Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-00875-112

Interim Report

Review of Phoenix VA Health Care System's Urology Department Phoenix, AZ

January 28, 2015

Washington, DC 20420

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Telephone: 1-800-488-8244
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Department of Veterans Affairs

Memorandum

Date: January 28, 2015

From: Assistant Inspector General for Healthcare Inspections, VA Office of Inspector General (OIG) (54)

Subj: Interim Report – OIG Review of Phoenix VA Health Care System's Urology Department

To: Interim Under Secretary for Health, Veterans Health Administration

During OIG's 2014 review of scheduling practices and wait times at the Phoenix VA Health Care System (PVAHCS), we found that large numbers of patients who were referred for urological evaluation and/or treatment experienced significant delays in either obtaining an appointment, scheduling follow-up, and/or receiving authorizations for non-VA urology care.[1] This prompted OIG's Office of Healthcare Inspections (OHI) to open an expanded review, specifically focusing on access to care within PVAHCS' Urology Department.

While our review is ongoing, some concerning preliminary findings require your immediate attention. These findings suggest that delays associated with the processing of referrals through the Office of Non-VA Care Coordination (NVCC) could potentially be putting patients at risk for being lost to follow-up.

In September of 2014, a list of 3,321 veterans whose care had likely been affected by the staffing shortages within the Urology Department was provided to the OIG by PVAHCS. To date, we have completed a first level review of the electronic health records (EHRs) of those patients. Our focus has been on identifying patients who were referred for evaluation to either PVAHCS' Urology Department or to a non-VA urologist via a voucher or fee basis authorization. To determine the potential impact of delayed evaluations, we reviewed follow-up documentation including clinic notes, imaging and laboratory results, and urologic procedure reports. In approximately 2,500 EHRs, we determined there was enough information to make a reasonable assessment of the impact of delayed care and/or an assessment of the quality of care a patient received.

In approximately 23 percent (759)[2] of the total cases reviewed, we frequently found approved authorizations for care, notations that authorizations were sent to contracted providers, and often scheduled dates and times of appointments with non-VA urologists. However, in these instances, we found no scanned documents verifying that patients were seen for evaluations and, if seen, what the evaluations might have revealed. This finding suggests that PVAHCS has no accurate data on the clinical status of the patients who were referred for urologic care outside of the facility. Included in this group are also

[1] OIG report *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, VA OIG Report 14-02603-267, August 26, 2014.

[2] On January 23, 2015, an OHI staff member delivered this list of 759 patient names to VHA to begin an immediate review.

patients who may have been followed routinely by the Urology Department prior to mid-2013 but, in the midst of the staffing crisis, were lost to follow-up.

During the week of January 12, 2015, OIG inspectors conducted a site visit to PVAHCS' Office for NVCC. We found:

- The office is understaffed and unable to keep up with many of the administrative tasks required to process authorizations.
- Non-VA providers are unaware of VA's policies for authorizing outside care. Frequently, vouchers are misinterpreted as authorizing only one visit. This causes delays because the non-VA provider will submit another request to NVCC or advise the patient that s/he needs to contact the facility for further authorizations. This results in the creation of a backlog of unnecessary secondary authorizations, further delaying care.
- With respect to scanning and reviewing outside clinical documents, when the services are provided by a TriWest provider, providers submit documents to the TriWest Portal. In order to access this information, a fee basis staff member must log into the TriWest Portal to print and scan these records into the EHR. Presently, only one employee is consistently assigned this task because of staffing shortages. According to staff, the office is "hundreds of records behind," so unless a provider or patient specifically requests the clinical results from the outside provider, this information may remain "unseen" (thus, unassessed) for several months.
- The facility maintains a Secondary Authorization Request List. This list is compiled from information gathered in the TriWest Portal and is used to track the requests from TriWest providers for authorization extensions as well as requests for further studies that would require additional authorization. Such requests are assigned an urgency level. At the time of the site visit, staff reported that they were six weeks behind in processing "Stat" or urgent requests.

While OIG's review of EHRs is ongoing, absent complete information being available within the medical record, an accurate assessment of care is impossible for close to 23 percent of patients who were identified as needing urological care. This finding supports that PVAHCS has no accurate data on the clinical status of these veterans as it relates to that care. This finding also suggests that potentially important recommendations and follow-up are not being addressed by the referring providers because they do not have access to the outside records.

As the facility continues to recruit and hire physicians and mid-level providers to staff its Urology Department, it is critical that staffing and administrative processes related to non-VA authorized care be properly administered.

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

Appendix A

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