



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 14-00875-334

Healthcare Inspection

Follow-Up Review Access to Urology Service Phoenix VA Health Care System Phoenix, Arizona

August 14, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to follow up on concerns regarding access to care in the urology service at the Phoenix VA Health Care System (system) in Phoenix, AZ. Specifically, we limited our inspection to whether a delay in care was associated with adverse patient impact.

During OIG's 2014 review of scheduling practices and wait times at the system, we reported that large numbers of patients who were referred for urological evaluation and/or treatment experienced significant delays. We found that the delays involved obtaining an appointment, scheduling follow-up, and/or receiving authorizations for non-VA urology care. For additional information see: *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, Phoenix, Arizona*; (Report No. 14-02603-267, August 26, 2014). This prompted OIG's Office of Healthcare Inspections (OHI) to open an expanded review, specifically focusing on access to care within the system's urology service.

An interim report *Review of Phoenix VA Health Care System's Urology Department, Phoenix, Arizona*; (Report No. 14-00875-112, January 28, 2015), detailed our findings regarding incomplete documentation for 759 urology patients and concerns regarding the potential impact on those patients' care. In the OIG's final report *Review of Access to Urology Service at the Phoenix VA Health Care System, Phoenix, Arizona*; (Report No. 14-00875-03, October 15, 2015), we found a significant urology staffing shortage, inconsistent non-VA urology provider documentation of patient care, and untimely care to patients needing urological services. We committed to reviewing the records and management of the 759 patients with incomplete documentation once the Veterans Health Administration provided us with the necessary documentation. This report details these findings.

We determined that 148 (20 percent) of the 759 patients whose care we reviewed experienced delays in getting new evaluations or follow-up appointments within the system's urology service or through Non VA Care Coordination. When a delay was identified, an assessment of the impact of that delay on the patient's care was made. From a clinical standpoint, we found that none of the patients reviewed for this follow-up report was adversely impacted by a delay in care.

We made no recommendations.

Comments

The Veterans Integrated Service Network and System Directors concurred with our findings. (See Appendixes B and C, pages 6–7). No follow-up actions are required.



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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to follow up on concerns regarding access to care in the urology service at the Phoenix VA Health Care System (system) in Phoenix, AZ. Specifically, we limited our inspection to determining whether a delay in care was associated with adverse patient impact.

Background

The system comprises the Carl T. Hayden Veterans Affairs Medical Center and seven clinics; it is part of Veterans Integrated Service Network (VISN) 22.¹ The system serves more than 80,000 patients in central Arizona, including the rapidly expanding metropolitan Phoenix area, and provides acute medical, surgical, and psychiatric inpatient care, as well as rehabilitation medicine and neurological care.

Urology service combines the management of medical (non-surgical) conditions such as urinary tract infections and benign prostatic hyperplasia (noncancerous prostate gland enlargement) with the management of surgical conditions such as bladder or prostate cancer and kidney stones.² The system provides urological care to patients on an inpatient and outpatient basis through the urology service. The service is a consultative specialty within the Surgical Department.

The system's urology outpatient clinic provides urological follow-up care to eligible patients on an outpatient basis, including post-surgery follow-up, and medical management of disorders including bladder, prostate, and kidney cancer.

At the time of our October 2015 report, *Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona*; (Report No. 14-00875-03, October 15, 2015), the system referred specialized urology surgical procedures, such as radical robotic prostatectomies, through interfacility agreements with the VA hospitals in Tucson, AZ, and Albuquerque, NM, or with non-VA providers. In addition, contracted community providers managed radiation treatment for prostate cancer patients. The delays in care detailed in the October 2015 report and this follow-up report occurred prior to the October 25, 2016 implementation of the Veterans Choice Program.³

Timeline of Events

In November 2013, OIG received allegations regarding patient deaths, wait times, and scheduling practices at the system. We found that large numbers of patients who were referred for urological evaluation and/or treatment experienced significant delays in obtaining an appointment, scheduling a follow-up appointment, and/or receiving authorizations for non-VA urology care. For additional information see, *Review of*

¹ Phoenix VA Health Care System was in VISN 18 prior to the restructuring of the networks in 2016.

² American Urological Association, *Urology 101*. AUA.net.org. Retrieved December 15, 2016.

³ The Veterans Choice Program is used to provide hospital care and medical services to eligible veterans through non-VA health care providers.

Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, Phoenix, AZ; (Report No. 14-02603-267, August 26, 2014). This prompted OIG's Office of Healthcare Inspections (OHI) to open an expanded review, specifically focusing on access to care within the system's urology service. An interim report, *Review of Phoenix VA Health Care System's Urology Department Phoenix, AZ*; (Report No. 14-00875-112, January 28, 2015) detailed our findings regarding incomplete documentation for 759 urology patients and concerns regarding the potential impact on those patients' care.

During our review for the interim 14-00875-112 report, we determined that 229 of the 759 patients had enough evidence in their EHRs suggesting they received timely care, but complete records from non-VA appointments were not available for a thorough review. Because the lack of non-VA records did not allow a thorough review, we included those patients in this review.

We provided the names of the 759 patients and requested the VISN to upload clinical documents to Veterans Health Administration's (VHA) electronic health record (EHR) for those patients who were referred to a non-VA provider via voucher or authorization for Non-VA Care Coordination (NVCC),⁴ formally known as fee basis care. On June 22, 2015, we received notification that the VISN completed their internal review of the 759 patients and uploaded the supporting clinical documents.

In October 2015, OIG published a report, *Access to Urology Service Phoenix VA Health Care System, Phoenix, Arizona*; (Report No. 14-00875-03, October 15, 2015) in response to the access to care concerns in the urology service at the system. The findings of the October 2015 review included quality of care concerns caused by an unexpected provider shortage within the urology service. We also found that system leaders did not have a plan to provide urological services during significant unexpected provider shortages. In addition, we found that staffing shortages in the system's NVCC office, burdensome administrative processes associated with obtaining and scanning NVCC provider records, and general confusion among non-VA providers and patients regarding the NVCC authorization process contributed to the incomplete documentation for the 759 patients.

We made the following three recommendations in the October 2015 report:

1. We recommended that the Phoenix VA Health Care System Interim Facility Director ensure that resources are in place to deliver timely urological care to patients.
2. We recommended that the Phoenix VA Health Care System Interim Facility Director ensure that non-VA care providers' clinical documentation is available in the electronic health records in a timely manner for Phoenix VA Health Care System providers to review.

⁴ NVCC, formerly known as fee basis care, is the coordination of non-VA care referrals for patients who require health care services that are not available at the VA facility. We found that system staff, documents, and programs used various terms to describe non-VA care; however, for the purposes of this report, we used the term NVCC to include all non-VA purchased care.

3. We recommended that the Phoenix VA Health Care System Interim Facility Director ensure that the cases identified in this report are reviewed, and, for patients who suffered adverse outcomes and poor quality of care, confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.

System leaders concurred with the recommendations and provided an acceptable action plan to the OIG. Based on information received, we closed the recommendations and the subject report effective June 16, 2016.

On November 9, 2016, OHI completed the review of the 759 patients. This follow-up report describes our findings from the review of those patients' care.

Scope and Methodology

We initiated our follow-up review on September 4, 2015, and completed our work in February 2017.

In January 2015, we hand delivered to VISN 22 the names of 759 patients who were referred to the system's urology service or a non-VA provider via voucher or fee basis authorization from June 2011 through June 2014.

On September 4, 2015, we received notification that VISN staff had completed their internal review of 759 patients and had uploaded clinical records to the VHA EHRs for those patients. A team of two registered nurses within OHI reviewed each EHR to determine if urological care was delayed and, if so, the impact of the delay. Delayed care was defined as >90 days from a routine request for urology services or if follow-up care was provided beyond the timeframe specified by the provider. We assessed the impact of the delay using the following criteria: (1) no impact, (2) minor, (3) intermediate, (4) major long-term consequences, and (5) death.

A physician conducted a second level review of the more complex cases as well as a review of all deceased patients.

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.

Inspection Result

Impact of Delays on Patient Care

We determined that 148 (20 percent) of the 759 patients whose care we reviewed experienced delays in getting new evaluations or follow-up appointments within the system's urology service or through NVCC. When a delay was identified, an assessment of the impact of that delay on the patient's care was made.

From a clinical standpoint, we found that none of the patients reviewed for this follow-up report was adversely impacted by a delay in care. We recognized that these patients likely experienced frustration, confusion, and often fear related to not getting appointments that they were told they needed. While our review focused on the clinical impact of delays, we recognized that many of these patients and their families faced unnecessary and excessive obstacles related to accessing care.

Conclusion

We determined that 148 (20 percent) of the 759 patients whose care we reviewed experienced delays in getting new evaluations or follow-up appointments within the system's urology service or through NVCC. When a delay was identified, an assessment of the impact of that delay on the patient's care was made. From a clinical standpoint, we found that none of the patients reviewed for this follow-up report was adversely impacted by a delay in care.

We made no recommendations.

Prior Relevant OIG Reports

Facility/System Reports

Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ

10/15/2015 | 14-00875-03

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

1/28/2015 | 14-00875-112

Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System

8/26/2014 | 14-02603-267

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VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: July 3, 2017

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Follow-Up Review, Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona

To: Director, (Regional Office) Office of Healthcare Inspections (54SD)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the OIG Draft Report, “Healthcare Inspection—Follow-Up Review, Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona.”
2. If you have any questions, or require further information, please contact Terri Elsholz, Deputy Quality Management Officer, at (480) 397-2782.



MARIE L. WELDON, FACHE
Network Director, VISN 22 (10N22)

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 28, 2017

From: Director, Phoenix VA Health Care System (644/00)

Subj: Healthcare Inspection—Follow-Up Review, Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona

To: Director, Desert Pacific Healthcare Network (10N22)

1. I have had the opportunity to review the OIG draft report *Follow-up Review, Access to Urology Service, Phoenix VA Health Care System*. I concur with the report.
2. I appreciate the opportunity for this review as part of our ongoing process to improve care for our Veterans.
3. If you have any questions or require further information, please contact Linda Swan, Chief of Quality, Safety, and Improvement Service, at (602) 277-5551, extension 6092.


RIMAANN O. NELSON

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Judy Montano, MS Julie Kroviak, MD Derrick Hudson, Management and Program Analyst

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