medical center), Iowa City, Iowa.

Background

The medical center provides acute and long-term care for a veteran population of approximately 184,000 in 32 eastern Iowa and 16 western Illinois counties. It is affiliated with the University of Iowa Carver College of Medicine and is part of Veterans Integrated Service Network (VISN) 23.

A complainant sent an electronic mail message to the OIG Hotline Section on January 5, 2010, on behalf of a patient. The complainant alleged that physicians failed to recognize symptoms and order appropriate tests, resulting in delayed diagnosis and treatment of pancreatic cancer. The complainant also alleged that managers refused a request for chemotherapy treatment near the veteran's home and provided incorrect information regarding travel pay to Omaha, Nebraska, for a second opinion at the VA Nebraska-Western Iowa Health Care System.

Scope and Methodology

We interviewed the complainant and the patient's spouse, and also interviewed the oncologist who provided a second medical opinion. During a site visit on April 19–23, 2010, we interviewed medical center managers and employees. We reviewed the patient's medical records regarding care at the medical center and during an oncology

consultation at the VA Nebraska-Western Iowa Health Care System (VANWIHCS) in Omaha, Nebraska. We also reviewed medical center policies and procedures, patient complaints, an Issue Brief prepared by VISN 23 for Veterans Health Administration (VHA) Central Office, letters to Congressional stakeholders, published news reports, and management correspondence.

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

Case Summary

The patient had a history of coronary artery disease, peripheral vascular disease, diabetes mellitus, hypertension, hyperlipidemia, and chronic shoulder, lower back, and leg pain. He had a remote history of coronary artery and aorto-femoral bypass surgeries. Beginning in 2001 he was evaluated regularly at the medical center by primary care and specialty physicians.

In the spring of 2009, an anesthesiologist evaluated the patient in follow-up of back and leg pain and noted that the patient “denies changes in bladder and bowel function.” At a routine visit 3 months later, a primary care physician described that the patient “alternates diarrhea and constipation, and has occasional discomfort in the lower abdomen when he is constipated...No chest pain, SOB [shortness of breath], or other concerns.” The physician prescribed a bulk-producing laxative.

Three weeks after the primary care visit the patient telephoned the medical center with complaints of dizziness and abdominal pain “over the past few days to weeks.” On the following day he was evaluated by his primary care physician, who noted that

He still has abdominal pain, but now describes it as a diffuse, dull pain that is always present. It has no aggravating or alleviating factors. He denies nausea, vomiting, diarrhea, constipation, or GI bleeding. (His diarrhea resolved when we added Metamucil, but his pain did not improve.) This pain started nearly a month ago.

The physician noted that on examination “Abdomen soft without masses. He is diffusely tender and has some guarding but no rebound. BS [bowel sounds] normal.” Laboratory studies revealed normal hepatic and renal function, with markedly elevated amylase and lipase. The patient was considered to have pancreatitis and was instructed to restrict intake to clear liquids. Computed tomography (CT) of the abdomen was requested.

An abdominal CT scan was interpreted as follows:

1. Hypoattenuating mass of the proximal body of the pancreas with distal dilatation of the pancreatic duct and surrounding lymph nodes.

Recommend clinical, laboratory, and MRI correlation. Inflammatory process or tumor process are primary considerations.

2. Multiple hypoattenuating foci of the liver which are likely cysts; recommend ultrasound correlation or MRI correlation.

At a visit with the primary care case manager on the day of the CT scan, the patient reported improvement.

One month later the patient telephoned the medical center with complaints of loss of appetite and constipation, and was advised to “consume plenty of fluids.” On the following day the primary care case manager contacted the patient and advised him to report to the Emergency Department because of persistent symptoms now including abdominal pain. On admission to the hospital a 15-pound weight loss over the previous 6 weeks was documented.

An abdominal CT scan showed a pancreatic mass and hepatic lesions that had enlarged in comparison with the scan performed 37 days earlier. Biopsy was planned but was delayed because the patient was on aspirin, which can increase the risk of bleeding. The patient was discharged home after 3 days. Biopsy of the liver performed 12 days later revealed the diagnosis of metastatic adenocarcinoma.

Five days after the liver biopsy, the patient was seen by an oncologist and informed about his diagnosis, prognosis, and treatment options. Chemotherapy (gemcitabine IV weekly X 3) was initiated the following week. Medical center managers ordered a review of the care provided by Primary Care and Imaging Service.

During the second week of chemotherapy, the patient requested a second opinion, and arrangements were made for an appointment with an oncologist at VANWIHCS. Approximately 2 weeks later, a VANWIHCS oncologist evaluated the patient and documented concurrence with the medical center’s treatment plan. The patient expressed concerns about the long distance (approximately 240 miles roundtrip) for weekly treatment at the medical center, and arrangements were made for the patient to receive chemotherapy treatment at a non-VA site of care closer to his home. After a final chemotherapy infusion at the medical center 4 weeks following the initial treatment, chemotherapy was initiated by a local oncologist.

Two weeks later, the patient presented to the medical center emergency department with continued abdominal pain, weakness, and poor appetite. After an evaluation, which included laboratory testing, he was discharged to home.

During the ensuing 2 months, the patient’s local care was coordinated with the spouse by social workers and the medical center oncology case manager. Multiple arrangements were made for tests, treatment, equipment for home use, and home nursing care. The patient was hospitalized for approximately 10 days at a local facility. After discussion of

various options for continued care, a medical center social worker made arrangements for in-home hospice care. The patient died approximately 7 months after initially presenting with abdominal pain.

Inspection Results

Issue 1: Delay in Diagnosis

We substantiated that there was a delay in the patient's diagnosis. This delay had been recognized and was acknowledged by primary care physicians and medical center management.

A radiologist coded the report of the patient's initial CT scan as abnormal and requiring attention, but failed to notify the requesting physician, and that physician did not check the results. Medical center policy requires that the requesting clinician be notified for all significantly abnormal results. We found no documentation of notification and the requesting physician reported that he did not recall receiving an electronic alert regarding the abnormal CT or a call from the radiologist.

After a biopsy was performed, 52 days after the initial CT scan, the patient was evaluated promptly and provided information about treatment options.

Issue 2: Payment for Travel and Non-VA Care

We substantiated the allegation.

The complainant described being told that there were no options for treatment outside of the medical center and that the patient would have to continue weekly trips. The complainant also stated that an oncologist informed the patient about Medicare options for treatment at a private facility of the patient's choice, and that the patient would be responsible for the 20 percent co-pay.

The patient's oncologist told us that as long as treatment was available at the medical center payment for non-VA care would not be an option. However, approval for non-VA care near the patient's home was subsequently authorized.

We also confirmed that the patient and family were misinformed regarding travel pay eligibility for the second opinion consult at the VANWIHCS. The medical center's Business Manager informed us that incorrect information was given to the patient regarding reimbursement for travel to and from his home. Medical center managers recognized the error and arranged to reimburse the family.

Conclusions

We concluded that there was a delay in diagnosis and treatment of a patient with metastatic pancreatic cancer. A radiologist did not follow medical center policy regarding notifications about abnormal test results, and the patient's primary care physician did not pursue the results. The patient and family were incorrectly informed about travel pay entitlement and the availability of fee-basis care.

Recommendations

Recommendation 1. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director monitors the reporting of abnormal imaging results to improve the process for Radiology Service notification of requesting physicians.

Recommendation 2. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director ensures that clinical staff refer patients to the travel section and Business Office when there are questions related to fee-basis care and travel pay, and that administrative staff provide accurate information.

Comments

The Acting VISN and Acting Medical Center Directors agreed with the findings and recommendations and provided acceptable improvement plans. See pages 6–9 for the full text of their comments. We will follow up on the planned actions until they are complete.

(original signed by:)

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

Acting VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 9, 2010

From: Acting Director, VA Midwest Health Care Network 23
(10N23)

Subject: Healthcare Inspection – Delay in Cancer Diagnosis, Iowa City
VA Medical Center, Iowa City, Iowa

To: Director, Chicago Office of Healthcare Inspections (54CH)

The purpose of this memorandum is to provide our response to the OIG Healthcare Inspection: Delay in Cancer Diagnosis, Iowa City VA Medical Center, Iowa City, Iowa.

Recommendation 1. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director monitors the reporting of abnormal imaging results to improve the process for Radiology Service notification of requesting physicians.

COMMENT: Concur – I have reviewed and discussed the action plan submitted by the Acting Iowa City VAMC Director with the VISN 23 Chief Medical Officer and I concur with the action as proposed by Iowa City VAMC leadership.

Recommendation 2. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director ensures that clinical staff refers patients to the travel section and Business Office when there are questions related to fee-basis care and travel pay, and that administrative staff provide accurate information.

COMMENT: Concur with the Iowa City VAMC Acting Director's action plan as written.



BARRY D. SHARP

Acting Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: August 6, 2010

From: Acting Director, Iowa City VA Medical Center (636A8/00)

Subject: **Healthcare Inspection – Delay in Cancer Diagnosis, Iowa City
VA Medical Center, Iowa City, Iowa**

To: Acting Director, VA Midwest Health Care Network 23
(10N23)

1. The purpose of this memorandum is to provide our response to the OIG Healthcare Inspection: Delay in Cancer Diagnosis, Iowa City VA Medical Center, Iowa City, Iowa.
2. If you have any questions regarding this response, please contact me directly at 319-339-7100.



GARY MILLION, FACHE

Acting Medical Center Director's Comments to Office of Inspector General's Report

The following Acting Medical Center 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 Acting VISN Director ensure that the Acting Medical Center Director monitors the reporting of abnormal imaging results to improve the process for Radiology Service notification of requesting physicians.

Concur

Target Completion Date: December 31, 2010

The Iowa City VAMC Medical Center Memorandum 83, Reporting of Imaging Critical Test and Critical Abnormal Results and Imaging Service Policy 20, Reporting of Imaging Results, have been revised to clarify the process for monitoring the reporting of abnormal imaging results and improve the process for notification of the requesting physicians. An audit of the critical abnormal results is performed on a monthly basis, and the results are sent to Quality and Performance Improvement. Attached you will find the monthly audit for this fiscal year (October 2009 through June 2010). *(Attachments were provided on the original response to the OIG).* The VISN 23 Imaging Service Line, in cooperation with the Primary Care Service Line, is in the piloting stage of an Abnormal Lung Nodule project. This project will provide VISN-wide follow-up of patients with lung nodules on chest x-rays and CT examinations. (These make up the majority of critical and non-critical abnormal results). This project is set to be implemented VISN-wide by the end of the year. The VISN 23 Imaging Service line is requesting the purchase of an automatic software notification system for all abnormal results. This will provide notification to the ordering practitioner at the completion of the dictated imaging report. Documentation of the notification and time of receipt of notification would be provided.

Recommendation 2. We recommended that the Acting VISN Director ensure that the Acting Medical Center Director ensures that clinical staff refer patients to the travel section and Business Office when there are

questions related to fee-basis care and travel pay, and that administrative staff provide accurate information.

Concur

Target Completion Date: Completed

The Business Office Manager has conducted training for Travel Office staff regarding the appropriate payment for beneficiary travel eligible patients seeking second opinions at the VAMC and non-VA facilities. Patients seeking second opinions from non-VA providers are not eligible for beneficiary travel pay because they are not being seen at a VA Medical Center. The Business Office Manager also conducted training for the Case Managers and Social Workers regarding beneficiary travel benefits and provided them with contact information for the Travel Office for answers to any questions.

A Medical Center Bulletin was distributed to all employees on August 4, 2010, that explains beneficiary travel regulations for patients seeking second opinions with the Business Office Manager's contact information for any additional questions or concerns.

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, MN, RN Director, Chicago Office of Healthcare Inspections VA Office of Inspector General (708) 202-2672
Acknowledgments	Paula Chapman, CTRS Jerome E. Herbers, Jr., MD Judy Brown, Program Support Assistant

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