(October 15, 2015)

In order to further improve the lines of communication and to respond to the concerns between the National VA Council and you our members, I have established a National VA Council Briefing. This NVAC Briefing will bring you the latest news and developments within DVA and provide you with the current status of issues this Council is currently addressing. I believe that this NVAC Briefing will greatly enhance the way in which we communicate and the way in which we share new information, keeping you better informed.

Alma L. Lee
National VA Council, President

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In This Briefing: Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ

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Click on link below to review the report by OIG

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

10/14/2015 08:00 PM EDT

OIG conducted an inspection to evaluate access to care concerns in the Urology Service at the Phoenix VA Health Care System (PVAHCS), Phoenix, Arizona. We determined that PVAHCS leaders did not have a plan to provide urological services during unexpected provider shortage in the Urology Service. PVAHCS leaders did not promptly respond to the staffing crisis, which may have contributed to patients being "lost to follow-up" and staff frustration due to lack of direction. We determined that non-VA providers' clinical documents were not available for PVAHCS providers to review timely. We concluded that referring providers may not have addressed potentially important recommendations and follow-up because they did not have access to non-VA clinical records. We also concluded that PVAHCS Urology Service and Non-VA Care Coordination staff did not provide timely care or ensure timely urological services were provided to patients needing care. We identified 10 patients who experienced significant delays that may have affected their clinical outcomes in some instances. Such delays placed patients at unnecessary risk for adverse outcomes. 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 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 VA electronic health records in a timely manner for review; and (3) 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.