Administrative Closure

Urology Section Evaluation Delays in Patients with a History of Cancer
Veterans Health Care System of the Ozarks (564/00)
Fayetteville, AR
MCI #2014-00463-HI-0355

The VA Office of Inspector General Office of Healthcare Inspections (OHI) received allegations about care at the Veterans Health Care System of the Ozarks, Fayetteville, AR (facility). The allegations included the following: patients with a known history of cancer were waiting extended periods of time for urology appointments; it was rumored that more than 200 veterans, many of whom had cancer, were waiting for care in the urology department; and open communication had been suppressed, creating a threat to patient care and safety. Additional allegations related to personnel issues and resource allocation were outside OHI's purview and not reviewed.

We conducted an onsite review November 19–20, 2013. We interviewed selected facility leadership and staff and reviewed pertinent documents, policies, and procedures related to the allegations.

We did not substantiate that patients with a known history of cancer were waiting extended periods of time for urology appointments or that open communication had been suppressed. We did substantiate that rumors existed that more than 200 veterans were waiting for care. We found that:

- Patients were not waiting extended periods of time for urology appointments. Chronic staffing issues in the Urology Section worsened over time as an advanced practice nurse in urology left the facility in October 2012, a physician assistant in urology worked part-time when transitioning to another section from April 2013 through October 2013, and a staff urologist unexpectedly (b)(6) starting in August 2013. The facility took actions to ensure timeliness of urology services including: (1) hiring and training a new advanced practice nurse, (2) referring all new patients to community providers through non-VA (fee) services or to other facilities within VISN 16, (3) discharging stable patients back to primary care, (4) establishing nurse-managed surveillance clinics for established patients with a history of prostate cancer, (5) clinically reviewing all established patients in recall scheduling clinics to determine when follow-up is appropriate, and (6) developing agreements with VA facilities for urology TeleHealth services.

- Rumors existed that more than 200 veterans, allegedly with cancer, were waiting for care in the Urology Section. The rumors were misleading. Although the complainant could not be interviewed for additional information or clarification,

the allegation implied that patients were waiting excessive or inappropriate lengths of time for care. The number of patients waiting for urology care fluctuated based upon supply and demand. For this reason, the number of patients awaiting care could be more or less than 200 patients. However, the Chief of Staff, Chief of Surgery, Urology Physician, and Urology Nursing staff described the process of clinically reviewing all established patients in recall scheduling clinics to ensure that patients were seen appropriately and when clinically indicated.

- Interviewed staff communicated with each other, with section and service-level leadership, and with facility leadership about the ongoing challenges within Urology Section. A System Redesign Collaborative focusing on Urology Section challenges has been in place since 2012 and includes membership from Quality Management, Surgical Service, Urology Section, Primary Care, and Nursing Service. Information and analyses that result from the collaborative meetings are provided to the Chief of Staff for review. Interviewed staff did not state or imply that communication had been suppressed.

During the course of our interviews, we were told that the facility made a disclosure to an unidentified patient around August 2012 and that delays in receiving urology services may have resulted in the patient's cancer progressing to a less treatable stage. The facility acknowledged that an institutional disclosure had been made in May 2013 for similar reasons; however, the delays were related to diagnosis and referral by the patient's primary care provider, not due to access to urology services.

Based on our review, I am administratively closing this case.

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Healthcare Inspections
5/4/14