Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-01855-336

Healthcare Inspection

Quality of Care Issues

Erie VA Medical Center, Erie, Pennsylvania

VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania

September 25, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to evaluate the care and services a patient received at the Erie VA Medical Center, Erie PA; the Warren Community Based Outpatient Clinic, Warren, PA; and the VA Pittsburgh Healthcare System, University Drive Campus, Pittsburgh, PA. Complainants alleged VA providers did not recognize a patient had cancer and did not manage his pain appropriately. The complainants also alleged scheduling delays and poor coordination of the patient's care, and that an outpatient specialty care provider was rude to the patient and family.

We substantiated the allegations that VA providers missed the patient's cancer diagnosis, did not manage his pain appropriately, and that there were scheduling delays in the patient's referrals and follow-up care. We could not confirm the allegation that an outpatient specialty care provider was rude to the patient and family during the patient's care visit. However, we found there was a significant disconnect between the provider's perception of care provided and the family members' perceptions and satisfaction with the care experience.

We found factors that contributed to the missed diagnosis and opportunities for improvement in system processes that affected this patient's care. The oversight of the patient's care continuum was lacking and there was inadequate communication between primary care and specialty care providers and VA and community health care facilities. VA Pittsburgh Healthcare System has reviewed this case and taken action as needed.

We recommended that the Veterans Integrated Service Network Director initiate a root cause analysis to evaluate system issues outlined in this report and evaluate the care of the patient discussed in this report with Regional Counsel for possible disclosure to the surviving family member(s) of the patient.

Comments

The Veterans Integrated Service Network Director concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 12–13 for the Director's 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 conducted an inspection to determine the validity of allegations regarding a patient's quality of care at the Warren Community Based Outpatient Clinic (CBOC), Warren, PA; Erie VA Medical Center (Erie VAMC), Erie, PA; and VA Pittsburgh Healthcare System, University Drive Campus (Pittsburgh HCS), Pittsburgh, PA. The purpose of the review was to determine whether the allegations had merit.

Background

Erie VAMC and Pittsburgh HCS are part of Veterans Integrated Service Network (VISN) 4. The two facilities and their satellites serve a population of approximately 400,000 in western Pennsylvania, northern West Virginia, and eastern Ohio.

Erie VAMC is a general medical and surgical facility with 65 inpatient beds. It provides a full range of primary care outpatient services and inpatient acute, hospice, rehabilitative, and long-term care. The Warren CBOC is one of five Erie VAMC CBOCs and is located in Warren, PA. The CBOC provides outpatient services and refers patients to other facilities for emergency, inpatient, and specialty care.

Pittsburgh HCS is adjacent to the University of Pittsburgh Medical Center and has 146 inpatient beds. It is a tertiary care facility and serves as a referral center for cardiac surgery, liver and kidney transplantation, and for multiple other specialized services, including mental health, oncology, and geriatrics. During 2012, 48 liver transplants and 39 kidney transplants were performed at the Pittsburg HCS.

The Erie VAMC and the Pittsburgh HCS employ a patient-centered oversight of patient care approach and use a Patient Aligned Care Team (PACT) model.[1] The model organizes care around an interdisciplinary team of providers who should work together to increase access and clinical effectiveness by identifying and removing barriers to high-quality care. Patients are provided a continuous link with the core team even when the care is provided at a facility away from the location of primary care. Coordination of care is a responsibility of all team members involved in the care of the patient.[2]

Allegations

The complainants contacted the OIG's Hotline Division with allegations regarding a patient's quality of care. Specifically, the complainants alleged that:

- VA providers did not diagnose the patient's cancer.
- VA providers did not adequately address the patient's complaints of pain.

[1] PACT overview and information from http://www.va.gov/primarycare/pcmh/, accessed June 4, 2013.
[2] Patient-Centered Medical Home Concept paper, http://www.va.gov/PRIMARYCARE/docs/pcmh_ConceptPaper.doc, accessed June 4, 2013.

- The patient was "shuffled around" in the appointment system, providers ignored his critical condition when scheduling follow-up care and referrals, and no one provided oversight for his scheduling or care.
- A VA provider was rude to the patient and his family.

Scope and Methodology

We interviewed the complainants on March 29, 2013. We conducted site visits at the CBOC, Erie VAMC, and Pittsburgh HCS, from April 8–11. We interviewed primary and specialty care providers, leadership staff, a radiologist, a pathologist, patient advocates, call center and scheduling staff, and pertinent clinical and administrative staff. We consulted with VHA radiology leadership for independent review of the patient's computed tomography (CT) scans. We reviewed the patient's electronic health record (EHR), relevant facility policies, standards of practice, clinical guidelines, and VHA directives. We also interviewed medical providers who cared for the patient at a community hospital shortly before his death.

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, a male in his mid-sixties, received his only VHA health care services August 15 through October 1, 2012, and died on October 6, 2012. His self-reported medical history included smoking 1–2 cigarettes per day and heavy alcohol use until 1996.

August 15: The patient had his first encounter with his assigned primary care provider (PCP) at the CBOC. During this encounter, the patient complained of back pain that began after he lifted a lawnmower. He said he thought he had strained a muscle, and said taking Tylenol™ and laying down helped decrease the pain. He rated the pain a 7 (0–10 scale).

The PCP noted that the patient appeared chronically ill, the whites of his eyes were slightly yellow, his lungs had reduced breath sounds, and his abdomen was distended with evidence of the presence of excess fluid in the abdomen. The PCP diagnosed ascites,[3] possible liver cirrhosis, and back pain. The PCP ordered a CT (CT 1) of the patient's abdomen and pelvis without contrast; and blood tests that included Hepatitis B and C, white blood count,[4] metabolic chemistry panel,[5] and liver enzyme tests. The

[3] Ascites is fluid in the peritoneal cavity
[4] White blood cells (WBC) are disease-fighting cells (leukocytes) circulating in the blood. An increase in WBCs occurs as a result of bacterial infection, environmental exposure, and some cancers.
[5] This is a group of blood tests that provide an overall picture of the body's chemical balance and metabolism.

PCP also ordered a colorectal cancer screen test[6] and immunizations; and counseled the patient to stop smoking, drinking alcohol, and taking Tylenol™. The patient was scheduled for his 2014 annual examination before he left the CBOC.

August 23: The patient's blood tests as ordered above were drawn at the CBOC.

August 24: The PCP noted in the patient's EHR that the Hepatitis B and C blood tests were pending. The PCP also noted patient's blood glucose, liver enzymes, white blood count, and prostatic specific antigen[7] were elevated.

August 27: The RN called and discussed the lab results with the patient. The RN advised the patient to get another blood glucose test and to follow-up with a urologist.

August 30: The patient's blood was redrawn and he received CT 1 of the abdomen and pelvis at the Erie VAMC. His blood glucose was markedly lower and the initial interpretation of CT 1 revealed the patient's liver had changes consistent with cirrhosis, there was massive ascites, and there were varices (dilated veins) in the upper abdomen. There were no other abnormalities noted with the exception of a "tiny" calculus (stone) in the left kidney.

August 31: The patient's daughter called the CBOC and told an RN the patient's back pain was worse and now extended into his entire back and shoulder blades. The daughter was concerned because the patient had been immobile for 3 weeks due to the increased pain and would not take any pain medication because he was told not to take Tylenol™. In addition, the daughter reported the patient was experiencing shortness of breath and numbness in his right thigh, hip, and knee. The RN advised the daughter that the patient should be seen in the Erie VAMC Emergency Department (ED) or a community ED. The daughter said that the patient preferred to see his PCP at the CBOC. The RN advised the daughter to make an appointment with the patient's PCP or take the patient to the ED if his symptoms worsened.

September 4: The patient presented to the Erie VAMC ED. He complained of back pain, shortness of breath, abdominal swelling, and difficulty moving. An ED RN documented the patient's reported pain level was 5 (0–10 scale). An ED physician ordered a CT (CT 2) of the abdomen without contrast, blood tests, admitted the patient to an inpatient unit, and transferred the care of the patient to the inpatient hospitalist.

The patient's admitting diagnosis was abdominal distension/ascites vs. spontaneous bacterial peritonitis vs. malignancy. CT 2 results indicated severe ascites throughout the abdomen with a nodular liver that suggested cirrhosis. The radiologist noted there were mass-like structures in the upper abdomen that were likely varices, but they could not be completely visualized without obtaining a CT scan with contrast and enlarged lymph nodes could not be excluded. The radiologist noted right lung base atelectasis

[6] A colorectal screen checks for hidden blood in three consecutive stool samples.
[7] Prostatic specific antigen (PSA) is a protein made in the prostate gland. Normally, very little is found in the blood. Rising levels of PSA in the blood indicate a problem with the prostate.

(collapse) and a small left-sided pleural effusion (fluid in the lung). No other abnormalities were noted.

September 5: A paracentesis was performed and 7 liters of abdominal fluid were removed. An analysis of the fluid did not identify microorganisms or malignant (cancer) cells.

September 6: The patient was discharged and advised to follow-up with his PCP at the CBOC on September 17. The hospitalist referred the patient to the Pittsburgh HCS Hepatology Clinic for evaluation of his liver disease. The referral was coded as routine.

September 10: The patient's daughter called the Pittsburgh HCS Call Center to follow-up on the patient's Hepatology Clinic referral. Following several phone transfers, the daughter spoke with the scheduling supervisor at the Rainbow Clinic[8] who informed her that the patient's referral was ordered as routine and had not been scheduled. The scheduler then made a September 21 Heptology Clinic appointment for the patient.

September 17: The patient arrived for his scheduled PCP appointment at the CBOC. He reported back pain and pain along his right rib margin. He rated his pain an 8 (0–10 scale). The PCP documented the patient's cirrhosis was likely alcohol induced. The PCP discussed the patient's diagnosis, treatment, prognosis, and possible need for a liver transplant with him. The PCP documented the patient's continued abdominal fluid accumulation would likely require a repeat paracentesis and advised the patient to keep the September 21 Hepatology Clinic appointment.

September 21: The patient and his family members traveled to the Pittsburg HCS for his scheduled Hepatology Clinic appointment and a provider conducted an evaluation. The provider documented the patient's past and present medical history and physical examination. The provider noted the patient's heart rate was elevated, his systolic blood pressure was low, and his abdomen was distended. The provider also noted the patient and family believed the patient was to be admitted for a liver biopsy and paracentesis and noted a discussion of the risks of a liver biopsy and paracentesis with the patient and his family.

The provider also consulted with a Gastroenterology Service physician (Hepatologist A)[9] by telephone; however, Hepatologist A did not have access to the patient's EHR during the consultation. The provider ordered lab studies, increased the patient's diuretics,[10] and set up a routine follow-up appointment with Hepatologist A for October 17. The provider reviewed the treatment plan with the patient and family before the patient and family left.

Approximately 2 hours later, the provider received the lab results. The results indicated abnormal liver and kidney functioning, and abnormally elevated Alpha-Fetoprotein

[8] The Pittsburgh HCS Rainbow Clinic is comprised of 19 specialty clinics, including the gastroenterology clinic. The Pittsburgh HCS Hepatology Clinic, also known as the liver clinic, is located within the gastroenterology clinic.
[9] A hepatologist is a physician who has obtained special training in liver diseases.
[10] Diuretics, sometimes called water pills, help to remove salt (sodium) and water from the body.

(AFP).[11] The provider called Hepatologist A again and they agreed to change the original plan of care based on the new available lab results. The new treatment plan included discontinuing diuretic medications, seeking emergency care if the patient's condition changed, and following up with Hepatologist A on October 17 as scheduled. The provider called the patient's daughter to review the new treatment plan. The family offered to return to the facility, but the provider told them it was not necessary.

September 27: The patient's daughter called his PCP to express her frustrations concerning her father's care and treatment within the VA system. The daughter said her father had lost 45 pounds and she did not believe his weight loss was caused solely from cirrhosis and was concerned that her father "would not be around" for his October 17 Hepatology Clinic appointment. The daughter also told the PCP that her father continued to have severe rib pain, shortness of breath, weakness and fatigue, and was too weak to come to the CBOC for evaluation. The PCP scheduled the patient for an October 1 paracentesis at Erie VAMC.

October 1: At Erie VAMC, the patient had a paracentesis and 10 liters of ascites fluid were removed at 1:30 p.m. Although the patient's vital signs were not recorded in the EHR, the radiologist noted that the patient tolerated the procedure and was sent home. At 4:30 p.m., the patient's daughter called the PCP and reported the patient was experiencing severe back and abdominal pain. The PCP directed her to take the patient to the local community ED for treatment and called the community ED provider to authorize care.

At the community ED, providers evaluated the patient's complaints of severe back pain, shortness of breath, abdominal distension, and weight loss. The patient received another CT (CT 3) without contrast of the abdomen and pelvis. The results of CT 3 showed an expansile lesion[12] of the left scapula, bony metastasis involving the costovertebral[13] margin of the right eighth rib, fractures of the right sixth rib and left fifth rib, an additional lesion involving the tenth thoracic vertebra, and a pathologic fracture within the first lumbar vertebra. The patient was admitted to the community hospital, placed in hospice care, and died on October 6.

Inspection Results

Issue 1: Cancer Diagnosis

We substantiated the allegation that VA providers did not diagnose the patient's cancer.

[11] Alpha-Fetoprotein (AFP) is a major blood plasma protein and can be used as a biomarker to detect a subset of tumors in non-pregnant women, men, and children. A level above 500 nanograms/milliliter of AFP in adults can be indicative of hepatocellular carcinoma, germ cell tumors, and metastatic cancers.

[12] A lytic or expansile lesion is the destruction of an area of bone due to a disease process, such as cancer. Definition is from the National Cancer Institute (NCI) website, http://www.cancer.gov/dictionary?expand=L, accessed May 9, 2013.

[13] Rib joints that connect each rib to the second through the tenth vertebrae in the upper back are called costovertebral joints.

We found VA providers missed opportunities to identify the patient's cancer and determined several factors that may have contributed to providers not making the cancer diagnosis.

During the patient's 6 weeks of VA health care, he complained of pain and had severe ascites, a rapid heartbeat, decreasing blood pressure, increasing fatigue, increasingly abnormal lab values, and episodes of shortness of breath. He was evaluated by many VA providers and was hospitalized once. He had seven sets of lab tests, a chest x-ray, two therapeutic paracentesis procedures, and two CT scans (CT 1 and CT 2) of the abdomen and pelvis.

Pain: The patient's pain was assessed six times and on three occasions, August 15, September 4, and September 17, he stated his level of pain was 5 or greater. Initially, the CBOC PCP believed the patient's pain was associated with a back strain. Later, providers associated the patient's pain with his ascites and relied on the patient's own statements that his pain and symptoms were relieved after paracentesis; however, providers did not document attempts to explore other causes of the patient's pain.

Lab Values: Initial blood tests taken at the CBOC were normal except for elevated liver enzyme tests, white blood cell count, glucose, and PSA; however, towards the end of the patient's VA health care treatment, blood tests became increasingly abnormal. On September 21, the patient's AFP was 393.4 ng/mL (normal 0-40 ng/mL).[14] The high values of the AFP are correlated with possible liver cancer.

There is no indication the Hepatology Clinic provider or Hepatologist A considered alerting the patient or his family that the AFP lab result might indicate cancer or that the provider considered hospitalizing the patient on September 21.

CT Results: CT 1 and CT 2 radiology interpretations did not indicate cancer with metastases. Ascites was the preliminary diagnosis listed on the request forms for both CTs.

At our request, an Erie VAMC radiologist re-reviewed CT 1 and CT 2 and noted bony changes in the lower back (first through fifth lumbar vertebrae) consistent with bone metastasis. A VHA radiology consultant also reviewed the Erie VAMC CTs and stated:

> The liver shows a nodular contour and heterogeneous density that one would expect from cirrhosis. While, in retrospect, I think I see the area that might be malignant, the appearance is within the spectrum of cirrhosis with regenerating nodules. The presence of [enlarged] lymph nodes is not unusual in cirrhosis. However, the presence of mass like densities beneath the right hemi diaphragm is unusual. One might argue these are varices, but implants [lesions or tumors] should be considered. Lytic lesions are clearly visible in the vertebral bodies and in one of the ribs. In summary, I think many radiologists would have raised the issue of metastatic disease, but few radiologists would have stated with certainty that there was a primary liver tumor.

[14] Nanograms per milliliter.

Hepatology Clinic Visit

During the patient's Hepatology Clinic visit, the provider telephoned Hepatologist A to discuss the patient's case. We learned that Hepatologist A was on leave and did not have the EHR in front of him nor sufficient time to discuss the patient at length with the provider. We also learned the provider preferred to work with Hepatologist A and chose to call Hepatologist A on leave rather than consult with another hepatologist (Hepatologist B) who was available for consultation on September 21. The provider also telephoned Hepatologist A after the patient's visit to discuss abnormal lab results and follow-up rather than discuss the case with Hepatologist B who was available on-site for consultation. After reviewing this case retrospectively, Hepatologist A said that the abnormal lab values and patient's rapid heartbeat and tense belly, could have received more attention, and the patient should have been admitted to Pittsburgh HCS for further evaluation.

Several additional factors may have contributed to providers missing the cancer diagnosis. Errors or ambiguity in CT scan interpretations may have occurred. Providers also relied on information that did not indicate cancer with metastases such as carcinoma-negative CT scan results, peritoneal fluid that did not show cancer cells, nearly normal initial blood tests, and the patient's own statements that his pain and symptoms were relieved after paracentesis. Patients with cirrhosis can be seriously ill and, like cancer, cirrhosis can cause ascites and pain.

Issue 2: Pain Management

We substantiated the allegation that the patient's pain was not fully addressed.

We found that providers followed VHA policy[15] for assessing the patient's ascites related pain and believed they were managing this pain through therapeutic paracentesis. However, by missing the cancer diagnosis and not looking beyond the liver cirrhosis diagnosis, they missed the underlying cause of his pain. Establishing the cancer diagnosis might have improved pain management.

During the patient's CBOC visits, Erie VAMC ED and inpatient admission, and Pittsburgh HCS Hepatology Clinic encounter, his providers and nurses adhered to VHA policy and documented pain scores and assessed his ascites-related pain. Providers then addressed the patient's pain by providing therapeutic paracentesis after which the patient expressed relief.

After the patient's October 1 paracentesis at Erie VAMC, his family called the PCP about his severe pain and difficulty in breathing. The PCP was concerned there might be a bowel perforation from an earlier paracentesis that day. The PCP told the family to take the patient to the local community ED, because the CBOC did not provide emergency services. During this community ED visit, the patient's main complaints were back pain with abdominal and chest wall pain. The nurse's notes listed his onset

[15] VHA Directive 2009-053, *Pain Management*, October 28, 2009.

of pain as hours and as occurring following paracentesis at Erie VAMC. The ED physician ordered a non-contrast CT scan, gave the patient morphine for pain, and admitted him. The diagnosis at the time of admission was ascites, chest wall pain secondary to metastasized disease, and hepatoma (liver cancer).

Although the patient's family may have advocated for more action for the patient's pain, the patient under-reported his pain to providers. Providers told us that when they asked the patient about his pain, he gave quiet, brief responses. The family described the patient as a stoic, self-sufficient individual who rarely complained about health issues. VA providers told us they tried to address his pain and believed at the time they had.

Issue 3: Coordination of Care

The family told us the patient was "shuffled around" in the appointment system, his critical condition was ignored when providers scheduled follow-ups and referrals, and no one provided oversight for his scheduling or care.

Appointment System Delays

We could not confirm that the patient's family was "shuffled around" in the scheduling system. While the family stated that they spent several hours on the telephone trying to get appointments scheduled, we found that appointments were scheduled according to local policy and providers' requested timeframes. These timeframes were determined by the urgencies marked by providers on consult referrals and follow-up appointment requests. For example, providers who requested CT 1 and the Hepatology Clinic consult both marked the urgency of the request as routine.

Follow-Up and Referral Scheduling Delays

We substantiated the allegation that there were scheduling delays in the patient's referrals and follow-up care. While we found that scheduling staff followed local and VHA[16],[17] policies for scheduling appointments, the follow-up and consult referral requests were all marked with routine urgencies rather than urgent or STAT.[18]

At both Erie VAMC and Pittsburgh HCS, providers have options when choosing the urgency of their requests: routine (30 days), urgent (7 days), or STAT (as soon as possible). The default setting for orders is routine. Because the patient's providers did not select urgent or STAT, scheduling staff had 30 days to schedule the appointments.

We found that the patient's abnormal lab tests and declining medical condition, consult and follow-up appointment urgencies marked routine were not commensurate with his needs.

Oversight of Care

[16] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
[17] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008.
[18] STAT is a common medical term used for do immediately or rush.

We substantiated the allegation that this patient did not receive comprehensive oversight through the continuum of his care.

Although both Erie VAMC and Pittsburgh HCS employ the PACT model for patient-centered care and oversight, we were unable to find documented evidence that the patient had a PACT or individual assigned for oversight of the patient's care. While we found two PACT notes in the patient's EHR, neither note addressed oversight of the patient's care. Thus, while we did find PACT notes, we did not find indication of overall PACT coordination.

Although we found the PCP and Erie VAMC hospitalist communicated and consulted about the patient's Erie VAMC ED care and hospital admission, we found there was insufficient coordination of care plans amongst three VHA facilities that had roles in caring for this patient. On September 21 and September 26, the PCP received two Information Communication Consults from the Hepatology Clinic provider, including the abnormal lab results. However, except for a Hepatology Clinic follow-up appointment scheduled for October 17, there were no other actions taken in response to the patient's abnormal lab results, tachycardia, or shortness of breath. The PCP told us specialty care was outside her expertise and the hepatology team was in charge of that phase of the patient's care. However, the hepatology team deferred follow-up with the patient's abnormal lab results, tachycardia, and low blood pressure to the PCP.

Assigning and/or more clearly and fully utilizing a PACT or a case manager may have resulted in better continuity and patient care.

Issue 4: Discourteous Communications

We could not confirm the allegation that the Hepatology Clinic provider was rude to the patient and his family during the patient's outpatient specialty care visit on September 21. However, we found there was a significant disconnect between the provider's perception of care provided and the family members' perceptions and satisfaction with the care experience.

The family told us the provider was rude and treated them disrespectfully. However, the provider believed the family was satisfied with their clinic experience. We interviewed two patient advocates and reviewed patient advocate complaint data. We found no patient complaints associated with the Hepatology Clinic provider.

Issue 5: Other Issues

During the course of this review, we found additional opportunities for improvement. These included issues with provider communications, specialty clinic initial visit expectations, and inter-facility transfers.

Provider Communications: We identified communication issues between referring and specialty clinic providers. During interviews, many referring providers from the CBOC, Erie VAMC, and Pittsburgh HSC told us it was difficult to communicate with the

gastroenterology and Hepatology Clinic specialists. They told us their phones calls occasionally go unanswered and the specialists did not always return phone messages.

Specialty Clinic Initial Visits: During our review, we found that patients may not receive sufficient information on what to expect during an initial specialty care clinic appointment. The patient's family told us they expected a physician would evaluate the patient during the Hepatology Clinic appointment, and the patient would receive a paracentesis, lab tests, and be hospitalized. The Hepatology Clinic provider told us that, during an initial Hepatology Clinic consult, patients receive a liver transplant evaluation, and information and education concerning liver transplantation. First visits typically do not include lab tests and procedures such as paracentisis.

Inter-Facility Transfers: We found that the transfer process between VA and community hospital providers may need improvement. We interviewed two providers who treated the patient at the community hospital in October. The providers told us they experienced difficulty reaching VA providers to facilitate transfers of VA patients and suggested streamlining and coordinating the transfer process to improve the care of veterans.

Conclusions

We substantiated the allegations that VA providers did not diagnose the patient's cancer, did not fully address his pain, and that there were scheduling delays in the patient's referrals and follow-up care.

We could not confirm the allegation that a VA provider was discourteous during the patient's outpatient specialty care visit. However, we found there was a significant disconnect between the provider's perception of care provided and the family members' perceptions and satisfaction with the care experience.

While onsite, we found additional opportunities for improvement in system processes that affected this patient's care:

- Oversight of patient's continuum of care.
- Communications between primary care and specialty care providers.
- Communication with patients about their expectations for initial specialty care visits.
- Provider communications and transfers between VA and community health care facilities.

This was a difficult and complex case. Although the outcome would most likely have been the same for this patient, there were several patient care, communication, and system processes that could have been improved. This patient needed a PACT or case manager to oversee and coordinate his care. His providers thought they were addressing pain caused by ascites, but ultimately missed the concomitant cause of his pain. While the family provided strong advocacy and support for the patient, they did

not receive coordinated oversight, which would have greatly improved their experience with using the VA health care system.

The Pittsburgh facility has reviewed this case and taken appropriate action with involved providers.

Recommendations

Recommendation 1. We recommended that the VISN Director initiate a root cause analysis to evaluate system issues outlined in this report.

Recommendation 2. We recommended that the VISN Director evaluate the care of the patient discussed in this report with Regional Counsel for possible disclosure to the surviving family member(s) of the patient.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 6, 2013

From: Director, VA Healthcare – VISN 4 (10N4)

Subject: **Healthcare Inspection – Quality of Care Issues, Erie VA Medical Center, Erie, PA, and VA Pittsburgh Healthcare System, Pittsburgh, PA**

To: Director, Denver Office of Healthcare Inspections (54DV)

1. I am submitting responses to your office as requested. I concur with both recommendations.

2. If you have any questions or require additional information, please contact Moira Hughes, VISN 4 Patient Safety Officer at 412-822-3294.

Michael E. Moreland, FACHE

Attachment

Comments to OIG's Report

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

Recommendation 1. We recommended that the Veterans Integrated Service Network Director initiate a root cause analysis to evaluate system issues outlined in this report.

Concur

Target date for completion: June 30, 2014

VISN response: A joint RCA was chartered by the respective Patient Safety Managers at the Erie VA Medical Center and the VA Pittsburgh Healthcare System with approval by the Medical Center Directors of jurisdiction and the Network Director. The RCA includes team members from both facilities. The charter has an expected target date for completion by October 18, 2013. The VISN 4 Patient Safety Office is facilitating the RCA team. The completed RCA will be presented to Erie and Pittsburgh Medical Center Leadership for concurrence. Currently, interviews and fact-finding is on-going, therefore no actions have been developed and no outcome measures identified at this point. Upon completion of the RCA and actions identified, the full RCA team will present a joint presentation to medical center leadership at both facilities for approval of root cause, actions and outcome measures anticipated to be completed within 4–6 months. The team meets via teleconference. Once the RCA is completed, it will be entered into the VA Patient Safety Database, SPOT for tracking action implementation. The actions will be tracked by the VISN 4 Patient Safety Office for implementation by date expected. The Patient Safety Office also tracks outcome measures due to be reported. This information is shared with VISN and medical center leadership at both Executive Leadership Council, and at the VISN Quality Management Oversight Committee.

Recommendation 2. We recommended that the Veterans Integrated Service Network Director evaluate the care of the patient discussed in this report with Regional Counsel for possible disclosure to the surviving family member(s) of the patient.

Concur

Target date for completion: September 30, 2013

VISN response: The Erie VA Medical Center is completing an Institutional Disclosure after discussion with VISN Patient Safety Officer and Regional Counsel. The date of disclosure will be at the convenience of the patient's family.

Appendix B

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Cheryl Walker, ARNP, MBA, Team Leader Laura Dulcie, BSEE Kathy Gudgell, RN, JD Stephanie Hensel, RN, JD Michael L. Shepherd, MD Virginia L. Solana, RN, MA

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