



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

**Office of Healthcare Inspections**

**Report No. 14-00875-03**

## **Healthcare Inspection**

# **Access to Urology Service Phoenix VA Health Care System Phoenix, Arizona**

**October 15, 2015**

**Washington, DC 20420**

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## Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections (OHI) conducted an inspection to evaluate access to care concerns in the Urology Service at the Phoenix VA Health Care System (PVAHCS), Phoenix, Arizona. During an extensive medical records evaluation in 2014 for the *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, (Report No. 14-02603-267, August 26, 2014), the OHI team of physician reviewers uncovered several quality of care issues and clinically significant delays related to patients' urological care. Our initial report identifies three urological cases that represented clear examples of delayed urologic care negatively impacting the patients' clinical outcomes. OHI launched this separate review when it became clear that the Urology clinic experienced extreme staffing shortages that potentially impacted thousands of patients. As the review continued and more complex cases were revealed, we also recognized the need for a more intense specialty level evaluation.

We determined that PVAHCS leaders did not have a plan to provide urological services during significant unexpected provider shortages in the Urology Service. In addition, PVAHCS leaders did not promptly respond to the staffing crisis, which contributed to many patients being "lost to follow-up" and staff frustration due to lack of direction.

We reviewed 3,321 electronic health records (EHRs) of patients who were referred to PVAHCS Urology. We determined that 1,484 (45 percent) experienced delays in getting new evaluations or follow-up appointments within the PVAHCS Urology Service or through Non-VA Care Coordination (NVCC). We also determined that in 759 (23 percent) of the records reviewed, non-VA providers' clinical documents were not available for PVAHCS providers to review in a timely manner. We concluded that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to these non-VA clinical records. This finding suggested that PVAHCS did not have accurate data on the clinical status of the patients who were referred for clinical care. Even in the event that further recommendations were not needed, or there were no critical findings identified, this disconnect between the referring provider and the non-VA specialist compromised the overall management of the patient. We have provided the Veterans Health Administration (VHA) with the 759 names of the patients with incomplete records, and once VHA receives the information from the non-VA providers and uploads all the necessary clinical documents into the EHRs, we will complete and publish that review.

We also concluded that PVAHCS Urology Service and NVCC staff did not provide care or ensure that timely urological services were provided to patients needing care. We identified 10 patients who experienced significant delays, which may have affected their clinical outcome in some instances. Such delays placed patients at unnecessary risk for adverse outcomes. In addition, we found that the quality of non-urological care in two cases was not acceptable, which placed these patients at unnecessary risk for harm.

We recommended that the PVAHCS Interim Facility Director ensure that (1) resources are in place to deliver timely urological care to patients; (2) non-VA care providers' clinical documentation is available in the VA EHR in a timely manner for PVAHCS providers to review; and (3) 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.

## Comments

The Acting Veterans Integrated Service Network Director and Interim Facility Director concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 17–20, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



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## Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection in 2014 to evaluate access to care concerns in the Urology Service at the Phoenix VA Health Care System (PVAHCS), Phoenix, Arizona. During an extensive medical records evaluation, the OHI team of physician reviewers uncovered several quality of care issues and clinically significant delays related to patients' urological care. This problem is discussed in the OIG report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, (Report No. 14-02603-267, August 26, 2014). As the initial review ensued, it became clear that the Urology Service was not able to manage the volume of patients in need of either diagnostic evaluation, treatment, or routine follow-up related to multiple urological conditions. Many complaints pointed to delays in getting an initial appointment, delays in scheduling follow-up, and delays in coordinating care with non-VA urology services.

OHI decided to launch a separate review to carefully assess Urology Service access and its impact on patients' clinical outcomes.

## Background

PVAHCS comprises the Carl T. Hayden Veterans Affairs Medical Center and seven clinics and is part of Veterans Integrated Service Network (VISN) 18. PVAHCS serves more than 80,000 patients in central Arizona including the rapidly expanding metropolitan Phoenix area. The medical center provides acute medical, surgical, and psychiatric inpatient care, as well as rehabilitation medicine and neurological care.

Urology combines the management of medical (that is, 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. PVAHCS 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.

A shortage of urology specialty providers is recognized nationwide. As many conditions treated by this specialty are age-related, and since the VA generally serves an older patient population, the impact of this shortage can be significant. PVAHCS is not affiliated with a urology residency training program, which can pose additional challenges with provider recruitment.

PVAHCS Urology Service provides 24 hours, 7 days a week on-call coverage for the inpatient units and the Emergency Department (ED). The service provides the following procedures/services:

- Cystoscopy (use of a scope to examine the bladder)
- Prostate Ultrasound
- Prostate Biopsy

- UroFlow (procedure used to calculate the rate of flow of urine)
- Post-Void Residual Scan
- Catheterization
- Circumcision

PVAHCS refers 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 manage radiation treatment for prostate cancer patients.

PVAHCS Urology Outpatient Clinic provides urological follow-up care to eligible patients on an outpatient basis. Patients who require post-surgery follow-up, medical management of disorders including bladder, prostate, and kidney cancer are seen in the clinic. The clinic receives referrals from other outpatient clinics, inpatient units, the ED, and other VA hospitals. At the time of our review, the clinic was open for patient care Monday through Friday, 8:00 a.m. to 2:30 p.m.

The clinic workload for fiscal year (FY) 2013 through FY 2014 is shown in the Figure 1.

**Figure 1. Urology Clinic Workload FY 2013 through FY 2014**

	<b>FY13</b>	<b>FY14</b>
<b>Encounters</b>	6,773	4,205
<b>Visits</b>	6,713	4,150
<b>Veterans</b>	3,249	1,933
<b>OR Cases</b>	215	135

*Source: PVAHCS*

## Scope and Methodology

The period of this review was from August 1, 2014, through April 1, 2015. We conducted site visits to the medical center August 6–8, 2014, and January 12–16, 2015. We interviewed the Chief of Staff (COS); Chiefs of Urology, Primary Care, Health Administration Service (HAS), and Quality Management; a urologist; an NP; two medical administrative support (MAS) staff; and, nurse managers, registered nurses, supervisors, and voucher examiners who processed referrals for Non-VA Care Coordination (NVCC).<sup>1</sup> We reviewed PVAHCS' urology clinic workload data, staffing levels, and urology consult and non-VA urology consult data for FY 2013 and FY 2014. We also reviewed 3,321 electronic health records (EHRs) of patients who were referred to or received continuous care in PVAHCS Urology Service and patients who were referred to non-VA urologists. We consulted with a board certified urologist for in depth

<sup>1</sup> 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 PVAHCS staff, documents, and programs used various terms to describe non-VA care; however, for the purposes of this report, we use the term NVCC to include all non-VA purchased care.

reviews of the more complex cases. In addition, we reviewed Veterans Health Administration (VHA) and local policies and other pertinent documents.

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 Results

### Issue 1: Urology Service Provider Shortage

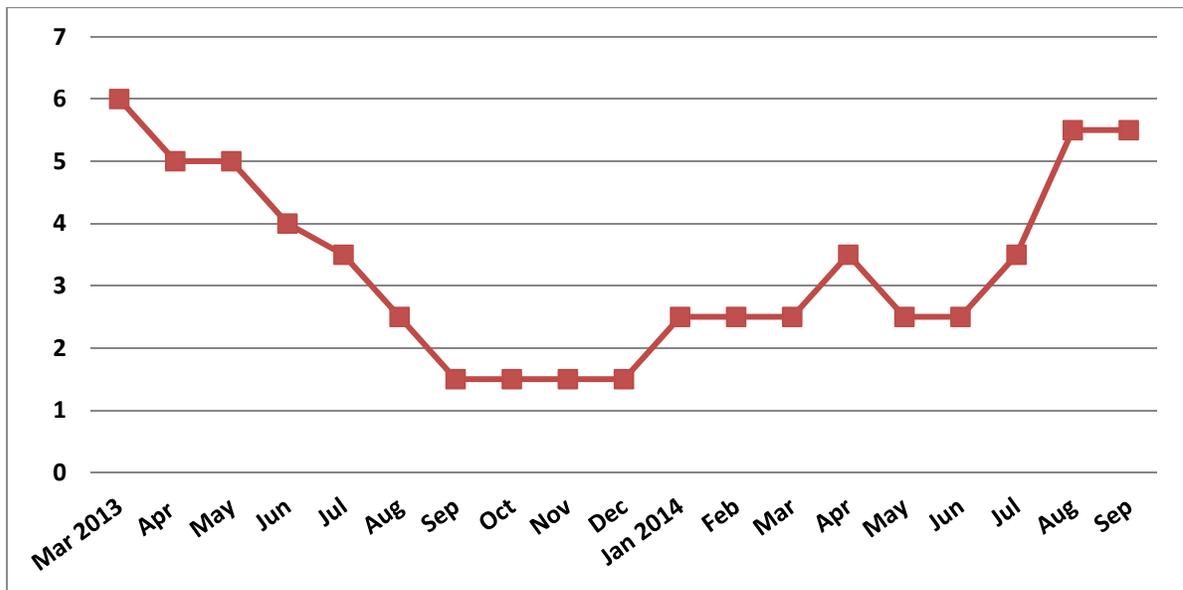
At the beginning of FY 2013, the Urology Service was fully staffed with three urologists and three nurse practitioners (NP). We determined that PVAHCS Urology Service began to suffer significant unexpected staffing shortages in April 2013.

Urologists: In April 2013, the Chief of Urology Service required extended unplanned leave for over a month. Within 6 weeks of the Chief of Urology Service departure, another urologist also took extended leave. In late June 2013, a third urologist resigned. The other urologist returned from leave in early July but worked only part-time. In July, the Chief of Urology retired with little notice, leaving the part-time urologist as the only physician to cover the entire service for over 2 months. At this time, PVAHCS recruited two urologists who accepted the proffered positions. One of the urologists started in early September 2013; however, the other urologist abruptly retracted her acceptance of the job offer a few weeks before the agreed upon start date.

Mid-Level Providers: In early August 2013, an NP resigned, and a second NP resigned in late September. Two days later, the remaining NP required extended leave which lasted approximately 16 weeks.

With the NP losses, the service was operating with one full-time and one part-time urologist for approximately 4 months. Figure 2 illustrates the staffing levels (number of urologists plus mid-level providers) beginning in March 2013 and the resulting staffing levels as providers resigned or required extended leave.

**Figure 2. Urology Service Staffing March 2013 through September 2014**



Source: PVAHCS

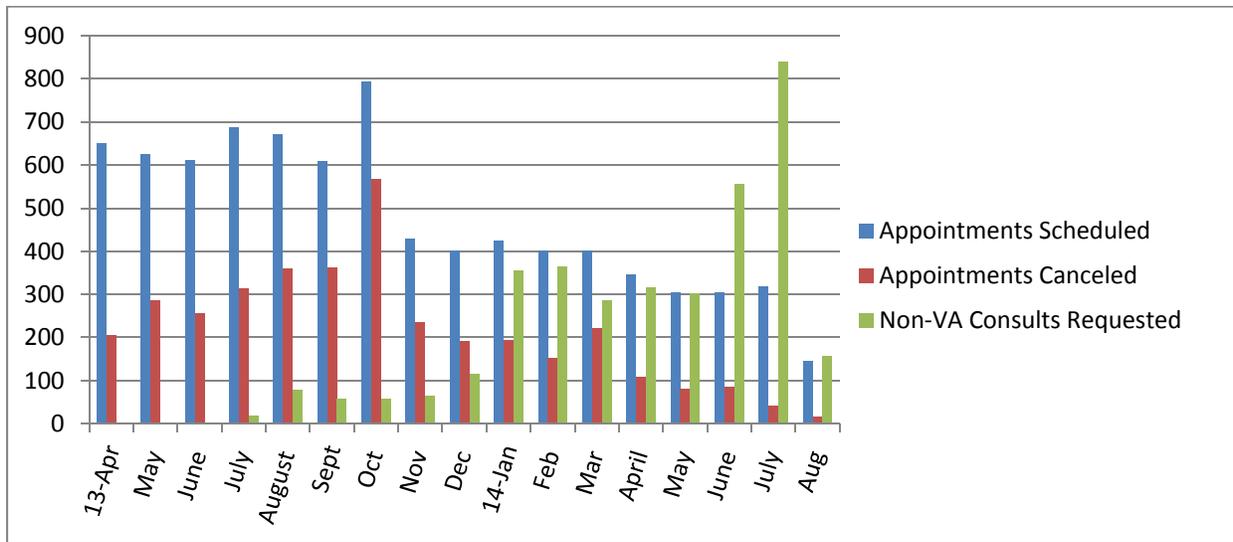
## Issue 2: Impact of Provider Shortage on Access to Urology Services

As providers left or became unavailable, the PVAHCS process was to cancel scheduled appointments, send notification letters of appointment cancellations, and inform patients that they would receive referrals for non-VA care. Despite the notification letters, MAS staff reported that patients arrived at the clinic daily for scheduled visits because they were unaware that their appointments had been cancelled. In addition, patients were not referred to non-VA urologists. When comparing the clinic cancellations for urology with the non-VA consults requested for the same time period, we determined that far more clinic cancellations occurred than non-VA consult requests.

Figure 3 illustrates the following:

- 7,299 Urology appointments were scheduled between April 1, 2013 and August 14, 2014
- 4,321 Urology appointments were canceled between April 1, 2013 and August 14, 2014
- 3,369 Non-VA Consults were requested between July 1, 2013 and August 14, 2014

**Figure 3. Appointments Scheduled, Appointments Cancelled, April 1, 2013 through August 14, 2014 and Non-VA Urology Consults Requested July 1, 2013 through August 14, 2014**



Data does not include information regarding appointments cancelled by patients.

The cancelled appointments include those that may have been entered in error and later cancelled.

Source: PVAHCS

According to MAS staff, when patients arrived in the clinic to find that their appointments had been cancelled, rescheduling timely appointments was not possible. Initially, the only direction MAS staff could offer to patients was to refer them to the Patient Advocate; however, they were subsequently instructed to refer patients back to their primary care providers (PCPs). In September 2013, the following email was sent to a Health Administration Service (HAS) supervisor:

*We were told yesterday morning... that all urology patients were to be directed back to their PCP's [sic]. That would include All [sic] who had follow-up appointments with the providers who have left.*

*A patient who had an appointment with [name of provider] to follow-up on [Luteinizing Hormone Releasing Hormone] injection was just sent to me. All the MSA's [sic] need to be on the same page in terms of responding to patients.*

*Could someone please clarify. Are we are or are we not directed to send ALL patients back to the PCP's [sic].*

### **Issue 3: Leadership Response to Urology Provider Staffing Crisis**

Leadership Initial Reaction to Urology Crisis. In September 2013, the COS contacted other local VA facilities for assistance with the current urology "staffing crisis" at the suggestion of VISN 18 Chief Medical Officer. However, other regional VA facilities were unable to offer support because of their own staffing concerns. PVAHCS had also been actively recruiting for urologists, and in early September, a new full-time physician joined the Urology Service staff. Negotiations had also been successful with another urologist who was scheduled to begin within a month. According to the COS, the new provider expressed confidence that the backlog of patients awaiting care could be addressed in a timely manner, especially with the second urologist arriving shortly. However, 2 weeks prior to her start date, the COS received notice that the second urologist had decided to stay at her current place of employment.

Management of Consults and Follow-Up Clinic Appointment. From September through December 2013, PVAHCS referring providers, urologists, and NVCC managers were confused about what care was to be provided on site. Urology clinic staff often cancelled consults to urology with recommendations to referring providers to submit consult requests for NVCC. NVCC staff would cancel consults with the comment that these services could be provided within the PVAHCS Urology Clinic. This resulted in multiple patients in need of appointments and without active pending consults.

Also lacking, as evidenced from email communications from support staff, was clear timely instructions as to how to manage the scheduling of follow-up visits with providers and how to instruct the many patients awaiting urology appointments. An MSA forwarded the email below to an HAS supervisor in September 2013 requesting direction from leadership:

*Below is the name of a veteran who, according to his wife, has prostate cancer. She presented at my duty station while leaving her husband in their car after driving from Holbrook AZ (a 5-6 hour drive) only to find his Urology appointment had been cancelled. Of course they were not notified. At receiving the news the veterans [sic] wife spent the remainder of her time holding back tears given I could lonely [sic] offer a follow-up appointment. And that a month away.*

*Please, for the Veterans [sic] sake, empower me with direction in terms of what to offer the hundreds of veterans effected [sic] by the implosion in Urology.*

In December 2013, an email addressed to PVAHCS Director repeats the same concerns:

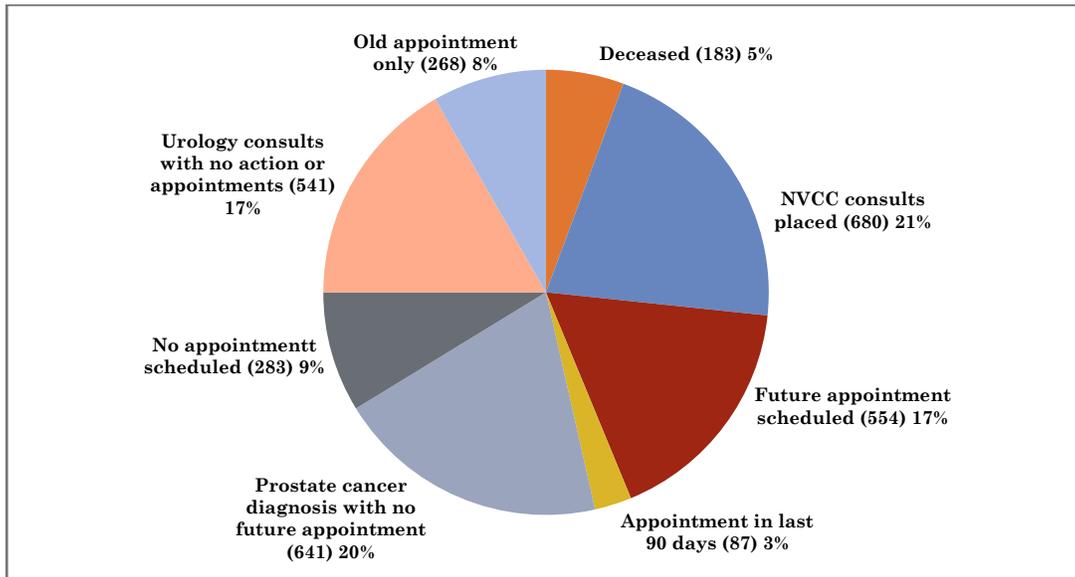
*We as clerks' [sic] are dealing with the frustrations of the veterans daily and we don't have any answers for them. We can't make appointments for them, can't send them to Patient Advocate, and can't send them back to their PCP. This has been going on now for months and still no guidance or answers.*

*We are getting our heads handed to us daily by the patients! How much are we supposed to endure... PLEASE HELP we are leaving our vets in limbo!*

Urology Action Plan Group. In January 2014, the COS convened a group to address the Urology Service access issues and the first Urology Action Plan Group meeting was held on January 8. The minutes from this initial meeting list members of the team as the COS, Deputy COS, Chief of Surgery, Chief of HAS, Chief of NVCC, Chief of Informatics, Chief of Ambulatory Care, NVCC manager, and one staff urologist. According to the minutes, the goal of the group was to focus on the recruitment of physicians, mid-level providers (NP or physician assistant), and nursing staff and to deactivate the in-house urology consult and redirect pending urology consults to NVCC. The group agreed to immediately disable the in-house Urology Outpatient Consult.

On January 9, 2014, the COS sent referring providers an email educating them on the new process. At the same time, the Urology Action Plan Group was attempting to identify patients who may have potentially been "lost to follow-up." A data management staff member was instructed to identify all patients with cancelled urology and non-VA urology consults, pending unscheduled consults, and cancelled urology appointments in FY 2013 and FY 2014 through January 9. The Urology Action Plan Group identified patients with active prostate cancer diagnoses and no future appointments as a group with potential to be "lost to follow-up." In total, the Urology Action Plan Group identified 3,237 patients in this process and instructed staff to review the EHRs of each patient to determine if follow-up urology care was still needed. Figure 4 illustrates the subsets of patients that were to be included in the review.

**Figure 4. Urology Patients Potentially Lost to Follow-Up  
FY 2013 and FY 2014 through January 9**



Source: PVAHCS Urology Action Plan Group January-August 2014.

On January 14, 2014, PVAHCS began closing 249 in-house “open” urology consults in batch. The consults were closed with the following statement:

*PVAHCS outpatient urology clinic is temporarily not accepting consults. Urology care will be provided through Albuquerque VA and Purchased Care. Current options for urology services are listed under the Urology Consult request in CPRS.*

When a consult is closed, an electronic notification or “view alert”<sup>2</sup> may be automatically generated and directed to the referring provider. In this case, the referring providers were to receive view alerts, which informed the providers that the consults were closed and instructed them, if clinically necessary, to resubmit the consults for NVCC. However, providers may elect to turn off the EHR “view alert” feature, or providers who were no longer on staff may not have designated surrogates to receive their patients’ view alerts. PVAHCS leaders were aware that providers were not receiving view alerts as evident in email dialogues among leaders. We determined, therefore, that this batch consult cancellation process was not a reliable method of ensuring that all patients were appropriately referred to community providers.

After January 14, 2014, PVAHCS urology services were limited to inpatient consultation and ED urgent consultation because all new outpatient referrals to urology were directed to NVCC.

<sup>2</sup> A “view alert” is a notification or message triggered by certain events in the Computerized Patient Record System (i.e. consult change status).

In late March 2014, Urology Action Plan Group meeting minutes document that one new full-time urologist, one physician assistant, and one NP had accepted positions, but it would be several months before they would begin work. However, progress in reviewing records and directing care for the 3,237 patients was slow. Nursing staff within NVCC offered to assist in the review process. At this time, the process did not include authorizing care through NVCC; instead, it was a review to determine the “status” of the patients’ need for urology care. Quality Management staff reviewed all deceased patients, and two urology providers determined which patients could be managed by current staff, which patients could be managed within Primary Care, and which patients would need to be seen outside PVAHCS.

In late May 2014, PVAHCS leaders directed NVCC staff to approve authorizations for non-VA care. However, limited NVCC staffing and complicated administrative processes further delayed care.

#### **Issue 4: NVCC Staffing Shortage and Processing Delays**

In September 2014, the COS provided us with a list of 3,237 urology patients who may have been “lost to follow-up.” We also had a paper list recovered during our 2014 review of patients awaiting an appointment with the Urology Service. We reconciled the paper list of 200 patients with the 3,237 patients and determined that 3,321 urology patients may have been “lost to follow-up.” An OHI team of 12 inspectors reviewed the EHRs of all 3,321 patients, focusing on whether delays occurred in scheduling evaluations for urology services.

In 759 (23 percent) of the 3,321 cases, reviewers identified approved authorizations for NVCC urological care and a notation that an authorization was sent to the non-VA provider. Often a scheduled date and time of an appointment with the non-VA urologist was documented. However, the OHI reviewers were unable to locate scanned documents from non-VA providers in these patients’ EHRs verifying that the patients had been seen for evaluations, and if seen, what the evaluations might have revealed. This finding suggested that PVAHCS did not have accurate data on the clinical status of the patients who were referred for the specialty care.

Our review also revealed that NVCC staffing was below their authorized number of positions, and thus the department was not able to keep up with many of the administrative tasks required to process the authorizations. In January 2015, staffing in the department was 12 full-time positions below their staffing limit, and efforts to recruit continue.

In addition, we determined that many non-VA providers were not familiar with VA care authorization policies, which also contributed to delays. PVAHCS modified the language of all authorizations to read “evaluate and treat” instead of “evaluate and recommend.” Non-VA providers frequently misinterpreted vouchers as authorizing only one visit for an initial evaluation. This caused a delay because the non-VA providers submitted another request for NVCC or advised patients to contact PVAHCS for further

authorizations. This created a tremendous backlog of secondary authorization requests that further delayed care to patients.

With respect to scanning and reviewing outside clinical documents (for example, clinic notes, labs, or imaging results), when the services were provided by TriWest Health Care Alliance (TriWest),<sup>3</sup> the treating providers' office submitted this data to the TriWest Portal. To access that information, an NVCC staff member was required to log into the TriWest Portal to print and scan these records into the patients EHRs. This process was delayed because of the NVCC staffing shortages, which could have resulted in important clinical information not being reviewed for several months.

We provided VHA with the names of all patients for whom critical follow-up information from non-VA providers was unavailable in their EHRs at the time of our review. When PVAHCS scans those records into the EHR, our review team will complete a quality of care assessment.

### **Issue 5: Impact on Patient Care**

We determined that 1,484 (45 percent) of the 3,321<sup>4</sup> patients we reviewed experienced delays in getting new evaluations or follow-up appointments within the PVAHCS 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. The impact of these delays varied based on the indication for the referral, the diagnosis requiring the specialty care, and the age and co-morbidities of the patient. Patients who experienced delays also 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 recognize that many of these patients and their families faced unnecessary and excessive obstacles related to accessing care.

As noted above, we found that 759 of the 3,321 EHRs had approved authorizations for NVCC but did not include sufficient information for us to determine the impact of delayed care. Although care was not delayed in 229 of the 759 EHRs, we could not assess the quality of the care these patients received due to missing clinical documents. We provided VHA a list of those 759 patients and continued our review of the remaining 2,562. Once VHA receives the information from the non-VA providers and uploads all the necessary clinical documents into the EHR, we will complete our review.

In the 2,562 EHRs, reviewers determined that the EHRs contained enough information to make reasonable assessments of the impact of delayed care and/or assessments of the quality of care patients received. Of the 2,562 records, 553 (22 percent) were sent for secondary level review to a team of OHI physicians. This secondary review involved

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<sup>3</sup>TriWest, a government contracted program that has agreements with several VHA facilities including VISN 18 facilities, provides patients with coordinated, timely access to quality health care through a comprehensive network of TriWest's civilian providers when VA care is not available in-house.

<sup>4</sup>We were able to determine whether care was delayed in the 759 cases sent to VHA, so these cases are included in the 3,321.

a more in-depth review and, in some cases, consultation with a board certified urologist. These cases were often more complex in that patients may have had multiple co-existing medical problems, received care in multiple facilities, or undergone multiple specialty level procedures that made a careful assessment more challenging. From the secondary level review, we identified significant access and/or quality of care concerns in 12 patients.

#### A. Patients with Delayed Access to Urology Services

The following cases are of those patients whose delayed access to urology services significantly impacted their care:

**Case 1** – This patient was a man in his early 60s who had a history of prostate cancer since 2010. PVAHCS Urology Service provided follow-up care for 3 years at 6 month intervals. His scheduled follow-up appointment in February 2013 was “cancelled by clinic” for unknown reasons and was not rescheduled. Ten months later, during a routine primary care appointment, his PCP ordered a prostate-specific antigen (PSA) level. This level was markedly elevated, and follow-up bone imaging showed metastatic disease in his spine. He died in April 2014 from metastatic prostate cancer.

PVAHCS staff should have rescheduled the cancelled appointment in a timely manner. That appointment could have indicated an elevation in the patient’s PSA level that would have prompted his urology provider to initiate a more aggressive treatment plan.

**Case 2** – This patient was a male in his early 70s whose PCP noted an elevated PSA in May 2013. The PCP referred him for a urology evaluation, but his August 2013 urology appointment was “cancelled by clinic” and not rescheduled. The PCP then placed a consult for urology services to NVCC in September 2013. Within days of placing the consult, NVCC staff closed the consult with the comment “PVAHCS provides these services.” In January 2014, the original consult (which was still open as an appointment had never been scheduled) was closed with comments, “PVAHCS is no longer accepting consults to Urology, place NVCC.” Another NVCC consult was placed, and after many delays with authorizing and scheduling that appointment with a non-VA urologist, a biopsy was performed in June 2014. The patient was diagnosed with prostate cancer metastatic to the pelvic lymph nodes. During a primary care appointment in September 2014 with a VA provider, records from the non-VA provider were still unavailable in the VA EHR. The PCP documented that he would try to obtain these records in order to clarify the treatment plan. The patient began radiation therapy in December 2014 at a non-VA facility for what the radiation oncologist described as “an aggressive prostate cancer.”

This patient experienced excessive delays in not only obtaining an initial consultation with PVAHCS Urology Service, but also in the coordination of care through NVCC. The lack of communication between PVAHCS and the NVCC urologist continued well into the treatment phase of this patient’s metastatic prostate cancer.

This lack of communication not only interfered with timely diagnosis and management of this patient's care, but also placed unnecessary administrative burdens on the PCP.

**Case 3** – This patient was a male in his early 70s when PVAHCS Urology Service evaluated him in June 2013 for an enlarged prostate and initiated medication to treat his symptoms. According to his daughter, the patient noticed blood in his urine (hematuria) in February 2014, and within weeks he was passing large clots. His daughter reported that he kept calling the PVAHCS Call Center as well as his VA PCP to get an appointment with the Urology Service. In March 2014, three separate entries in the EHR document these calls in which the patient complained to the call center nurse that he is “frustrated with the blood in his urine, the fatigue and incontinence.” His daughter reported to us that he was told to “be patient, there are still no providers.” The patient saw his PCP in April 2014 and reported that the hematuria continued. Blood tests performed that day showed a significant drop in his red blood cell count compared with previous results. An NVCC referral was requested, and an appointment was scheduled with a non-VA urology provider in May. The VA EHR documents that the patient did not attend and did not cancel (no showed) the NVCC appointment. However, the daughter reported to us that she took her father to that appointment. Records from the non-VA provider eventually confirmed that the patient had been seen as scheduled and needed a procedure that required additional authorization from PVAHCS. The patient died 10 days after the NVCC appointment.

Evidence in the EHR and interviews with family indicated that this patient experienced significant obstacles in getting an evaluation of his symptoms. A more timely evaluation within Primary Care could have initiated an urgent referral to a urologist. Further delays in authorizing outside care, and the errors in accurately documenting the patient's compliance with his non-VA follow-up appointment, compromised this patient's care.

**Case 4** – This patient was a male in his early 60s who had a history of prostate cancer since 2003. The Urology Service followed up with the patient every 6 months. A urology appointment in September 2012 documented a stable PSA and the recommendation was that he be seen in January 2013 for follow-up. Prior to the follow-up appointment, the patient reported to the PVAHCS laboratory for blood tests, including a PSA; however, his January appointment with a urology provider was “cancelled by clinic.” The PSA result showed a significant elevation, but we found no evidence that the ordering provider reviewed this result with the patient. According to the patient's wife, during this same time, he was having significant swelling and pain in his groin area and lower extremities and repeatedly tried to get an appointment with the Urology Service but was unsuccessful. During an April 2013 appointment with the Renal Service, the patient complained of flank pain. The nephrologist placed a consult to the Urology Service. PVAHCS Urology Service saw the patient in July 2013. During that appointment, the provider referred him to an outside facility for imaging studies and a diagnostic procedure. He was found to have metastatic prostate cancer and died in May 2014.

PVAHCS staff should have rescheduled the cancelled January 2013 appointment in a timely manner. In addition, the provider should have reviewed the laboratory results

with the patient. Had either occurred, a more aggressive treatment plan should have been initiated earlier.

**Case 5** – This patient was a paraplegic male in his late 60s followed by the PVAHCS Spinal Cord Injury Clinic. In January 2014, the Spinal Cord Injury Team evaluated the patient for hematuria and placed a consult to the Renal Service. Two weeks later, the Renal Service closed the consult with the recommendation to “place an Urgent Urology Consult.” One week later, the Spinal Cord Injury Team placed an urgent urology consult, with a comment specifically requesting an appointment within 72 hours. The patient was scheduled an appointment in urology in March 2014. Three days prior, he was admitted to a community hospital for urosepsis.

A more timely appointment with a urologist may have prevented the serious infection that required hospitalization.

**Case 6** – This patient was a man in his late 80s with a history of an aggressive bladder cancer. The Urology Service last saw him in April 2013 for a surveillance cystoscopy. At that appointment, a urologist prescribed a 30-day course of antibiotics and instructed the patient’s caregiver that at the completion of the antibiotics, the patient would be scheduled for a repeat cystoscopy. The procedure was never scheduled. PVAHCS ED saw the patient in February 2014 for renal failure. The Urology Service was consulted and attempted to perform a cystoscopy but was unable to pass the cystoscope because of extensive tumor growth within the bladder causing complete obstruction. The recommendation was consultation with hospice. The patient died in June 2014.

Based on the patient’s history of bladder cancer, PVAHCS staff should have scheduled the patient for a cystoscopy as recommended by the treating provider. Had the procedure occurred, tumor recurrence could have been detected and treatment of that tumor could have prevented the resultant renal failure.

**Case 7** – This patient was a male in his late 60s with a history of elevated PSA. He had undergone several prostate biopsies, all of which were negative for prostate carcinoma. During an appointment with a urology provider in September 2013, the provider ordered a magnetic resonance imaging (MRI) scan of the prostate to evaluate the persistently elevated PSA. The MRI scan was completed in a timely manner. The findings suggested prostate cancer and a lesion suspicious for bladder cancer. The patient was not informed of the results, as his follow-up appointment in urology was “cancelled by clinic.” During a routine primary care appointment in May 2014, the patient asked his PCP to review the findings of the MRI scan. The PCP immediately placed a consult for urology services to NVCC. An appointment was scheduled with a non-VA urologist who performed a cystoscopy and the patient was diagnosed with bladder cancer. Weeks later, a prostate biopsy confirmed a diagnosis of prostate cancer.

Failure to reschedule the cancelled appointment, as well as failure to notify the patient of the significant findings on the MRI scan, placed him at unnecessary risk for metastatic disease.

**Case 8** – This man was in his early 60s with a history of prostate cancer. PVAHCS Urology Service followed the patient routinely in the clinic. His provider managed the prostate cancer with Eligard®<sup>5</sup> injections every 3 months. In June 2013, his PSA spiked to a significantly high level. A 3-month follow-up appointment was scheduled, and the patient was reminded to schedule a previously ordered bone scan. His September 2013 urology appointment was “cancelled by clinic,” and the patient did not get his scheduled Eligard® injection. In January 2014, a community hospital saw the patient for weakness and severe back pain. The patient was diagnosed with diffuse metastasis from his prostate cancer to his spine. He died in April 2014.

PVAHCS staff should have rescheduled the patient’s cancelled appointment in a timely manner. An evaluation by urology provider could have initiated a more aggressive treatment plan, as well as provided an opportunity to address the patient’s severe pain.

**Case 9** – This patient was a man in his early 50s with a family history of prostate cancer. The patient’s PCP placed a referral to PVAHCS Urology Service in August 2013 for blood work results that were suggestive of prostate cancer. An appointment was scheduled for approximately 1 month later, then “cancelled by clinic.” In January 2014, the original consult was cancelled. In July 2014, the PCP placed a consult to NVCC, and the patient was evaluated by a non-VA urologist in August 2014. A biopsy in September 2014 confirmed a diagnosis of prostate cancer.

This patient experienced excessive delays in obtaining an evaluation with a urologist. Such delays placed the patient at unnecessary risk for metastatic disease.

**Case 10** – This patient was a male in his late 60s with a history of an elevated PSA. In February 2014, the patient underwent a prostate biopsy at the PVAHCS. The results indicated the patient had prostate cancer, and the pathologist documented in the EHR that he conveyed the results to the urologist who performed the biopsy. The urologist did not inform the patient of the biopsy results. A consult for urology services was placed by the patient’s PCP to NVCC in July 2014 for “an elevated PSA,” but the consult does not mention the biopsy results. An EHR entry by the Chief of Urology Service in March 2015 states that the patient needs a follow-up appointment scheduled, as “he was never given biopsy results after [sic] his prostate biopsy” in February 2014. According to the EHR, the patient was evaluated by a non-VA urologist in February 2015; however, records from that visit were not scanned into the record for us to review.

This patient experienced excessive delay not only in the initiation of treatment for his cancer, but also in being made aware of initial biopsy results. Such delay placed the patient at unnecessary risk for metastatic disease.

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<sup>5</sup> Eligard is given by injection for the management of advanced prostate cancer.

## B. Patients with Timely Urology Care but Other Quality of Care Concerns

Our review also revealed instances where PVAHCS Urology Service delivered timely and appropriate care, but we identified other quality of care issues.

**Case 1** – This was a man in his late 80s when the PVAHCS Urology Service evaluated him in April 2013 for hematuria and planned for a cystoscopy for approximately 2 months later. However, the patient decided against the procedure and cancelled the appointment. Approximately 1 year later, the patient’s daughter called the Patient Aligned Care Team nurse stating her father was having new symptoms of nausea and abdominal pain and described his abdomen as “firm and round.” The daughter was concerned that the symptoms were related to new medications that the neurology team had initiated for myositis. The nurse recorded the conversation in the EHR, and the physician reviewed the message. There is no documentation that the provider called the daughter, requested to evaluate the patient, or directed the family to seek urgent care. However, the provider did request that the nurse call the daughter and suggest an over the counter medication for reflux. Three days later, the patient was admitted to a community hospital for an acute gastrointestinal bleed and adrenal crisis. He died 10 days later.

The patient’s daughter reported acute and very concerning symptoms in an elderly male with multiple medical problems. The patient and his family should have been instructed to seek more urgent medical attention.

**Case 2** – This patient was a male in his 80s with multiple medical problems including severe kidney disease, recurrent aggressive bladder cancer, and memory loss. Several entries in the EHR indicate that the patient had great difficulty coordinating his appointments due to lack of transportation, he was frequently confused about the medications he was taking, and he appeared to lack insight into the severity of his illnesses. During an inpatient stay at PVAHCS in August 2013, a consult with the Social Work Department indicated that the patient would be referred for a home health aide who could assist the patient with medication compliance. We found no evidence within the EHR that home health aide services were initiated. During an appointment with the Renal Service in January 2014, the nephrologist details a list of concerns regarding the patient’s ability to take care of himself including that the patient is eating “only milk and cookies, got a speeding ticket and has a recurrence of bloody urine.” The provider started her note close in time to the patient’s visit and signed it 11 days later. The provider then forwarded the note to the renal team social worker, who acknowledged receipt of the information with her signature, yet no action was taken. The following day, the patient died at home.

The EHR supports that this patient had significant challenges related to self-care. Although social work needs were clearly identified, the lack of coordination with providing those services placed the patient at unnecessary risk for harm.

## Conclusions

We determined that PVAHCS suffered a significant urology staffing shortage, and leaders did not have a plan to provide urological services during the shortage of providers in the Urology Service. PVAHCS leaders did not promptly respond to the staffing crisis, which may have contributed to many patients being “lost to follow-up” and staff frustration due to lack of direction.

We also determined that non-VA providers’ clinical documents were not consistently available for PVAHCS providers to review in a timely manner. We concluded that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to these non-VA clinical records. Even in the event that further recommendations were not needed, or there were no critical findings, this disconnect between the referring provider and the specialist compromised the overall management of the patient.

We also concluded that PVAHCS Urology Service and NVCC staff did not provide timely care or ensure that timely urological services were provided to patients needing the care. We identified 10 patients who experienced significant delays that may have affected their clinical outcomes. Such delays placed patients at unnecessary risk for adverse outcomes. In addition, we found that the quality of non-urological care in two cases was not acceptable, which placed these patients at unnecessary risk for harm.

## Recommendations

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.
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.

## Acting VISN Director Comments

### Department of Veterans Affairs

### Memorandum

**Date:** July 15, 2015

**From:** Acting Network Director, VISN 18 (10N18)

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

**To:** Director, San Diego Office of Healthcare Inspections (54SD)  
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed and concur with the findings and recommendations in the Healthcare Inspection – Access to Urology Service, Phoenix, VA Phoenix VA Health Care System, Phoenix, AZ.
2. If you have any questions or concerns, please contact Jennifer Kubiak, VISN 18 Quality Management Officer, at 480-397-2781.

  
Kathleen R. Fogarty

## Interim Facility Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** July 1, 2015

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

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

**To:** Acting VISN Director, VA Southwest Health Care Network (10N18)

1. Please find the facility response regarding the Office of the Inspector General's Draft Report – Healthcare Inspection – Access to Urology Services review. Implementation and subsequent actions are currently being completed.
2. If you have any questions, please contact Michelle Bagford, Chief, Quality, Safety and Improvement at (602) 277-5551, extension 6092.



GLEN W. GRIPPEN  
Interim Medical Center Director

## Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

### OIG Recommendations

**Recommendation 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.

Concur

Target date for completion: Completed

Facility response: The Phoenix VA Health Care System (PVAHCS) has already initiated action to address this recommendation. The facility has hired additional staff to provide urologic care as noted in the table below. Recruitment continues for another staff Urologist. However, all Urology care, except erectile dysfunction, is now provided in-house. Erectile dysfunction is referred for non-VA care. When the final staff urologist arrives, erectile dysfunction will be provided internally.

POSITION	ON BOARD FTEE	ALLOCATED FTEE
Chief, Urology	1.0	1.0
Staff Urologist	2.5	3.5
Nurse Practitioner	1.0	1.0
Physician's Assistant	3.0	3.0

According to VSSC data for June 2015, wait time for Urology appointments now averages less than 4 days from preferred date and 99.6% of appointments are completed within 30 days of the preferred date. Urgent appointments are available within one day.

**Recommendation 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.

Concur

Target date for completion: Ongoing; December 31, 2015

Facility response: PVAHCS has been meeting with TriWest leadership on a monthly basis to improve the communication system and timely availability of records. PVAHCS has developed a system by which patient records are downloaded from the TriWest portal on a daily basis. As the patient records are taken from the TriWest portal, they are placed in a facility folder where they are uploaded to Document Manager and linked

to complete the non-VA care consult in the Computerized Patient Record System (CPRS) as a PDF document. The completion of the consult notifies the Ordering Provider automatically via CPRS Alert that the non-VA care consult results are available.

All TriWest non-VA care providers are obligated by contract to provide medical records within 14 days. TriWest is obligated by contract to load those records into the portal within 48 hours of receipt so VA staff can retrieve the information.

The results of services provided outside of the TriWest contract are returned to the Purchased Care Service and scanned into the computerized patient record system within four business days.

If the non-VA provider requests additional information, a secondary authorization request is immediately directed to a Purchased Care Registered Nurse (RN) for review and approval. The Purchased Care RN is authorized to approve secondary authorizations in accordance with the established hierarchy of care and as described by the Standard Operating Procedure.

**Recommendation 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.

Concur

Target date for completion: March 31, 2016

Facility response: The Phoenix VA Health Care System (PVAHCS) has reviewed all cases identified in the OIG Report. Final determinations regarding the appropriate responses, including disclosures to patients and families, is being made. Over 90 clinical staff have been formally trained to conduct disclosure discussions, which consistently involve clinical leadership, such as the Chief of Staff or Nurse Executive. These discussions and this process are used to develop opportunities for improvement for the facility. Regional Counsel will be included in these discussions. The facility conducted in-depth quality of care reviews of the twelve cases identified in this report and determined that eight protected peer reviews and two/three institutional disclosures were warranted. These planned actions are in-process.

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the OIG at (202) 461-4720.
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