



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection Alleged Misdiagnosis and Other Care Issues Atlanta VA Medical Center Atlanta, Georgia

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations of misdiagnosis and other care issues at the Atlanta VA Medical Center (the facility) in Atlanta, GA, and two community based outpatient clinics (CBOCs) in Veterans Integrated Service Network 7. The purpose of this inspection was to determine the validity of the allegations.

We did not substantiate that a facility emergency department physician misdiagnosed a stroke as vertigo (a feeling of motion while one is stationary) in September 2010. We determined that the facility emergency department physician's evaluation and management of the patient's complaints and hyperglycemia were appropriate.

We did not substantiate that the patient received deficient care or that facility and CBOC providers failed to appropriately meet the patient's vision, hearing, and stroke rehabilitation needs. Although we found VA transportation failed to provide scheduled transportation on two occasions, we did not find these failures affected the patient's ability to receive health care or indicated a systematic transportation problem. We did not substantiate that patient advocate services were not accessible to the patient. We did not substantiate a lapse in civility by a CBOC provider.

We made no recommendations.



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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Alleged Misdiagnosis and Other Care Issues, Atlanta VA Medical Center, Atlanta, Georgia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations of a misdiagnosis at the Atlanta VA Medical Center (the facility); quality of care issues at two community based outpatient clinics (CBOCs); VA transportation and Patient Advocate (PA) deficiencies; and a lack of civility by a CBOC provider. The purpose of the review was to determine the validity of these allegations.

Background

The facility is a teaching hospital that provides a full range of emergency, medical, surgical, mental health, and long term care services. The facility also provides outpatient services at eight CBOCs located in Austell, Blairsville, East Point, Lawrenceville, Newnan, Oakwood, Rome, and Stockbridge, GA. The facility is part of Veterans Integrated Service Network (VISN) 7.

On June 25, 2012, a patient contacted the OIG hotline and stated that her health benefits were “lacking.” The patient alleged that she:

- Had a stroke misdiagnosed as vertigo.¹
- Received deficient care: no diagnosis of an eye problem, no resolution of an ear infection, and no rehabilitation after a stroke.
- Missed three appointments because scheduled transportation services did not show up.
- Was unable to reach the PA after dialing six extensions.
- Was treated rudely by a primary care physician (PCP), who would not listen to her problems and told her she needed a “shrink.”

¹ Vertigo is a type of dizziness where there is a feeling of motion when one is stationary.

Scope and Methodology

We conducted telephone interviews with the patient, the patient's PCPs from two CBOCs, a CBOC team lead physician and registered nurse, a facility emergency department (ED) physician, and other administrative VA staff. We reviewed the patient's VA and non-VA electronic health records (EHRs), quality management information, PA reports, transportation records, and other documents pertaining to these allegations.

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

Case Summary

The patient is a female in her 60s whose medical history includes insulin-dependent diabetes, neuropathy, retinopathy, heart disease treated with bypass surgery and stents, hypertension, major depression, and a stroke² which left her with balance and mobility problems.

In July 2010, the patient sought care from her PCP at a CBOC with complaints of dizziness, drifting to the left when walking, and nausea. She brought social security disability forms with her and asked the PCP to fill them out prior to her examination. She became upset and tearful when the PCP told her that he could not fill out the social security disability forms. She then refused to allow the PCP to examine her and requested reassignment to a different PCP and CBOC. After discussion with the CBOC team lead physician, the PCP ordered a computerized axial tomography³ (CT) of the head for dizziness. A CBOC registered nurse reviewed written discharge instructions with the patient which included instructions on how to schedule the CT of the head. The CBOC team lead physician facilitated the patient's reassignment to a different PCP. Review of the patient's EHR reveals the patient did not schedule the CT of the head as instructed.

Two weeks later, the patient was given a comprehensive physical examination by her new PCP at another CBOC. The PCP documented in the patient's EHR that the patient had no neurological deficits⁴ or complaints of headache, dizziness, walking with drifting to the left, nausea, or vomiting.

One month later, the patient reportedly presented to a local, non-VA ED and received a CT of the head for complaints of dizziness, weakness, and headache. EHR

² A stroke occurs when there is restriction of blood flow to the brain.

³ Computerized tomography is a medical imaging test that uses x-rays to provide cross-sectional pictures of specific areas of the body for diagnostic purposes.

⁴ A neurological deficit is a functional abnormality in a part of the body due to a decrease in the function of the brain or nervous system.

documentation indicates the CT showed no evidence of stroke or any other acute changes, and the non-VA ED provider diagnosed vertigo.

At 10:04 p.m., that same day, the patient presented to the facility ED with complaints of dizziness, nausea, vomiting, and numbness of her lower extremities. She did not complain of a headache. EHR documentation indicates the patient reported to the ED triage nurse and physician that she left a non-VA ED earlier that day against medical advice because she was receiving inadequate care. EHR documentation does not indicate the patient informed ED staff she received a CT of the head at the non-VA ED earlier that day.

The physician ordered an electrocardiogram (EKG) and blood tests. The physician performed a neurological examination and reviewed the patient's EKG and blood test results. The neurological examination and EKG were normal, but the blood test results revealed the patient's blood glucose was 444 milligrams/deciliter (mg/dL).⁵ The ED physician ordered intravenous fluids and 8 units of regular insulin intravenous to treat elevated blood glucose, 4 mg of Zofran intravenous to treat nausea, and 25 mg of Meclizine by mouth to treat dizziness.

After several hours of treatment and observation, the patient's blood glucose was 291 mg/dL, and she was given a sack lunch. The patient told staff she felt better and the numbness in her lower extremities was resolved. The ED physician determined she was stable for discharge and instructed her to return for increased dizziness, fevers, chest pain, or other issues. The patient was discharged from the ED accompanied by her daughter and had prescriptions for nausea (Phenergan) and dizziness (Meclizine).

Three days later, the patient was taken by ambulance to another local, non-VA ED at 6:47 p.m. with complaints of worsening dizziness, weakness with falling, and difficulty swallowing. A CT of the head during this encounter revealed an acute or subacute cerebellar infarct.⁶ Magnetic Resonance Imaging⁷ the next day confirmed an acute stroke.⁸ She remained hospitalized for acute, comprehensive, stroke rehabilitation and was discharged to the care of her daughter after three and a half weeks.

Inspection Results

Issue 1: Alleged Misdiagnosis

We did not substantiate the allegation of misdiagnosis of stroke during the facility ED encounter. The patient left against medical advice from a non-VA ED prior to being treated at the facility ED. The patient's clinical presentation at the facility ED included

⁵ Normal blood glucose is 70-110 mg/dL (dL is a volumetric measurement equal to 1/10 percent of a liter).

⁶ An acute or subacute infarct has occurred within the last few days to months.

⁷ Magnetic Resonance Imaging is a medical imaging test used to visualize internal structures of the body in detail.

⁸ An acute stroke has occurred within 24 hours.

an initial blood glucose level of 444 mg/dL, with greater than 400 mg/dL considered a critical result. The patient was given a comprehensive examination by a board certified⁹ ED physician.

There were several factors that lowered the suspicion of stroke: resolution of the patient's headache prior to arrival, a negative neurologic examination, and improvement in her symptoms with treatment of hyperglycemia. When her blood glucose levels were closer to normal after fluids and insulin, her symptoms improved, and she was discharged stable and in no acute distress. Written discharge instructions told the patient to return to the ED if her symptoms returned or worsened.

Issue 2: Vision, Hearing, and Rehabilitation Needs

Vision: We did not substantiate the patient was not given a diagnosis of her eye condition. Facility ophthalmologists¹⁰ treated the patient for dry eyes and diabetic retinopathy¹¹ six times over a one year period. She also had several telephone contacts with Eye Clinic staff and providers regarding her vision problems. Nursing clinic documentation states discharge information was reviewed with the patient, who indicated understanding.

Hearing: We did not substantiate the patient was inappropriately treated for an ear infection. The patient had recurring otitis media (ear infection) and saw both VA and non-VA providers numerous times from October 2010 until the infection cleared in July 2011. She received a comprehensive audiology workup in April 2011, and was diagnosed with asymmetric hearing loss. She declined hearing aids.

Rehabilitation: We did not substantiate the patient received no rehabilitative care following a stroke. The patient received comprehensive, acute rehabilitation at the Northeastern Georgia Medical Center immediately following the stroke in September 2010. She continued rehabilitation with physical therapy at the facility but stopped in January 2011 when hearing problems caused balance problems. Despite encouragement from providers to resume physical therapy, she did not do so.

Issue 3: VA Transportation

The patient was eligible to receive VA transportation to scheduled health care appointments. Although we found VA transportation failed to provide scheduled transportation on two occasions, these failures did not affect the patient's ability to receive health care or indicate a systematic transportation problem.

⁹ Board certification is a process by which a physician demonstrates by written or oral examination a mastery of knowledge and skills in a specialized area of medicine.

¹⁰ Medical doctors with special training in the medical and surgical treatment of eye diseases.

¹¹ Diabetic retinopathy is damage to the eye's retina that occurs with long-term diabetes and is a major cause of blindness in American adults.

A review of VA transportation and appointment records from September 2009 through June 2012 indicated the patient received transportation to many health-related appointments. On two occasions, records indicated transportation did not arrive as scheduled. One appointment was immediately rescheduled, and the patient did not reschedule the other appointment.

While we recognize the two failures of scheduled transportation caused the patient inconvenience and frustration, we determined the patient's transportation needs were generally met.

Issue 4: Patient Advocate Services

We did not substantiate that PA services were not accessible to the patient. During an interview, the patient told us that she called the PA office six times but did not leave a message. The lead PA representative said that incoming calls go to voicemail. The office policy is to return all calls within 24 hours with the goal of returning calls the same day. However, if the caller does not leave a message, the office cannot return the call.

The patient had two documented encounters with the PA office. In July 2010, the patient contacted the PA to discuss her clinic visit the day before. At the patient's request, the PA contacted a clinic coordinator who expedited the patient's transfer to another CBOC. In March 2011, the patient contacted the PA to again discuss her care in July 2010. The PA contacted the CBOC PCP and team lead physician from that encounter and asked the CBOC team lead physician to call the patient to further discuss her concerns.

Issue 5: Lapse of Civility

We did not substantiate that there was a lapse of civility during the clinic visit. A CBOC PCP recalled this patient's visit in July 2010. The PCP said the patient became upset and tearful when he could not fill out social security disability paperwork for her. The PCP recommended the patient see a mental health provider for severe, ongoing family and financial problems and worsening depression. The patient left the exam room. The PCP asked the CBOC team lead physician to intervene. Neither the CBOC team lead physician nor clinic registered nurse recall unprofessional behavior toward the patient.

Conclusions

We did not substantiate the allegations in this investigation. We found that the facility ED management of the patient's complicated medical conditions was appropriate; the patient received, or was offered and did not schedule, appropriate care for vision, hearing, and rehabilitative needs; transportation services were provided; and PA services were accessible. We did not substantiate that there was a lapse of civility toward the patient. We made no recommendations.

Comments

The Veterans Integrated Service Network and Medical Center Directors concurred with the report. No further action is required.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 19, 2012

From: Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection – Alleged Misdiagnosis and Quality of Care Issues, Atlanta VA Medical Center, Atlanta, GA**

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

Thru: Director, VHA Management Review Service (VHA 10AR MRS)

I fully concur with the attached report.

(original signed by:)
Charles E. Sepich, FACHE
Director, VA Southeast Network, VISN 7

Medical Center Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: October 15, 2012

From: Director, Atlanta VA Medical Center (508/00)

Subject: **Healthcare Inspection – Alleged Misdiagnosis and Quality of Care Issues, Atlanta VA Medical Center, Atlanta, GA**

To: Director, VA Southeast Network (10N7)

Thank you for your thorough review of the allegations. I concur with this report.

(original signed by:)
James A. Clark, MPA
Director, Atlanta VA Medical Center (508/00)

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Virginia Solana, RN, MA, Project Leader Diane McNamara, RN, MS, Team Leader Michel Bishop, MSW Robert Yang, MD

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