Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00190-146

Healthcare Inspection

Inadequate Follow-Up of an Abnormal Imaging Result Charlotte Community Based Outpatient Clinic Charlotte, North Carolina

March 9, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections reviewed an allegation of improper notification of test results and delayed care at the Charlotte Community Based Outpatient Clinic, Charlotte, NC.

We did not substantiate the allegation that the patient was not properly notified of his magnetic resonance imaging (MRI) results. The electronic health record reflects that the primary care provider (PCP) sent a letter to the patient 6 days after his MRI documenting the findings and requesting that the patient contact the office to discuss treatment options. However, we found that the clinical process of discussing the test results, negotiating a treatment plan, and educating the patient about his condition did not comply with Veterans Health Administration guidelines.

The patient requested a surgery consult; however, the PCP submitted a Pain Management consult for steroid injections instead without discussing the rationale for this change with the patient. Further, after the patient completed a urine drug screen, which was required before the Pain Management consult could occur, he received no information or communication from his PCP or other providers about his plan of care. Neither the PCP nor the nurses educated the patient on signs and symptoms that would require emergent evaluation or would change the course of management from medical therapy to surgical interventions.

We substantiated the allegation that the patient's treatment was delayed. The PCP did not adequately follow up after receiving the patient's abnormal MRI results or follow through on the patient's plan of care. Failure to take clinical action may have contributed to a more complex clinical course for this patient.

We made three recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 7–9 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed an allegation of improper notification of test results and delayed care at the Charlotte Community Based Outpatient Clinic (CBOC), Charlotte, NC. The purpose of the review was to determine whether the allegations had merit.

Background

The Charlotte CBOC is associated with the W.G. (Bill) Hefner VA Medical Center (facility) and is part of Veterans Integrated Service Network (VISN) 6. It is located 37 miles from the facility and provides primary care, some specialty care, and tele-health[1] services.

Cervical spondylotic myelopathy.[2] Cervical spondylotic myelopathy (CSM) is a degenerative spinal disease that results from the narrowing of the cervical spinal canal by degenerative and congenital changes. It is the most common type of spinal cord dysfunction in patients 55 years and older. The signs and symptoms of CSM include neck pain, sensory changes in the lower extremities, motor weakness, gait difficulties, and bowel and bladder dysfunction. A magnetic resonance imaging (MRI) scan is the preferred diagnostic tool because it allows for specific evaluation of the spinal cord, intervertebral discs, vertebral osteophytes,[3] and ligaments.

Management of Tests Results. The Veterans Health Administration (VHA) requires that ordering practitioners document treatment actions in the patient's electronic health record (EHR) in response to critical, emergent, or abnormal test results.[4] VHA also requires that outpatient test results are communicated to patients no later than 14 calendar days from the date on which the results are available to the ordering practitioner. The ordering practitioner should initiate and document treatment actions in response to the abnormal test.

Allegation

On September 9, 2014, the OIG received a complaint alleging that a patient was not properly notified of his MRI results. Consequently, his treatment was delayed, and he later lost his ability to walk, necessitating emergency surgery on his neck.

[1] Telehealth Services refer to services provided under the VA Telehealth program (http://www.telehealth.va.gov/).
[2] Myelopathy is "the clinical syndrome that results from a disorder in the spinal cord that disrupts or interrupts the normal transmission of the neural signals."
[3] Osteophytes are bony projects that form along joint margins.
[4] VHA Directive 2009-019, *Ordering and Reporting Test Results*, March 24, 2009.

Scope and Methodology

We interviewed the patient's primary care provider (PCP), the covering physician when the PCP was on leave, several involved primary care nurses, the Non-VA Care Coordination (NVCC) medical director, and the NVCC administrative coordinator. We attempted multiple times to interview the person we had on file as the complainant, but we were unable to make contact.

We reviewed the patient's EHR for the period January 1 to October 31, 2014. We also reviewed VHA and facility policies related to NVCC, outpatient test results, pain management, and Patient-Aligned Care Teams (PACTs).

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 is a male in his early 50s who saw his PCP in early May 2014 for complaints of fever, muscle aches, low back pain, right foot pain, and right arm numbness for the past 2 weeks. On physical exam, the PCP documented mild left leg weakness and increased reflexes to the left patella and left Achilles tendons. A straight leg raising test was positive on the right.[5] The PCP ordered x-rays of his low back and right arm and prescribed prednisone for the back pain. The patient was also treated for an upper respiratory infection during this visit.

The x-rays were completed 5 days later. The radiologist noted that the neck x-rays showed foramen narrowing in the cervical area.[6] The low back x-rays were unremarkable. Within 3 days, the PCP notified the patient via letter of the x-ray results, informed the patient that a cervical MRI would be ordered to "clarify your slight weakness and limp," and ordered the MRI. However, the MRI was discontinued a month later with a recommendation to resubmit the MRI request through Non-VA Care Coordination (NVCC).[7] The PCP immediately ordered a MRI through a NVCC consult.

At the end of June, the PCP evaluated the patient in clinic for sinus congestion. The PCP documented that the patient's left leg pain was improved with the oral steroid but that the pain had moved to his right side.

The MRI that was completed around mid-July, noted multi-level neck issues resulting from arthritis with evidence of spinal cord compression and severe stenosis on both sides of the neck where the nerves exit. The MRI findings, the May neurologic exam, and the lack of abnormal imaging of the low back were strongly suggestive of a CSM diagnosis. Six days after the MRI was completed, the PCP sent a letter to the patient notifying him of the MRI results and asking him to contact the primary care clinic if he was interested in further evaluation for possible surgery or steroid injections.

About 1 week later, the patient's wife contacted the clinic and left a message requesting a return call. A nurse contacted the patient and reviewed the information noted in the letter. The patient asked about post-surgery healing time, and the nurse responded that the orthopedic surgeon should answer this question. The patient requested a surgery consult,[8] which the nurse communicated to the PCP. On the same day, the PCP acknowledged the request but noted that the patient's symptoms were "non-specific" and that the Pain Management team would be consulted for consideration of steroid injection. The PCP ordered the NVCC Pain Management consult.

[5] Clinical signs on examination that may indicate a combination of disc disease of the low back and nerve damage to a level higher than the low back.
[6] The foramen is the opening where nerves exit from the spinal cord; both sides showed narrowing. CX-CX1 denotes the location in the neck where the narrowing occurred.
[7] NVCC is medical care provided to eligible veterans outside of VA when VA facilities and services are not reasonably available.
[8] The nurse informed the patient that questions regarding surgery would be best answered by an orthopedic doctor.

The NVCC Pain Management consult was cancelled 6 days later, as a urine drug screen (UDS) was needed prior to referral. The PCP was on leave, so a cross-covering physician ordered the UDS, which the patient completed at the end of July. The results of the UDS would not have precluded the patient receiving non-opiate pain therapy; however, the Pain Management consult was not resubmitted.

In early September, the patient presented to a private-sector emergency department via ambulance complaining that his left leg was dragging in the morning and that he was unable to walk by the evening. He was admitted to the private sector hospital, and a repeat MRI showed worsening cervical spinal stenosis. He was diagnosed with severe CSM causing incomplete spinal cord injury. He had surgery the next day at the private hospital to relieve the compression to his spinal cord and nerves. Subsequently, he received physical rehabilitation and at the time of our inspection was recovering at home.

Inspection Results

Issue 1: Notification of MRI Results

We did not substantiate the allegation that the patient was not properly notified of his MRI results. The EHR reflects that the PCP sent a letter to the patient 6 days after exam completion documenting the MRI findings and requesting he contact the office to discuss treatment options. This letter complied with VHA guidelines for patient notification of test results.

However, the clinical process of discussing the test results, negotiating a treatment plan, and educating the patient about his condition did not comply with VHA guidelines.

Poor Communication – The PCP did not speak directly with the patient about his CSM diagnosis, explain the possible treatment options, or discuss his plan of care. The MRI result letter, which identified the clinical findings and options for surgery or steroid injections, did not provide sufficient information for the patient to make an informed decision. The patient requested a surgery consult; however, the PCP submitted a Pain Management consult for steroid injections instead without discussing the rationale for this change with the patient. Further, after the patient completed his UDS, which was required before the Pain Management consult could occur, he received no information or communication from his PCP or other providers about his plan of care.

Inadequate Patient Education – Providers did not document important patient education elements. Because the PCP decided on a conservative approach to treatment, patient education regarding the symptoms of advancement of cord compression was critical as CSM's natural course is to advance.[9] Neither the PCP nor the nurses educated the

[9] Sadasivan KK, Reddy RP, Albright JA. *The natural history of cervical spondylotic myelopathy*. Yale J Biol Med 1993; 66:235–242.

patient on signs and symptoms that would require emergent evaluation or that would change the course of management from medical therapy to surgical interventions.

Issue 2: Delay in Treatment

We substantiated the allegation that the patient's treatment was delayed. The PCP did not adequately follow up after receiving the patient's abnormal MRI results or follow through on the patient's plan of care. Specifically:

- The MRI showed severe canal stenosis at multiple levels in the neck with evidence of compression to the spinal cord. However, the patient was not re-examined, nor was he asked about symptom progression, after the PCP received the MRI results. This information would assist the PCP in devising an appropriate plan of care.

- The PCP did not request surgical consultation, although this would have been the correct approach given the MRI findings. A surgery consult would have provided an expert evaluation of the patient's condition and possible treatment strategies.

- The PCP chose the less invasive alternative of a pain management consult for steroid injections. Steroid injections could have provided relief of the patient's symptoms by reducing spinal cord and nerve root inflammation. However, neither the PCP nor the cross-covering physician resubmitted the Pain Management consult once the UDS was completed.

- No actions were taken to implement the patient's plan of care after the UDS.

Each of the conditions outlined above represented an opportunity for the PCP to take clinical action, and the failure to do so may have contributed to a more complex clinical course for this patient.

Conclusions

We did not substantiate the allegation that the patient was not properly notified of his MRI results. The EHR reflects that the PCP sent a letter to the patient 6 days after his MRI documenting the findings and requesting that he contact the office to discuss an evaluation for treatment options. However, we found that the clinical process of communicating and discussing the test results, negotiating a treatment plan, and educating the patient about his condition did not comply with VHA guidelines.

We substantiated the allegation that the patient's treatment was delayed. The patient was not re-examined, nor was he asked about symptom progression, after the PCP received the MRI results. Further, the PCP did not request surgical consultation given the MRI findings. Neither the PCP nor the cross-covering physician resubmitted the Pain Management consult once the UDS was completed. Additionally, no actions were taken to implement the patient's plan of care after the UDS. Failure to take clinical action may have contributed to a more complex clinical course for this patient.

Recommendations

1. We recommended that the Facility Director ensure that clinicians involve patients in the treatment planning process and discuss any proposed changes to treatment plans with patients.

2. We recommended that the Facility Director ensure that patients receive education on their medical conditions and that education is documented in the electronic health record.

3. We recommended that the Facility Director evaluate the VA care provided to the patient summarized in this report and confer with Regional Counsel regarding the need for possible disclosure.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: February 4, 2015

From: Network Director, VA Mid Atlantic Health Care Network (10N6)

Subj: **Draft Report** – Healthcare Inspection—Inadequate Follow-Up of an Abnormal Imaging Result, Charlotte Community Based Outpatient Clinic, Charlotte, North Carolina

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the Salisbury VA Medical Center (VAMC), Salisbury, NC and concur with the facility's responses.

2. If you have any further questions, please contact Kaye Green, Director, Salisbury VAMC, at (704) 638-3344.

DANIEL F. HOFFMANN, FACHE

Appendix B

Facility Director Comments

Department of
Veterans Affairs

Memorandum

Date: January 23, 2015

From: Facility Director, W.G. (Bill) Hefner VA Medical Center, Salisbury, NC

Subj: **Draft Report** – Healthcare Inspection—Inadequate Follow-Up of an Abnormal Imaging Result, Charlotte Community Based Outpatient Clinic, Charlotte, North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. I have reviewed the draft report of the Office of Inspector General and I concur with the recommendations.
2. I have included my response in the attached Director's Comments.
3. Please contact me if you have any questions or comments.

(original signed by:)

Linette L. Baker for
Kaye Green, FACHE
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that clinicians involve patients in the treatment planning process and discuss any proposed changes to treatment plans with patients.

Concur

Target date for completion: March 31, 2015

Facility response: Providers will complete refresher training related to the importance of involving patients in the treatment planning process. Training will be completed by March 31, 2015.

Recommendation 2. We recommended that the Facility Director ensure that patients receive education on their medical conditions and that education is documented in the electronic health record.

Concur

Target date for completion: March 31, 2015

Facility response: Providers will complete refresher training related to the importance of providing and documenting patient education related to each patient's medical conditions. Training will be completed by March 31, 2015.

Recommendation 3. We recommended that the Facility Director evaluate the VA care provided to the patient summarized in this report and confer with Regional Counsel regarding the need for possible disclosure.

Concur

Target date for completion: February 27, 2015

Facility response: After review of the case, facility leadership determined that an institutional disclosure was appropriate. The patient has been contacted and a date/time to complete the institutional disclosure has been scheduled at a site most convenient for the Veteran.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Victoria Coates, LICSW, MBA Sheyla Desir, RN, MSN Thomas Wong, DO

Appendix D

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