Approved. 1/14/11

Administrative Closure
Hotline Inspection MCI# 2011-00037-HI-0013
Perry Point VA Medical Center, Perry Point, MD

Healthcare Inspection – Delay of Diabetes Mellitus Diagnosis, VA Maryland Healthcare System, Perry Point, Maryland (10N)

Purpose

Baltimore OIG OHI received an allegation of delayed diabetes mellitus diagnosis for a patient seen by primary care (PC) at the Perry Point VA Medical Center (medical center). We reviewed the patient's medical record and conducted an interview with the complainant.

Background

The facility provides comprehensive mental health care to veterans in the Baltimore-Washington Metropolitan area and a full range of inpatient medical, intermediate and long-term care programs. It also has a domiciliary care program to help rehabilitate homeless veterans.

In early April 2010, the patient, an unemployed homeless veteran in his fifties, went to the medical center following his release from prison. He met with a social worker who helped him obtain housing assistance through the VA's Housing Grant & Per Diem Program. Later that week, a nurse practitioner examined the patient and found him to have an elevated blood pressure and assessed him as being obese with a body mass index (BMI)[1] of 38.3 (weight of 244.3 pounds). The patient complained of knee pain. The nurse practitioner spoke to him about weight reduction and the VA's Managing Obesity in Veterans Everywhere (MOVE) program[2] but the patient declined to participate in that program. She spoke to him about the risks of diabetes and other problems associated with obesity, and scheduled him for a primary clinic appointment.

In mid-May, the patient went to the PC Clinic for a physical examination -- reportedly his first physical in 10 years. The history and physical documented in his medical record showed that his mother died from diabetes and his brother died at age 42 from heart disease. The patient had not smoked for about 7 years; but, he reportedly smoked 2 ½ packs of cigarettes from age 14 to 52-years old. The patient's BMI had increased to over 40 (weight of 256 pounds) in the past month, and he complained of skin changes, knee pain, and recent chest and left arm pain after walking a mile. The PC physician ordered a dermatology consultation, ordered several screening and laboratory studies,

[1] BMI is a measure of body fat based upon height and weight. Normal BMI range is 19-25.
[2] The MOVE (weight management) program addresses nutrition, physical activity, and healthy behavior.

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as well as a knee x-ray. He prescribed nitroglycerine, pain medication, and ordered echocardiogram (ECHO) and electrocardiogram (EKG) studies for his chest pain. He scheduled the patient for a follow-up appointment in 3-months.

The patient's non-fasting laboratory results included a blood glucose level of 284 mg/dL. His chest x-ray showed chronic obstructive pulmonary disease (COPD), and the x-ray of his knees showed degenerative changes. In early June, the EKG and ECHO studies were completed with normal results.

During the next few months, the patient returned for his scheduled appointments in the Homeless Veterans Clinic, as well as the Dental and Orthopedic Clinics. In mid-August, the patient returned for his follow-up PC appointment. He told clinicians that he did not have any pain at that time, but he described recently having chest pain after walking short distances. The PC physician sent the patient to the urgent care (UC) clinic where the UC physician ordered several tests to rule out a heart attack. The tests showed that his EKG and cardiac laboratory results were normal, but that his blood glucose was elevated at 401 mg/dL. The UC physician diagnosed the patient with a new onset diabetes mellitus and ordered insulin. He transferred the patient to the Baltimore VA Medical Center Emergency Department (ED) for further evaluation and treatment.

The Baltimore ED physician evaluated the patient, found him to be in stable condition, and admitted him to the medical unit. The next morning, his attending physician diagnosed him with "typical exertional angina and new onset diabetes mellitus" and ordered a cardiac catheterization. Later that day, a cardiologist performed a cardiac catheterization, which showed severe coronary disease. He referred the patient to the Washington DC VA Medical Center for possible heart surgery.

In early September, the patient transferred to Washington DC VA Medical Center for further cardiac evaluation and treatment. In early September, a cardiac surgeon performed open-heart surgery. One week later, the attending physician found the patient to be in stable condition and discharged him back to the Perry Point medical center. Since then, he continued to receive his outpatient care at the Perry Point PC clinic.

The confidential complainant (b)(3):5 U.S.C. App 3 (IG Act) who contacted OIG after the patient reported that his diabetes was not diagnosed immediately after the May blood work. During our interview in mid-November, the complainant denied communicating this information to the primary care provider, patient advocate, or other staff member at Perry Point before filing a complaint with OIG. The complainant stated that this was an isolated case and denied knowledge that failure to diagnose diabetes was a problem with more than one patient (homeless or otherwise), by the medical staff at large, or by the subject provider.

Scope and Methodology

According to the Veterans Administration/Department of Defense (VA/DoD) clinical practice guidelines, diabetes mellitus is to be considered when a patient has a casual blood glucose level of more than 200mg/dL and symptoms of diabetes, such as polyuria, polydipsia, and unexplained weight loss.[3] Based upon the available documentation, the patient did not report or have evidence of any symptoms of diabetes other than the casual elevated blood sugar; in fact, he gained weight between his April and May appointments.

An OIG physician reviewer determined that it would have been appropriate for the provider to repeat the patient's blood sugar level sooner than 3 months; however, no direct patient harm from the omission was identified. When the patient's cardiac symptoms and elevated glucose levels worsened, VAMC clinicians transferred the patient to acute care for definitive evaluation and treatment.

Conclusions

We did not substantiate the allegation. Despite an elevated casual blood sugar in May, the patient's symptoms at the time did not meet the VA/DoD criteria for diagnosis of diabetes. We made no recommendations and administratively closed the case.

Co-prepared by _____//es//_____ and _____//es//_____
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[3] VA/DoD Clinical Practice Guideline for the Management of Diabetes Mellitus in Primary Care, Version 3.0, October 2003.