ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

VA Community Based Outpatient Clinic in Oxnard, California November 9, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was prompted by information provided by a confidential complainant who alleged that a delay in care might have contributed to the death of a patient in 2012. It was alleged that a physician under contract at the Department of Veterans Affairs (VA) Community Based Outpatient Clinic (CBOC), in Oxnard, CA, had failed to properly refer a patient to the VA Medical Center (VAMC), Los Angeles, CA, for a surgery consult—specifically a "g-tube placement" (feeding tube placement). The referral was placed following a 67-day delay. The patient died 16 days after the referral but before the surgery consult was completed.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed the complainant, a VAMC Los Angeles service chief, and the non-VA physician assigned to the patient.

- **Records Reviewed:** VA OIG reviewed the patient's medical record and three peer reviews.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant explained the CBOC's workflow and clinic processes. The CBOC is a contract clinic where primary care is provided by a contract provider. The CBOC uses VA systems to schedule appointments and maintain VA records. The complainant stated that a non-VA physician failed to put in a timely referral for a g-tube placement and the delay resulted in the veteran's death. The complainant explained that an automated message stating that the patient had called about the pending placement had been received by the physician, who had ignored it. The complainant provided a copy of the alert.

  Los Angeles VAMC's service chief stated during the interview that he also was concerned regarding the delay in care issue seen by the complainant. However, he noted that the patient was under the care of a physician at the time and any eminent life-threatening condition would have been addressed. He stated that the medical record

showed a precipitous and long-term weight loss, yet it showed no course of treatment specific to this symptom until shortly before the patient's death. He remarked that the "general" surgery consult for the g-tube placement indicated a non-emergent medical situation (not requiring emergency care), which meant that the surgery clinic would most likely take a considerable amount of time to address the consult. He would not expect the consult to be addressed on the same day it was written. He also stated that the consult would have been more appropriately referred to the Interventional Radiology or Gastroenterology Clinic. After reviewing the patient's medical record, he concluded that a peer review should be conducted. (Peer reviews are not normally conducted when an outpatient dies, but his concerns warranted it.) The VAMC service chief subsequently reported that three peer reviews were completed on this case and provided the results of these peer reviews to the OIG investigators.[*]

The non-VA Primary Care physician assigned to the patient stated that he recalled the patient as one of 1,200 on his panel. He also stated that he acknowledged the patient's swallowing problem by referring the patient to Neurology at the VAMC's Sepulveda Campus. They responded to his consult by placing their own general consult for a g-tube placement by Surgery at the VAMC. He acknowledged and concurred with that consult placement. He stated that in his opinion the veteran received constant and adequate care by VA and the contract provider, adding that the patient was a very sick man but was doing well the last time he was seen by the Primary Care physician. He further stated that the patient's care was not delayed and disagreed with the service chief about the appropriateness of the clinic selected for the g-tube placement.

Records Reviewed

- VA OIG reviewed documentation provided by the complainant. The review determined that the complainant may not have accurately recorded the time the phone alert was received. The documentation also indicated that the phone alert was made after the g-tube consult had been placed, reducing the potential delay in care to within the 2-week window before the patient's death. The complaint therefore is better characterized as involving a failure to diagnose rather than a delay in care.

- The VA OIG's Office of Healthcare Inspections (OHI) reviewed documentation pertaining to the patient and determined that the patient had experienced a delay in obtaining a surgical consult to address his complaints of dysphagia, which is difficulty in swallowing. OHI determined that this delay resulted from the Primary Care provider's failure to diagnose the patient's dysphagia in a timely manner. OHI determined the Primary Care provider's failure to coordinate the patient's care by following up on the requested Neurology consult, as well as the neurologist's failure to classify the 2012 surgical consult as urgent also contributed to the delay. However, OHI could not substantiate that the patient died as a result of the failure to address his dysphagia. (http://www.va.gov/oig/pubs/VAOIG-14-02890-497.pdf)

[*] Pursuant to 38 U.S.C. § 5705, release of peer review material is prohibited.

4. Conclusion

The investigation determined that there was an issue of timeliness with initiating treatment for the patient, as well as some coordination of care issues. The investigation did not find, however, that the patient died because of this delay.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on June 9, 2016.

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