DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana

HEALTHCARE INSPECTION | REPORT #21-02612-53 | FEBRUARY 1, 2023

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Executive Summary

The VA Office of Inspector General (OIG) initiated a healthcare inspection to determine the validity of an allegation that in 2019, a primary care provider from the Longview Community Based Outpatient Clinic (CBOC), part of the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana, did not timely identify a liver abnormality nor inform a patient about a terminal cancer diagnosis.[1] The patient later expired while in community-based home hospice care.[2] In addition to the allegation, the OIG identified concerns related to

- care coordination,
- resident supervision,
- communication of abnormal imaging results,
- assignment of primary care provider surrogate coverage, and
- patient safety event reporting.[3]

Background

The patient was in their early sixties with a history of multiple medical conditions including coronary artery disease, coronary artery bypass graft, peripheral arterial disease, stroke, and diabetes mellitus.[4]

In early 2019 (day 1), a primary care provider evaluated the patient at the Longview CBOC and referred the patient to the facility's Emergency Department for left lower leg and foot pain and redness. The patient was seen in the Emergency Department and admitted to the inpatient medicine unit for further evaluation. On day 2, the inpatient medicine team ordered a computed tomography angiogram (CTA) to determine whether there were arterial occlusions that may be

[1] The allegations were sent to the OIG on April 2, 2021.

[2] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[3] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. A resident "refers to an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, and podiatrists, and who participates in patient care under the direction of supervising practitioners." "Supervision is an intervention provided by a supervising practitioner (attending) that occurs as residents provide patient care through direct or indirect contacts with patients." VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. Within the context of this report, the term "surrogate" references a provider identified to cover for an absent PACT provider, and who will manage any view alerts in the electronic health record (EHR) and ensure "continuity of and access to care when patients' designated PCP [primary care provider] is not available." VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, October 7, 2015, amended January 24, 2022. VHA-Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[4] The OIG used the singular form of they (their) in this instance for the purpose of patient privacy. Information in the case summary was taken from the patient's EHR. All EHR entry dates referenced in this case summary occurred in 2019, unless otherwise noted.

causing ischemia.[5] The CTA results showed multiple arterial occlusions but also showed a lesion in the right lobe of the liver. The interpreting radiologist recommended further testing to better define the liver lesion. The treating inpatient medicine resident physician (resident) copied the radiologist's report into the patient's electronic health record (EHR) daily progress notes on days 3 and 4 but made no comments regarding clinical follow-up for the liver lesion. On day 5 the patient was discharged, and the resident and supervising attending physician (attending) completed a discharge summary. Notably, the summary did not include documentation of the liver lesion or the radiologist's recommendations for follow-up.

The patient received primary care services on day 18, day 25, day 158, and day 165; however, the primary care provider did not document discussions or treatment plans regarding the liver lesion identified on day 2, nor make recommendations for further radiological studies of the liver.

On day 174, the patient developed nausea and vomiting and went to a community hospital emergency department where a provider ordered an ultrasound and an abdominal computed tomography (CT) scan. The CT scan results showed a mass in the left lobe of the liver.

On day 185, the patient visited the primary care provider for an annual follow-up and told a primary care nurse that the CT scan performed at the community hospital identified cysts and a liver tumor. The patient requested a consult to hematology as a result of being told by a community hospital that it was needed. The primary care provider documented in the patient's EHR that community hospital records would be requested.[6] A new diagnosis of liver neoplasm was added to the patient's problem list.

The primary care provider ordered a focused CT scan of the patient's liver. The scan was completed at the facility on day 200 and showed a mass occupying the left lobe of the liver, a lesion in the right lobe of the liver, and possible spread to nearby lymph nodes and lungs. The radiologist recommended a complete chest CT scan for further work-up. A review of the patient's EHR showed no documentation that the primary care provider, who ordered the CT scan of the patient's liver, informed the patient of the abnormal findings or ordered the recommended chest CT scan.

[5] The inpatient medicine team included a resident and supervising attending physician. The ordering provider was an inpatient medicine resident who reported to the inpatient attending; however, the OIG concluded that it would not be unusual for one resident to place an order, and the primary treating resident to serve as the surrogate and follow up on results.

[6] The OIG found no evidence in the EHR that the primary care provider requested the community hospital records from the day 174, visit.

On day 229, the patient was admitted to a community hospital with a diagnosis of sepsis. A liver biopsy was completed day 233 confirming a diagnosis of liver cancer.[7]

On day 233, the primary care provider sent a letter to the patient about recent laboratory test results that indicated abnormalities specific to the liver. However, there was neither communication regarding the abnormal CT scan completed at the facility on day 200, nor recommended follow-up.

On day 241, while in a community hospital, the patient underwent a revision of a partial foot amputation previously performed in summer 2019. Postoperatively, the patient was found to have symptoms consistent with a stroke and underwent a stat CT scan, which showed a significant infarct of the left side of the brain. On day 243, the patient was discharged to home hospice and died on day 245.

Inspection Results

Early 2019 Abnormal Imaging Study

The OIG substantiated that the patient's primary care provider failed to timely identify and inform the patient of a terminal cancer diagnosis. Additionally, the OIG found that in early 2019, the resident and attending failed to coordinate the patient's care that would have allowed a timelier diagnosis of the patient's liver cancer.

The OIG found that in early 2019, the resident and attending did not coordinate the patient's care at the time of discharge from the inpatient medicine unit, and that the attending failed to appropriately supervise the resident.[8] The attending told the OIG they could not explain why the findings of abnormalities in the patient's liver were not included in the care plan and discharge summary and believed it was human error. The lack of care coordination between the inpatient medicine team and the primary care patient aligned care team (PACT) resulted in a delayed evaluation of the patient's liver abnormalities.[9]

The resident, attending physician, and primary care provider failed to take the recommended clinical action in response to the patient's abnormal imaging findings of the liver noted in early

[7] The community hospital faxed records to the facility on July 20, 2021, showing that the patient had undergone a liver biopsy and was diagnosed with liver cancer. The OIG found no documentation in the patient's EHR that the community provider notified the patient's primary care provider of the cancer diagnosis following the day 233 biopsy. The OIG reviewed the EHR from the community hospital but was unable to determine why the liver biopsy was conducted.

[8] VHA Handbook 1400.01.

[9] VHA Handbook 1101.10(1). "The Patient Aligned Care Team (PACT) is a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care."

2019.[10] The resident copied the early 2019 CTA radiologist's report into the EHR, but neither the resident nor the attending commented on the abnormal findings, and failed to specifically address the liver lesion or the recommended follow-up. The resident and attending also failed to complete a comprehensive discharge plan in early 2019 that would have communicated relevant findings to other providers, consistent with coordination of care requirements. The patient presented to primary care on five occasions from day 18 through day 185, but the primary care provider did not document awareness of the day 2 abnormal liver imaging findings, ensure follow-up based on recommendations, or inform the patient of the findings.[11]

The OIG found that deficiencies in care coordination and communication between inpatient and primary care staff, specifically related to the inpatient discharge summary, contributed to delays in the patient's care. Further, the OIG found the attending failed to provide adequate oversight of the resident by not ensuring the resident both documented a comprehensive discharge summary and communicated with the PACT to ensure follow-up care.

The OIG also determined that the providers did not consider all available prior medical history when making healthcare decisions and documenting treatment plans. The OIG concluded that a more comprehensive review of the inpatient admission and prior studies and recommendations may have informed the primary care provider and led to a timelier evaluation of the liver abnormalities.

Summer 2019 Abnormal Imaging Study

In summer 2019, while the patient's primary care provider was on leave, an Emergency Department physician assistant was assigned as a surrogate to cover for the primary care provider and respond to the view alerts, including when the results of the imaging study were posted. The OIG found no documentation in the patient's EHR that the primary care provider, who ordered the liver CT scan in summer 2019, or the surrogate who received the results, took follow-up action or documented notification to the patient of the abnormalities that were suspicious for a new malignancy. The surrogate told the OIG of being unaware of that assignment and, although a view log indicated the surrogate opened the EHR notification

[10] The OIG could not determine if the primary care provider saw the early 2019 view alert related to the recommended liver study. The Chief of Staff informed the OIG that the data from the early 2019 alert was beyond the "shelf life," and the historical data was not available.

[11] The patient's 2019 primary care provider retired in June 2021 and told the OIG of not recalling details about the patient's episode of care. Additionally, the provider no longer had access to the EHR to support responses to OIG inquiries, so an interview was not conducted.

regarding the abnormal results from the day 200 CT scan, took no action on the patient's abnormal imaging results, further delaying a timely clinical response.[12]

The OIG was unable to determine whether the clinical outcome for the patient would have been different had the early 2019 recommendation for an additional imaging study of the liver been completed, or if the patient had been informed about the summer 2019 abnormal imaging results. However, the OIG concluded that the failure to notify the patient of test results delayed clinical care and precluded the patient's ability to make informed healthcare decisions.

Additional Concerns

In 2019, the facility had no written processes in effect for assignment of provider surrogates, although required by policy issued in 2014. Veterans Health Administration (VHA) policy required the PACTs to establish and implement written processes for coverage during absences of individual PACT staff, and to ensure the covering provider managed EHR view alerts and secure messages.[13] In January 2020, the facility implemented written standard operating procedure for provider surrogates.[14]

On June 23, 2021, the OIG notified facility leaders and the Veterans Integrated Service Network 16 Director of intent to review the patient's episode of care, including the allegation of deficiency in care related to the patient's liver cancer. According to the former patient safety manager and the chief of quality, safety and value (QSV), notification from the OIG was the leaders' first awareness of the concerns regarding the patient's care.

The OIG found that following awareness of the patient's death and delayed diagnosis (adverse event), QSV staff failed to

- enter the event into the Joint Patient Safety Reporting System,
- review the event and assign a safety assessment code score, and

[12] The Chief of Staff told the OIG that usually other primary care providers covered for primary care, but that a physician assistant had the necessary training to provide outpatient clinical work; however, it was not a regular practice. The OIG was unable to determine who assigned the Emergency Department physician assistant as the surrogate.

[13] VHA Handbook 1101.10(1). Secure messaging allows patients to communicate privately with their VA healthcare team. "VA Secure Messaging," VA, accessed October 26, 2021, https://www.va.gov/health-care/secure-messaging/.

[14] Facility Standard Operating Procedure, *Provider Surrogate Procedures for Primary Care Providers Standard Operating Procedure*, January 5, 2020.

- ensure a root cause analysis was conducted.[15]

The former patient safety manager informed the OIG of not entering the patient's adverse event into the Joint Patient Safety Reporting System or conducting a root cause analysis after discussing the event with another patient safety manager and the chief of QSV. On January 10, 2022, the facility clinical risk manager advised the OIG, "An RCA [root cause analysis] was not warranted per Patient Safety."

VHA requires that when a patient safety event is deemed to be a sentinel event, the patient safety manager must initiate an immediate investigation, "may be an RCA [root cause analysis], or, in the case of an intentionally unsafe act, administrative action." Sentinel events are adverse events "defined by TJC [The Joint Commission] as unexpected occurrences involving death, serious physical or psychological injury, or risk thereof." Sentinel events must be scored using the Safety Assessment Code matrix and may receive a score of 3, mandating a root cause analysis.[16]

The former patient safety manager told the OIG of becoming aware of the circumstances of the patient's death in July 2021 and discussing the event with another patient safety manager and the chief of QSV. The discussion resulted in a decision that the adverse event was too far in the past to warrant filing an electronic incident report, and therefore, the former patient safety manager did not assign a safety assessment code score. The former patient safety manager stated that if a safety assessment code score had been assigned, it would have indicated a root cause analysis should have been completed.

The OIG concluded that facility leaders' failure to perform the required patient safety actions precluded a detailed analysis of a patient safety event to identify factors which could have resulted in missed opportunities for improvements in patient care.

In August 2021, upon awareness of concerns regarding the patient's care, facility leaders provided an institutional disclosure to a family member and conducted peer reviews in July 2021 for multiple providers per VHA policy.

The OIG made four recommendations to the Facility Director related to communication of abnormal radiology results, resident supervision, assignment of provider surrogates, and patient safety reporting.

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[15] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011.The Safety Assessment Code matrix uses severity and probability to guide patient safety managers when rating patient safety events. A safety assessment code score of 3 is given to events that are deemed "catastrophic" or "major" with a probability of high frequency. Catastrophic is defined as actual or potential "death or major permanent loss of function (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying condition." VA National Center for Patient Safety, "Joint Patient Safety Reporting (JPSR) System Business Rules," May 1, 2018.

[16] VHA Handbook 1050.01.

VA Comments OIG Response

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

CBOC	community-based outpatient clinic
CT	computed tomography
CTA	computed tomography angiogram
EHR	electronic health record
OIG	Office of Inspector General
PACT	patient aligned care team
QSV	Quality, Safety and Value
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of an allegation that a primary care provider from the Longview Community Based Outpatient Clinic (CBOC), part of the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana, did not timely identify or inform a patient about a cancer diagnosis. The patient later expired while in community-based home hospice care.[1]

Background

The facility is part of Veterans Integrated Service Network (VISN) 16 and includes three CBOCs in Monroe, Louisiana; and Longview and Texarkana, Texas.[2] The facility offers a variety of inpatient and outpatient services in Shreveport, Louisiana. The Veterans Health Administration (VHA) classifies the facility as a complexity level 1c.[3] From October 1, 2019, through September 30, 2020, the facility served 37,684 patients.[4]

Allegations

On April 2, 2021, the OIG received an allegation that a primary care provider did not timely identify or inform the patient of a terminal cancer diagnosis. The OIG initiated a healthcare inspection to review the allegation and subsequently identified related concerns including

- care coordination,
- resident supervision,[5]

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] VA, "VA Shreveport Health Care, Locations," accessed November 30, 2021, https://www.va.gov/shreveport-health-care/locations. Facility staff confirmed as of November 2021, there were three operating CBOCs.

[3] VHA Office of Productivity, Efficiency and Staffing, "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex. A level 1c has "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs."

[4] VHA Support Service Center (VSSC).

[5] VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. "Supervision is an intervention provided by a supervising practitioner (attending) that occurs as residents provide patient care through direct or indirect contacts with patients." A resident "refers to an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, and podiatrists, and who participates in patient care under the direction of supervising practitioners." VHA Handbook 1400.01, *Resident Supervision*, dated December 19, 2012, was rescinded and replaced with VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019.

- communication of abnormal imaging results,[6]
- assignment of primary care provider surrogate coverage, and[7]
- patient safety event reporting requirements.[8]

Scope and Methodology

The OIG initiated the inspection on May 27, 2021, and conducted a virtual site visit from July 26–28, 2021.[9]

The OIG interviewed the complainant; facility leaders; a former patient safety manager; associate chief of clinical informatics; clinical applications coordinators; and providers and clinical staff familiar with the patient's care.[10] The OIG contacted, but did not interview, the patient's 2019 primary care provider who, according to a human resource specialist, retired in June 2021.[11]

The OIG reviewed the patient's electronic health record (EHR), and VHA directives and handbooks, facility policies, and standard operating procedures (SOPs) related to care coordination, communication of diagnostic imaging results, EHR documentation, consults, resident supervision, patient safety, adverse events, patient aligned care team (PACT), and primary care.[12]

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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[6] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, October 7, 2015, amended January 24, 2022.

[7] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. Within the context of this report, the term "surrogate" references a provider identified to cover for an absent PACT provider, and who will manage any view alerts in the electronic health record (EHR) and ensure "continuity of and access to care when patients' designated PCP [primary care provider] is not available."

[8] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

[9] The site visit was conducted virtually due to COVID-19. World Health Organization, "Coronavirus disease (COVID-19)," accessed November 30, 2021, https://www.who.int/health-topics/coronavirus#tab=tab_1. COVID-19 is an infectious disease that can cause serious illness or death.

[10] For the purposes of this report, the OIG considered facility leaders to include senior level executives and service chiefs.

[11] The patient's 2019 primary care provider told the OIG of not recalling details about the patient's episode of care. Additionally, the provider no longer had access to the EHR to support responses to OIG inquiries.

[12] VHA Handbook 1101.10(1). "The Patient Aligned Care Team (PACT) is a team of health care professionals that provides comprehensive primary care in partnership with the patient (and the patient's personal support person(s)) and manages and coordinates comprehensive health care services consistent with agreed upon goals of care."

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summary

The patient was in their early 60s with a history of coronary artery disease, status post coronary artery bypass graft, peripheral arterial disease, stroke, diabetes mellitus, atrial fibrillation, chronic obstructive pulmonary disease, bipolar disorder, and obstructive sleep apnea.[13]

In early 2019 (day 1), a primary care provider saw the patient at the Longview CBOC and referred the patient to the facility's Emergency Department for left lower leg and foot pain and redness. The patient was assessed in the Emergency Department and subsequently admitted to the inpatient medicine unit for further evaluation and treatment for presumed cellulitis. The inpatient medicine team requested evaluations from Vascular Surgery and Cardiology Services because the patient's skin changes were suggestive of a vascular disease.[14] On day 2, the inpatient medicine team ordered a computed tomography angiogram (CTA) to determine if there were arterial occlusions that may have been causing ischemia.[15] The CTA results showed multiple arterial occlusions but also showed a lesion in the right lobe of the liver. The interpreting radiologist recommended further testing to better define the liver lesion. The treating inpatient resident (resident) copied the radiologist's report into the patient's EHR daily progress notes on days 3 and 4, but made no comments regarding a clinical follow-up for the liver lesion.

[13] The OIG used the singular form of they (their) in this instance for the purpose of patient privacy. Information in the case summary was taken from the patient's EHR.

[14] The inpatient medicine team included a resident and supervising attending physician. For the purposes of this report, the treating inpatient resident will be referred to as the resident. All EHR entry dates referenced in this case summary occurred in 2019, unless otherwise noted.

[15] The ordering provider was an inpatient medicine resident who reported to the inpatient attending; however, the OIG concluded that it would not be unusual for one resident to place an order, and the primary treating resident to serve as the surrogate and follow up on results.

On day 4, the cardiology team stented the occluded artery, and the patient was discharged the next day (day 5) with instructions to return to cardiology clinic in six weeks. The resident and supervising attending physician (attending) completed a discharge summary but did not include documentation of the liver lesion or the follow-up testing recommendations made by the radiologist.

On day 18, the patient returned to the CBOC with complaints of a nonhealing foot wound. A nurse evaluated the patient and documented discussing the patient's complaints and wound appearance with the patient's primary care provider. The primary care provider recommended that the patient be seen at the facility's Emergency Department. The patient was seen in the Emergency Department the same day and was admitted to the inpatient medicine unit due to discoloration of the toe. A cardiology fellow evaluated the patient, discussed the patient's condition and recommendations with the cardiology section chief, and documented the abnormal arterial results from the CTA done on day 2. The cardiology fellow made no comment about the liver lesion.

On day 19, the patient was transferred to community hospital 1 for additional care. The patient was discharged from the community hospital four days later with a follow-up plan for a toe amputation the following week.[16]

On day 25, day 158, and day 165, the patient's primary care provider documented having discussions with the patient; however, the liver lesion identified on day 2 was not included in the documented discussions or written plans, nor did the primary care provider make recommendations for further radiological studies.

In the summer (day 174), the patient developed nausea and vomiting and went to the community hospital 2 emergency department. As part of an evaluation, the community emergency department provider ordered an abdominal ultrasound and computed tomography (CT) scan. The CT scan results showed a mass in the left lobe of the liver.

On day 185, the patient visited the primary care provider for an annual follow-up. The patient reported to a primary care nurse that a CT scan was performed at community hospital 2 where cysts and a tumor were identified. The patient requested a consult to hematology as a result of being told by the community hospital 2 that it was needed.

During the day 185 visit, the primary care provider documented several items in the patient's EHR:

- An ultrasound had been done at the community hospital, and the patient was requesting to see a hematologist.

[16] The OIG reviewed the records from the community hospital 1 and noted that treatment focused on the patient's acute pain and infected foot wound. The OIG found no evidence of laboratory orders for liver function evaluation.

- The community hospital records were not available and would be requested.[17]
- A new diagnosis of liver neoplasm was added to the patient's problem list.

The primary care provider ordered a CT scan of the patient's liver.

In addition, the nurse documented the patient reported that a CT of the abdomen was done at community hospital 2.

On day 200, the patient had a liver CT scan at the facility that showed a mass in the left lobe of the liver, a lesion in the right lobe of the liver, and possible metastasis to nearby lymph nodes and lungs. The radiologist recommended a complete chest CT scan for further work-up. A review of the patient's EHR showed no documentation that the patient was informed of the abnormal findings on the liver CT scan or that an order for a chest CT scan was entered.

On day 229, the patient was admitted to community hospital 3 with a diagnosis of sepsis. A liver biopsy was completed in the fall (day 233) confirming a diagnosis of liver cancer.[18]

On day 233, the primary care provider sent a letter to the patient about recent laboratory test results that indicated abnormalities specific to the liver. The primary care provider stated in the letter that the patient's liver enzymes were elevated; however, there was no mention of the abnormal CT scan or that further work-up was needed. Previous liver function tests done at the facility on day 1 had been either low or in the normal range.

On day 241, while still at community hospital 3, the patient underwent a revision of a partial foot amputation that was previously performed on day 132. Postoperatively, the patient was unable to maintain normal blood oxygen saturation levels and had difficulty waking. Later that day, the patient was found to have symptoms consistent with a stroke and was transferred to community hospital 4 for a stat CT perfusion scan, which showed a significant infarct of the left side of the brain.

On day 243, the patient was discharged to home hospice. On day 246, the patient's wife left a voice mail message with a facility psychiatrist stating that the patient died the previous day.

[17] The OIG found no evidence in the EHR that the primary care provider requested the community records from the day 174 visit.

[18] During the OIG inspection, community hospital 3 faxed records to the facility on July 20, 2021, showing that the patient had undergone a liver biopsy and was diagnosed with liver cancer. The OIG found no documentation in the patient's EHR that the community provider notified the patient's primary care provider of the patient's cancer diagnosis. The OIG reviewed the community care hospital records but was unable to determine what events, laboratory values, or other studies prompted the liver biopsy.

Inspection Results

1. Failure to Act on Abnormal Imaging Results

The OIG substantiated that the patient's primary care provider failed to timely identify and inform the patient of a terminal cancer diagnosis. Additionally, the OIG found that in early 2019, the resident and attending failed to coordinate the patient's care that would have allowed a timelier diagnosis of the patient's liver cancer.

The OIG found multiple providers, including the inpatient medicine team and PACT, failed to communicate effectively to ensure follow-up of abnormal imaging results and integration of appropriate clinical treatment. Specifically, the resident and attending failed to complete a discharge plan in early 2019 that included required information regarding the abnormal imaging findings, and coordinate care with the PACT to ensure appropriate follow-up testing. The OIG also found that the attending failed to provide adequate oversight of the resident per VHA requirements.[19] The OIG further substantiated that the primary care provider and surrogate provider failed to notify the patient in summer 2019 about abnormal imaging results.

The OIG concluded that had the primary care provider performed a comprehensive review of imaging results and medical history related to the early 2019 inpatient admission, the abnormalities of the liver may have been evaluated earlier.[20] The OIG was unable to determine if the clinical outcome for the patient would have been different had the early 2019 recommendation for an additional imaging study of the liver been completed, or if the patient had been informed about the summer 2019 abnormal imaging results.

Early 2019 Abnormal Imaging Studies

The OIG found that the resident and attending on the inpatient medicine unit did not follow up on a radiologist's early 2019 recommendation for additional studies. On day 2, the inpatient medicine team ordered a CTA for the patient to evaluate for vascular disease.[21] The interpreting radiologist documented the results for the vascular study and recommended an additional multiphase CT scan or a magnetic resonance imaging (MRI) study of the liver based on abnormal findings.

The VHA PACT Handbook establishes procedures to provide quality primary care that includes timely, comprehensive, and coordinated care.[22] VHA policy identifies each PACT staff member,

[19] VHA Handbook 1400.01.

[20] The first documented diagnosis of liver cancer was made in a community facility in fall 2019.

[21] The ordering provider was also a resident, but the OIG concluded that it would not be unusual for one resident to place an order, and the primary treating resident to serve as the surrogate and follow up on results.

[22] VHA Handbook 1101.10(1).

which includes the primary care provider, as responsible for "managing communications and facilitating safe transitions of patients" between healthcare settings.[23] PACT care coordination includes care for patients who have been admitted to the hospital or emergency department, discharged from the hospital, receiving specialty care, surgical or interventional procedures, or care from community providers. Care coordination processes must ensure no lapses of care, communication between involved providers with necessary information for healthcare decision-making, and integration of clinically recommended care to minimize inefficiencies and avoid missed opportunities.[24] VHA policy states that "providers of specialty care apply the principles" to their scope of specialty care that include timeliness and care coordination.[25]

VHA policy outlines responsibilities for ordering providers of diagnostic tests to initiate "appropriate clinical action and follow-up for any orders that they have placed." Additionally, each diagnostic provider identifies and communicates "all critical life threatening test results and urgent non-life threatening abnormal test results to the ordering provider or their designee."[26]

Facility policy notes the ordering provider, or surrogate, is responsible for "initiating appropriate clinical action in a timely manner in response to significant radiology findings."[27] Facility policy specifies that appropriate clinical action may include notifying the patient, documenting a follow-up plan in the patient's EHR, and periodically reviewing test results.[28] Integral to this policy, the computerized patient record system (CPRS) generates view alerts to the ordering provider (or surrogate) and the attending physician, and to "any Provider whose personal list includes the patient."[29]

The OIG found discrepant understandings of how view alerts for abnormal results are managed and communicated to providers. During interviews with the OIG, facility leaders and a clinical applications coordinator reported as follows:

- The Chief of Staff reported that an abnormal radiology result would generate an alert to the ordering provider who could be an intern or resident. If the primary care provider ordered the test, then that same provider would receive the alert.

[23] VHA Handbook 1101.10(1).

[24] VHA Handbook 1101.10(1).

[25] VHA Handbook 1101.10(1).

[26] VHA Directive 1088(1). Diagnostic providers in this inspection are radiologists. *Merriam-Webster.com Dictionary*, "radiology," accessed February 10, 2020, https://www.merriam-webster.com/dictionary/radiology#medicalDictionary. Radiology is a division of medicine that uses radiant energy (such as X-rays or ultrasound) in diagnosing and treating disease.

[27] Facility Memorandum 114-04, *Guidelines for Communication of Diagnostic Imaging Results*, October 13, 2015.

[28] Facility Memorandum 114-04.

[29] Facility Memorandum 114-04.

- The interim chief of Medicine explained that an abnormal test result would go to the ordering provider and the PACT team, as the patient was a primary care patient.
- The associate chief of Clinical Informatics reported that in the past it was decided that a specific alert for abnormal imaging results needing attention would go to both the ordering provider and primary care provider.
- A clinical applications coordinator stated that certain types of alerts may be set up differently in the EHR.

The OIG found that the resident copied the early 2019 CTA radiologist's report into the EHR, but neither the resident nor the attending commented on the abnormal findings and failed to specifically address the liver lesion or the recommended follow-up. On day 3, the resident documented, "I have reviewed and discussed the diagnostic test results obtained to date with the patient and/or surrogate."[30] The OIG did not find evidence of a response to the patient's abnormal imaging findings of the liver or that an additional, and recommended, CT scan or MRI was ordered until summer 2019.

The OIG could not determine who received the view alert of abnormal finding and was unable to identify all providers, including the primary care provider, who were notified via the view alert in early 2019.[31] The Chief of Staff informed the OIG that the data from the early 2019 alert was beyond the "shelf life," and the historical data was not available.[32]

The OIG reviewed the EHR to evaluate whether the patient's primary care provider noted awareness of the early 2019 abnormal imaging findings. On day 18, day 25, day 158, and day 165, the patient received primary care services; however, the liver abnormality was not included in the documentation or written plans, nor did the primary care provider make recommendations for further radiological studies. The OIG concluded that a more comprehensive review of prior studies and recommendations may have informed the primary care provider and led to a timelier evaluation of the liver abnormalities.

Discharge Summary

The OIG found that deficiencies in communication between inpatient and PACT staff, specifically related to an inpatient discharge summary, contributed to delays in the patient's care. The OIG determined that providers did not consider all available prior medical history when making healthcare decisions and documenting the discharge plan. Further, the OIG found the

[30] The OIG noted the EHR documentation did not reflect a discussion with the patient specifically about the liver lesion and plan of care.

[31] The OIG could not determine if the primary care provider saw the early 2019 view alert, or other notes related to the recommended liver study.

[32] A clinical applications coordinator told the OIG that the electronic history of a view alert can be set to autodelete after a specific time frame, and this particular alert was set to auto delete at 730 days.

attending failed to provide adequate oversight of the resident by not ensuring the resident both documented a comprehensive discharge summary and communicated with the PACT to ensure follow-up care.

Facility policy establishes procedures and guidelines to provide continuity of care for patients.[33] The policy further specifies that the discharge summary is completed "for all releases from the [facility]" and must list the principal diagnosis for admission, other diagnoses treated in order of clinical importance, and "conditions noted but not treated."[34] The discharge summary should also include significant procedures, review of treatment, conclusions, and the condition of the patient upon release, enabling other providers, including the PACT, to have current information.[35]

VHA policy requires that attendings are ultimately responsible for the care provided by residents and must ensure that documentation of the care and oversight of the care is entered into patients' EHRs. Documentation of supervision in the EHR must be clear and may occur in the progress note or in a separate entry by the attending.[36]

Facility policy regarding resident supervision further requires the attending physician to document in the EHR "any clinically significant change in the patient's diagnosis, condition, or management."[37] An attending, in consultation with the resident, must ensure the discharge of the patient is appropriate, and the attending must document an independent progress note, an addendum to the resident note, or countersign the discharge summary within 30 days of discharge.[38]

The OIG found that during the patient's early 2019 inpatient stay, the resident and attending documented clinically significant changes in the patient's diagnoses and management; however, the providers did not address the liver lesion identified on the CTA scan in the patient's plan of care or the discharge summary. The OIG reviewed the EHR and found that the resident and attending failed to

- document a plan of care to address the liver abnormality,
- notify the PACT to ensure care coordination,
- enter orders or consults for follow-up testing, and
- include information regarding the liver lesion and recommended follow-up in the discharge summary.

[33] Facility Memorandum 136-12, *Medical Records*, March 24, 2017.
[34] Facility Memorandum 136-12.
[35] Facility Memorandum 136-12.
[36] VHA Handbook 1400.01.
[37] Facility Memorandum 142-02, *Resident Supervision and Monitoring Policy*, April 10, 2016.
[38] Facility Memorandum 142-02.

The attending told the OIG that while a resident may write the discharge summary, the attending is responsible to make sure the summary is completed and documented appropriately. In this inspection, the attending could not explain why the findings of abnormalities in the patient's liver were not included in the care plan and discharge summary and believed it was human error. During interviews with primary care team members, the OIG team learned that PACT care coordination processes for post-hospitalization discharge were viewed as dependent on the thoroughness of the inpatient discharge summary recommendations and the patient's own verbal report.

The attending acknowledged failing to ensure that the resident communicated the patient's abnormal imaging results and relevant discharge summary information to the PACT so that the patient would be informed and receive appropriate follow-up care. The OIG concluded that the inclusion of the abnormal liver imaging results in the discharge summary would have provided critical information to the PACT and other providers regarding the need for further testing.

Summer 2019 Abnormal Imaging Study

The OIG found no documentation in the EHR that the primary care provider requested records related to abnormal findings discovered in a CT scan at a community hospital. Additionally, the primary care provider failed to document follow-up actions related to the radiologist's early 2019 recommendation for additional studies, and the abnormal findings in the day 200 CT scan.

The OIG reviewed the EHR and found that, on day 185, the patient visited the primary care provider and reported to a primary care nurse that a CT scan was performed at community hospital 2 where cysts and a liver tumor were identified. The primary care provider documented an impression and plan for the visit citing, "Neoplasm liver uncertain" and ordered a CT scan of the liver. The patient requested a consult to hematology, as a result of being told by the community hospital 2 that it was needed. The primary care provider documented, "no records available from emergency room appointment [from summer 2019]," and documented in the plan to "request medical records from [hospital 2]." However, during the inspection, the OIG was unable to find the day 174 record. The OIG requested the facility request the day 174 records, which were obtained on July 13, 2021.

On day 200, the patient had a liver CT scan at the facility that showed a mass occupying the left lobe of the liver, a lesion in the right lobe of the liver, and possible metastasis to nearby lymph nodes and lungs. The interpreting radiologist noted, "There is mild cardiomegaly. There are two tiny nodules in the left lower lobe. Metastasis cannot be excluded. Complete chest CT is recommended." and "Suspicious for New Malignancy Need [follow up]." However, the primary care provider failed to comment on relevant prior abnormal imaging findings from early 2019 and did not document notification or follow-up action on the results of the CT scan completed on day 200.

The OIG found that the primary care provider did not ensure a timely request for, or review the community records, precluding an informed and timely evaluation of the patient's abnormal test finding.

Failure to Notify Patient of Imaging Results

The OIG substantiated that neither the primary care provider nor surrogate notified the patient of the day 200, abnormal imaging results.

VHA policy requires the ordering provider or designee communicate all test results requiring action to patients no later than seven calendar days from the date on which the results are available. VHA recognizes "[l]ack of timely follow-up of abnormal test results has been identified as a contributor to poor outcomes and can be a source of considerable anxiety to patients and families." Timely communication of test results is consistent with the tenet of patient driven care and safe quality health care.[39]

The OIG found no documentation in the patient's EHR that the primary care provider, who ordered the liver CT scan in summer 2019, or the surrogate who initially received the results, documented notification to the patient of the abnormalities that were suspicious for a new malignancy and needed follow-up.

The OIG concluded that the failure to notify the patient of test results precluded the patient's ability to make informed healthcare decisions regarding follow-up care.

2. Failure to Implement Surrogate Provider Processes

Lack of Written Processes

The OIG found that in 2019, the facility had no written processes in effect for assignment of provider surrogates, although required by VHA in 2014. The chief of primary care was unaware of a policy prior to November 2019 and the facility liaison was unable to provide a policy in effect for 2019.

VHA policy requires that staff coverage arrangements ensure patients receive access to and continuity of care.[40] PACTs "must establish and implement written processes for coverage" such that "PACT function, operations, and team-based care continue during absences of individual

[39] VHA Directive 1088(1).
[40] VHA Handbook 1101.10(1).

PACT staff." The coverage arrangements must ensure the covering provider manages EHR view alerts and secure messages.[41]

In January 2020, the facility implemented a written standard operating procedure for provider surrogates for primary care.[42] The standard operating procedure requires that "Primary Care providers must assign a surrogate provider to act in his/her absence for CPRS notifications, Secure Messages, and emergencies/urgent situations identified by PACT team members."

Failed Assignment of Primary Care Provider Coverage

The OIG determined that in summer 2019, there was a failed surrogate assignment of an Emergency Department physician assistant to cover for the primary care provider. Specifically, the surrogate was unaware of the assignment and, when in receipt of abnormal imaging results, took no action to ensure follow-up and continuity of care.

VHA policy requires the assignment of a covering provider, or surrogate, to respond to EHR notifications and "ensure patients receive continuity of and access to care."[43] The OIG found that the patient's primary care provider was on leave from day 200 through day 203, and then again on day 205. The Emergency Department physician assistant (surrogate) was listed as a surrogate on a view alert for the primary care provider during that time frame, although facility leaders were unable to identify who assigned the surrogate. The surrogate told the OIG of being unaware of that assignment and, although a view log indicated the surrogate opened the EHR notification regarding the abnormal results from the day 200 CT scan, took no action on the patient's abnormal imaging results.[44]

The OIG asked facility clinical leaders why an Emergency Department physician assistant was assigned to cover for a primary care provider. The Chief of Staff told the OIG that usually other primary care providers covered for primary care, but that a physician assistant had the necessary training to provide outpatient clinical work; however, it is not a regular practice. The chief of Emergency Medicine reported that it would be considered "very rare" for an Emergency Department physician assistant to be assigned as a surrogate for a primary care provider; though,

[41] VHA Handbook 1101.10(1). "Local service-level officials accountable for PACTs must establish and implement written processes for coverage of PACT staff." "VA Secure Messaging," U.S Department of Veterans Affairs, accessed on October 26, 2021, https://www.va.gov/health-care/secure-messaging/. Secure messaging allows patients to communicate privately with their VA healthcare team.

[42] Facility Standard Operating Procedure, *Provider Surrogate Procedures for Primary Care Providers Standard Operating Procedure*, January 5, 2020. This standard operating procedure was enacted after the patient's episode of care.

[43] VHA Handbook 1101.10(1).

[44] The OIG was unable to determine who assigned the physician assistant to serve as surrogate for the primary care provider.

it has happened in the past, with a different provider at the specific request of primary care, and only a few times.

The Chief of Staff provided a copy of the patient's summer 2019 view alert to the OIG. The view alert noted the patient's abnormal imaging results of day 200, and indicated that the alert was transmitted to the surrogate who opened the view alert the next day, but did not document corresponding clinical notes or patient notifications in the EHR. During an interview, the Emergency Department physician assistant did not recall being assigned as a surrogate for the primary care provider, or reviewing the patient's view alert, and denied being involved in the patient's care.[45]

The OIG was unable to determine who assigned, or why, the Emergency Department physician assistant was listed as a surrogate to cover in the primary care provider's absence. The OIG found the surrogate was unaware of the assignment, unfamiliar with the patient, and worked in a department outside of primary care. Further, the OIG reviewed the EHR and determined the assigned surrogate took no action on the abnormal imaging results, further delaying a timely identification of the patient's liver cancer.

3. Facility Leaders' Awareness and Response

On June 23, 2021, the OIG notified facility leaders and the VISN 16 Director of intent to review the patient's episode of care, including the allegation of deficiency in care related to the patient's liver cancer. According to the former patient safety manager and the chief of quality, safety and value (QSV), notification from the OIG was the leaders' first awareness of the concerns regarding the patient's care. The OIG found that upon this awareness, the facility leaders and QSV staff did not take timely administrative action in response to the patient's delayed diagnosis of cancer (adverse event). Specifically, the OIG found that the former patient safety manager failed to initiate a patient safety report and review the episode of care and the systemic issues related to coordination of care.[46] Facility leaders conducted peer reviews and made an institutional disclosure per VHA requirements.

Reporting and Assessment of Adverse Events

Per VHA policy, patient safety managers are responsible for reviewing patient safety events and scoring each event using the Safety Assessment Code matrix. To capture incident reports, VHA uses a patient safety event reporting system and database called Joint Patient Safety Reporting. The patient safety manager scores joint patient safety reports using a safety assessment code that

[45] The associate chief of Clinical Informatics provided the OIG with an email that indicated the patient's primary care provider requested surrogate coverage, but the listed surrogate in the email was not the Emergency Department physician assistant on the view alert.

[46] The facility patient safety manager reported to the chief of QSV.

evaluates frequency and severity of the event, which helps determine what type of assessment and resolution is needed.[47]

Patient safety events with scores of three require a root cause analysis.[48] A root cause analysis must be chartered for every adverse event or close call that requires analysis and must be completed, signed by the director, and submitted to National Center for Patient Safety "within 45 days of the facility becoming aware that [a root cause analysis] is required."[49]

VHA requires that when a patient safety event is deemed to be a sentinel event, the patient safety manager must initiate an immediate investigation, which "may be an RCA [root cause analysis], or, in the case of an intentionally unsafe act, administrative action." Sentinel events are adverse events "defined by TJC [The Joint Commission] as unexpected occurrences involving death, serious physical or psychological injury, or risk thereof." Sentinel events must be scored using the Safety Assessment Code matrix and may receive a score of 3, mandating a root cause analysis.[50]

VHA policy defines a look-back, as "an organized process for identifying patients or staff with exposure to potential risk incurred through past clinical activities, with the explicit intent to notify them and offer care and recourse, as appropriate."[51] If an adverse event is discovered through a look-back, facility leaders are required to report the event to the affected patient or their personal representatives.[52] VHA and facility policy requires any staff aware or witnessing an adverse event, to report the event, such as a failure to make a timely diagnosis, either through the electronic patient safety reporting system or using a facility accepted method, which is to be reviewed by the patient safety manager.[53]

The former patient safety manager told the OIG of becoming aware of the circumstances of the patient's death in July 2021.[54] Additionally, the former patient safety manager

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[47] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook,* March 4, 2011.The Safety Assessment Code matrix uses severity and probability to guide patient safety managers when rating patient safety events. VA National Center for Patient Safety, "Joint Patient Safety Reporting (JPSR) System Business Rules," May 1, 2018.

[48] VHA Handbook 1050.01. A safety assessment code score of 3 is given to events that are deemed "catastrophic" or "major" with a probability of high frequency. Catastrophic is defined as actual or potential "death or major permanent loss of function (sensory, motor, physiologic, or intellectual) not related to the natural course of the patient's illness or underlying condition."

[49] VHA Handbook 1050.01. A root cause analysis (RCA) "is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

[50] VHA Handbook 1050.01.

[51] VHA Directive 1004.08, 2018.

[52] VHA Directive 1004.08; VHA Handbook 1050.01.

[53] VHA Handbook 1050.01. Facility Memorandum 00-05, *Patient Safety Improvement Program,* January 21, 2015.

[54] The former patient safety manager reported learning of the patient's death from the facility liaison to the OIG in July 2021, following the announcement of the OIG inspection.

reported discussing the event with another patient safety manager and the chief of QSV, and it was determined that the adverse event was too far in the past to warrant filing an electronic incident report, and therefore, the former patient safety manager did not assign a safety assessment code score. The former patient safety manager stated that if a safety assessment code score had been assigned, it would have indicated a root cause analysis should have been completed.

The chief of QSV and the former patient safety manager informed the OIG that the patient's adverse event was not entered into the Joint Patient Safety Reporting System. The chief of QSV reported that after the Chief of Staff and the facility clinical risk manager reviewed the event, the patient safety manager could apply criteria to determine if a root cause analysis was warranted. The Chief of Staff reported to the OIG a root cause analysis would be considered after peer reviews and an institutional disclosure were completed. On January 10, 2022, the facility clinical risk manager advised the OIG, "An RCA [root cause analysis] was not warranted per Patient Safety."

The OIG found that following awareness of the patient's death and delayed diagnosis, QSV staff failed to

- enter the event into the Joint Patient Safety Reporting System,
- review the event and assign a safety assessment code score, and
- ensure a root cause analysis was conducted.

The OIG concluded that facility leaders' failure to perform the required patient safety actions precluded a detailed analysis of a patient safety event to identify causal factors, which could have resulted in missed opportunities for improvements in patient care.

Facility Protected Peer Reviews

The OIG found that the events related to the patient's delayed diagnosis met the criteria for peer review and facility leaders conducted peer reviews for several providers involved in the patient's care per VHA requirements. The peer reviews occurred after the OIG provided June 2021 notification of inspection to the facility leaders.

VHA policy notes that "Peer Review for Quality Management is intended to promote confidential and non-punitive assessments of care at the individual clinician level." The focus of the peer review is to determine if a provider's clinical decisions met the standard of care. VHA requires a peer review in certain circumstances including when a patient's death is "preceded by a change in the patient's condition when there are questions regarding response to, management

of, and/or communication related to the referenced change," or where a patient's death may "be associated with a health care related incident, adverse event, or a complication of treatment."[55]

The facility clinical risk manager provided information to the OIG that the peer reviews were conducted in July 2021 as requested by the Chief of Staff and multiple relevant peer reviews were addressed in a Peer Review Committee meeting in August 2021.

The OIG found that facility leaders conducted peer reviews for several providers who provided the patient's care. The OIG found peer reviews were completed through the peer review committee process in accordance with VHA policy.

Institutional Disclosure

The OIG found facility leaders provided an institutional disclosure to a member of the patient's family in August 2021. The facility clinical risk manager provided documentation during the inspection in which the OIG found no evidence that the facility addressed or reported issues, prior to the OIG inspection, with the patient's care that would warrant a disclosure.

VHA describes an institutional disclosure as a formal process where facility leaders and clinical staff inform a patient or the patient's personal representative that "an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." The disclosure occurs regardless of when the event was discovered.[56]

The facility clinical risk manager reported to the OIG that a review of the patient's care was initiated in July 2021, and submitted consideration for an institutional disclosure to the Chief of Staff. On August 19, 2021, facility leaders issued an institutional disclosure to the patient's family member and reported, "[O]n review of [the patient's] CT that was done in February 2019, there was [*sic*] were nodules in the liver and the radiologist did note that. Due to oversite, the [attending] did not copy that information to the orders/notes and that information was not passed along. We should have caught this so that you and [the patient] could have had the opportunity for further testing/studies."

The OIG found that upon awareness of concerns regarding the patient's care, facility leaders conducted the institutional disclosure per VHA policy.

Conclusion

The OIG substantiated that the patient's primary care provider failed to timely identify and inform the patient of a terminal cancer diagnosis. Additionally, in early 2019 the resident and

[55] VHA Directive 1190, *Peer Review for Quality Management,* November 21, 2018.
[56] VHA Directive 1004.08.

attending failed to coordinate the patient's care that would have allowed a timelier diagnosis of the patient's liver cancer. The resident and attending also failed to complete a discharge plan that included required information regarding abnormal imaging findings and a recommendation for additional testing. The OIG also found that the attending failed to provide adequate oversight of a resident per VHA requirements.

The OIG was unable to determine if the clinical outcome for the patient would have been different had the early 2019 recommendation for an additional imaging study of the liver been completed, or if the patient had been informed about the summer 2019 abnormal imaging results.

In 2019, the facility had no written processes in effect for assignment of provider surrogates, although required by VHA. In summer 2019 there was a failed surrogate assignment in that an Emergency Department physician assistant assigned to cover for the primary care provider was unaware of the assignment and took no action on the patient's abnormal imaging results even though the surrogate viewed the EHR view alert. The physician assistant did not recall being assigned as a surrogate for the primary care provider, or reviewing the patient's view alert, and denied being involved in the patient's care.

In June 2021, upon awareness of the patient-related concerns, facility leaders and QSV staff did not take timely administrative action in response to the patient's adverse event. The former patient safety manager did not initiate a patient safety report and review the episode of care and the communication issues related to coordination of care.

The OIG found that upon awareness of concerns regarding the patient's care, facility leaders conducted peer reviews and an institutional disclosure per VHA policy.

Recommendations 1–4

1. The Overton Brooks VA Medical Center Director evaluates the processes for the communication of abnormal radiology imaging results and ensures patients receive timely notification, per Veterans Health Administration and facility requirements.

2. The Overton Brooks VA Medical Center Director ensures supervising attending physicians oversee all clinical decisions and documentation made by residents and the oversight is reflected within the documentation.

3. The Overton Brooks VA Medical Center Director reviews the processes for assigning a provider surrogate and monitors compliance.

4. The Overton Brooks VA Medical Center Director ensures that concerns are entered into the Joint Patient Safety Reporting System and appropriate follow-up is completed.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 15, 2022

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison office (VHA 10BGOAL Action)

1. The South Central VA Health Care Network appreciates the opportunity to review and provide feedback to the draft healthcare inspection report – *Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center, Shreveport, LA.* Based on a thorough review of the report by VISN 16 Leadership, I concur with the recommendations and the facility's response to each one.

2. If you have questions regarding the information submitted, please contact VISN 16 Quality Management Officer.

(*Original signed by*:)

Skye McDougall, PhD
VISN 16 Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: December 12, 2022

From: Director, Overton Brooks VA Medical Center (667/00)

Subj: Healthcare Inspection—Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and respond to the draft report titled, *Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana.* I reviewed and concur with the findings and recommendations in the report. These recommendations will be used to evaluated and strengthen our process and improve the care that is provided by our facility.

2. Overton Brooks VA Medical Center remains committed to ensuring each Veteran that presents to our facility receives the highest quality of care.

3. If you need more information or have additional questions, please contact the Chief, Quality, Safety and Value Service.

(*Original signed by*:)

Richard L. Crockett, MBA
Medical Center Director

Facility Director Response

Recommendation 1

The Overton Brooks VA Medical Center Director evaluates the processes for the communication of abnormal radiology imaging results and ensures patients receive timely notification, per Veterans Health Administration and facility requirements.

Concur.

Target date for completion: February 1, 2023

Director Comments

In August of 2022, Overton Brooks VA Medical Center put a team in place to evaluate the process of communication of test results to patients and determine what actions should be taken, if any. This team has reviewed best practices from other facilities and has revised our Medical Center Policy that will govern the process of timely communication of abnormal radiology imaging results. Once this policy is finalized, these changes will be communicated to all providers by email and at a mandatory Medical Staff Meeting. The Deputy Chief of Staff or their designee will audit twenty-five (25) electronic health records each month for patients who had abnormal radiology imaging results to ensure results were communicated timely to patient. Data on the timeliness will be collected until 90% compliance has been met for three (3) consecutive months. This data will be reported to the Medical Executive Board for oversight.

Recommendation 2

The Overton Brooks VA Medical Center Director ensures supervising attending physicians oversee all clinical decisions and documentation made by residents and the oversight is reflected within the documentation.

Concur.

Target date for completion: February 1, 2023

Director Comments

The Chief of Staff is responsible for ensuring appropriate resident supervision by all attending physicians. Attending involvement in the care and medical decision-making for our Veterans will be documented during admission, discharge, or any change in status or level of care. In November of 2021, education was developed for newly assigned attending physicians. This education is provided to all attendings through our Talent Management System and is documented and tracked. The Chief of Staff is also working with our affiliate partners to further improve the oversight process by providing additional faculty-development opportunities for our

attending physicians. The Deputy Chief of Staff or designee will conduct audits of fifty (50) charts monthly to ensure that attending physician oversight is documented appropriately. Data will be collected until 90% compliance has been met for three (3) consecutive months and will be reported to Medical Executive Board quarterly.

Recommendation 3

The Overton Brooks VA Medical Center Director reviews the processes for assigning a provider surrogate and monitors compliance.

Concur.

Target date for completion: February 1, 2023

Director Comments

Overton Brooks VA Medical Center leadership has recently developed a Standard Operating Procedure (SOP) that establishes procedures for electronic notifications for patient care and surrogacy settings. Training on this SOP will be provided to current providers and new providers to our facility. The assignment of surrogates according to SOP will be tracked for three (3) consecutive months until 90% of continuous compliance is maintained.

Recommendation 4

The Overton Brooks VA Medical Center Director ensures that concerns are entered into the Joint Patient Safety Reporting System and appropriate follow-up is completed.

Concur.

Target date for completion: March 1, 2023

Director Comments

Overton Brooks VA Medical Center has a process in place to ensure safety issues are entered into the Joint Patient Safety Reporting System (JPSR). Newly hired staff are educated during New Employee Orientation on how and why to report adverse events and close calls in the JPSR system. Patient Safety staff also offer a virtual Patient Safety Forum monthly which covers a variety of safety topics including how to enter into the JPSR system. To further educate current employees, a virtual training will be developed and assigned to all employees through our Talent Management System.

Glossary

To go back, press "alt" and "left arrow" keys.

atrial fibrillation. "An irregular and often rapid heart rate that can increase [the] risk of strokes, heart failure, and other heart-related complications."[1]

bipolar disorder. "A mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression)."[2]

cardiomegaly. An enlarged heart.[3]

cellulitis. A common, potentially serious bacterial skin infection that usually affects the skin on the lower legs but can occur in other areas such as the face or arms.[4]

chronic obstructive pulmonary disease. "A chronic inflammatory lung disease that causes obstructed airflow from the lungs."[5]

computed tomography. "A method of producing a three-dimensional image of an internal body structure by computerized combination of two-dimensional cross-sectional X-ray images." This study is also known as a CT.[6]

computed tomography angiogram. CT [Computed tomography] angiography is a type of medical test that combines a CT scan with an injection of a special dye to produce pictures of blood vessels and tissues in a part of [the] body."[7]

computed tomography perfusion scan. "a type of brain test that shows the amount of blood taken up in certain areas of [the] brain." "Providers often superimpose brain perfusion images with other types of standard imaging tests, such as a computed tomography (CT) scan."[8]

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[1] Mayo Clinic, "Atrial fibrillation," accessed August 11, 2021, https://www.mayoclinic.org/diseases-conditions/atrial-fibrillation/symptoms-causes/syc-20350624.

[2] Mayo Clinic, "Bipolar disorder," accessed August 11, 2021, https://www.mayoclinic.org/diseases-conditions/bipolar-disorder/symptoms-causes/syc-20355955.

[3] *Merriam Webster.com Dictionary*, "cardiomegaly," accessed June 29, 2022, https://www.merriam-webster.com/medical/cardiomegaly.

[4] Mayo Clinic, "Cellulitis," accessed September 2, 2021, https://www.mayoclinic.org/diseases-conditions/cellulitis/symptoms-causes/syc-20370762.

[5] Mayo Clinic, "Chronic obstructive pulmonary disease (COPD)," accessed August 31, 2021, https://www.mayoclinic.org/diseases-conditions/copd/symptoms-causes/syc-20353679?p=1.

[6] *Merriam-Webster.com Dictionary*, "computed tomography," accessed September 28, 2021, https://www.merriam-webster.com/dictionary/computed%20tomographies.

[7] Johns Hopkins Medicine, Treatments, Tests and Therapies, "Computed Tomography Angiography (CTA)," accessed October 4, 2022, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/computed-tomography-angiography-cta.

[8] Johns Hopkins Medicine, Treatments, Tests and Therapies, "Brain Perfusion Scan," accessed October 26, 2022, https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/brain-perfusion-scan.

coronary artery bypass graft. A surgical procedure that redirects (bypasses) blood around a section of a blocked or partially blocked artery in the heart.[9]

coronary artery disease. "The coronary arteries supply blood, oxygen, and nutrients to [the] heart. A buildup of plaque can narrow these arteries, decreasing blood flow to [the] heart. Eventually, the reduced blood flow may cause chest pain (angina), shortness of breath, or other coronary artery disease signs and symptoms. A complete blockage can cause a heart attack."[10]

cyst(s). "A closed sac having a distinct membrane and developing abnormally in a cavity or structure of the body."[11]

diabetes mellitus. "A group of diseases that affect how the body uses blood sugar (glucose)."[12]

hematology. "A medical science that deals with the blood and blood forming organs."[13]

hospice. Care for individuals with advanced illness and in the final stage of life. "Hospice care is used when a disease, such as advanced cancer, gets to the point when treatment can no longer cure or control it."[14]

infarct. An area of tissue damage or organ damage resulting from obstruction of the local circulation by a thrombus or embolus.[15]

ischemia. A "deficient supply of blood to a body part (such as the heart or brain) that is due to obstruction of the inflow of arterial blood."[16]

Joint Patient Safety Reporting System. Is utilized by the Department of Defense and VA to report and document patient safety events.[17]

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[9] Mayo Clinic, "coronary bypass surgery," accessed August 31, 2021, https://www.mayoclinic.org/tests-procedures/coronary-bypass-surgery/about/pac-20384589.

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lesion. "An abnormal change in structure of an organ or part due to injury or disease especially: one that is circumscribed and well defined."[18]

magnetic resonance imaging. "A method used to produce images of the inside of a person's body by means of a strong magnetic field." This study is also known as an MRI.[19]

metastasis. "The spread of a disease-producing agency (as cancer cells or bacteria) or disease from the initial or primary site of disease to another part of the body."[20]

neoplasm. "A new growth of tissue serving no physiological function: tumor."[21]

obstructive sleep apnea. "Occurs when [the] throat muscles intermittently relax and block [the] airway during sleep" causing lower oxygen levels and increased carbon dioxide.[22]

occlusion. The shutting off or obstruction of something such as a coronary artery.[23]

oxygen saturation. "Blood oxygen saturation is the amount of oxygen …circulating in [the] blood…There are two main ways to measure or test blood oxygen levels: through a blood draw test and through pulse oximetry."[24]

peripheral arterial disease. "A common circulatory problem in which narrowed arteries reduce blood flow" to the legs or arms.[25]

psychiatrist. "A medical doctor who diagnoses and treats mental, emotional, and behavioral disorders."[26]

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[26] *Merriam-Webster.com Dictionary*, "psychiatrist," accessed September 29, 2021, https://www.merriam-webster.com/dictionary/psychiatrist.

sepsis. "A potentially life-threatening condition that occurs when the body's response to an infection damages its own tissues."[27]

stat. "Without delay: immediately."[28]

stent. A short narrow metal or plastic tube that is inserted in the opening inside of an anatomical vessel (such as an artery or a bile duct) to keep a previously blocked passageway open.[29]

stroke. "Occurs when the blood supply to part of [the] brain is interrupted or reduced, preventing brain tissue from getting oxygen and nutrients. Brain cells begin to die in minutes."[30]

ultrasound. "An imaging method that uses high-frequency sound waves to produce images of structures within [a patient's] body."[31]

view alert. A method for communicating test results to providers through the EHR.[32]

[27] Mayo Clinic, "Sepsis," accessed March 15, 2022, https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214.

[28] *Merriam-Webster.com Dictionary*, "stat," accessed September 10, 2021, https://www.merriam-webster.com/dictionary/stat.

[29] *Merriam-Webster.com Dictionary*, "stent," accessed September 10, 2021, https://www.merriam-webster.com/dictionary/stent.

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[31] Mayo Clinic, "Ultrasound," accessed September 10, 2021, https://www.mayoclinic.org/tests-procedures/ultrasound/about/pac-20395177.

[32] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, October 7, 2015, amended January 24, 2022.

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