Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Delays in Cancer Care
West Palm Beach VA Medical Center
West Palm Beach, Florida

Report No. 11-00930-210

June 29, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of delayed cancer care at the West Palm Beach VA Medical Center, West Palm Beach, FL.

We reviewed allegations that patients did not receive timely treatment after a diagnosis of lung or renal cancer; these patients did not receive timely cardiac risk assessment prior to surgery; and facility management was aware of, but unresponsive to, these issues.

We did not substantiate the allegation that lung cancer patients did not receive timely treatment. We found no delays in the initiation of treatment for lung cancer patients with a confirmed diagnosis, regardless of the treatment modality (surgery, chemotherapy, or Fee Basis radiation therapy).

We substantiated the allegation that renal cancer patients faced delays in treatment. For those patients who were referred to another VA Medical Center for care, there was no mechanism in place to follow their progress and verify that treatment was provided. These patients faced significantly longer wait times for treatment than those patients whose treatment option was available at the West Palm Beach VA Medical Center.

We also substantiated that management was aware of problems with timely renal cancer care for one patient, but made no effort to follow up on this. We did not substantiate that there were delays in obtaining cardiac risk assessment prior to patients' surgery for lung or renal cancer.

We made three recommendations. We recommended that the Medical Center Director ensure that formal processes are strengthened for tracking the timeliness of cancer care through the ongoing use of metrics and milestones, and ensure that processes are implemented to improve the coordination of care for patients referred to other VA Medical Centers for cancer treatment. We further recommended that the VISN Director require a review of surgical wait times for cancer patients at the Miami VA Medical Center.

The VISN and Medical Center Directors concurred with our findings and recommendations. Several process improvements have been implemented and the Chief of Surgery at the Miami VA Medical Center reviewed surgical wait times for lung and renal cancer patients.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: Healthcare Inspection – Delays in Cancer Care, West Palm Beach VA Medical Center, West Palm Beach, Florida

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of allegations of delayed cancer care at the West Palm Beach VA Medical Center (the facility), West Palm Beach, FL.

Background

The facility is a level 1c, tertiary care Medical Center within Veterans Integrated Service Network (VISN) 8. The facility offers a number of specialty services involved in the treatment of cancer, including oncology, pulmonology, urology, and surgery. Diagnostic radiology services are available at the facility while radiation therapy treatments are offered to patients through Fee Basis authorizations for services with non-VA community providers. Some surgical procedures not available at the facility are provided at the Miami VA Medical Center (VAMC), approximately 70 miles away.

In December 2010, a confidential complainant alleged that there were marked delays between diagnosis and treatment for patients with malignant lung or renal (kidney) tumors. No patient names were provided, although a time frame of September through December 2010 was referenced. Specifically, the complainant alleged that:

- Patients did not receive timely treatment after a diagnosis of lung or renal cancer.
- These cancer patients did not obtain timely cardiac risk assessment when needed for clearance prior to surgery.
- Management was aware of, but unresponsive to, the above issues.

Scope and Methodology

We conducted a site visit February 16–17, 2011, at the facility and interviewed the Chief of Staff and other clinical, administrative, and management staff with knowledge relevant

to the allegations. Follow-up phone interviews were completed on March 22 and April 25. We examined peer review reports, journal articles, clinical practice guidelines, case conference minutes, committee meeting minutes, cancer registry lists, service agreements, and presentations and toolkits from the Veterans Health Administration (VHA) Systems Redesign-Cancer Care Collaborative. We reviewed data from Veterans Health Information Systems and Technology Architecture (VistA)[1] Consult Tracking and Appointment Management. We analyzed data published on the Veterans Support Service Center website for timeliness of care by treating specialty. We also reviewed electronic medical records for patients recently diagnosed with, and treated for, lung or renal cancer.

The inspection was conducted in accordance with the *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Delays in Cancer Treatment

While we did not find that care was delayed for those patients diagnosed with lung cancer, we substantiated that some patients did not receive timely treatment following diagnosis of renal cancer.

Lung Cancer

The facility uses a designated Advanced Registered Nurse Practitioner (ARNP) as a "Tumor Navigator" (TN) to coordinate care, order diagnostic tests and consultations (consults), and ensure that multi-disciplinary treatment planning occurs as needed for cancer patients. The TN primarily focuses on lung cancer patients. She does not receive formal consults, but gets verbal referrals from any provider at the facility, for patients with known or suspected cancer. She also performs case finding via a review of imaging view alerts (radiology results suspicious for lung tumor). On a tracking spreadsheet, the TN records relevant data, including dates of clinical events in the treatment continuum, for the patients she follows. Cycle times are not calculated; therefore, overall timeliness of care has not been analyzed, nor has timeliness been reviewed by the Cancer Committee.

Patients with lung cancer are reviewed in the Chest Conference. This is an inter-disciplinary team meeting that convenes weekly to review treatment planning for patients with known or suspected lung cancer. The services typically involved with the treatment of lung cancer are pulmonology, oncology, thoracic surgery, and radiation therapy. Depending on the location and type of tumor, as well as the stage of disease and other medical factors, treatment options include surgery, chemotherapy, radiation therapy, or a

[1] VistA is a VHA health information system.

combination of these. After specialty consultation, and in some cases additional work-up, treatment is scheduled.

We found that 82 patients were newly diagnosed with lung cancer in calendar year 2010. We reviewed the medical records of these 82 patients to determine the timeliness of their cancer care. The median wait time for new lung cancer patients to be seen by pulmonology was 16.2 days. The median wait time for new lung cancer patients to be seen by oncology was 17.2 days. While we were on site in February 2011, Medical Administrative Service staff used VistA Appointment Management software to provide us with the next available appointment for an oncology consult; the wait for a new patient was 11 days.

The median wait time for new lung cancer patients to be seen by thoracic surgery was 9 days. Although the facility only had one 0.2 full time equivalent (FTE) thoracic surgeon, we found no delays due to the surgeon's limited availability.

Radiation therapy is available in the community through Fee Basis. For those patients whose treatment plan involved Fee Basis care (radiation therapy and/or "Cyberknife"[2]), the consults were responded to immediately, and authorizations for treatment were generally issued within 1 business day.

For cancer treatment, VHA follows evidence-based standards from the National Library of Medicine, National Cancer Institute, Physicians Data Query.[3] While these guidelines specify recommendations for treatment, they do not include expected timeframes for when treatment should occur after diagnosis. In November 2010, the VHA Office of Patient Care Services released a study on the timeliness of lung cancer care. The VHA data, from 2007, showed the national average time from confirmed diagnosis to treatment of lung cancer was 35 days. The facility was included in this study. Their average time on the same metric was 37 days. This study also reported national median timeframes by treatment modality. Diagnosis to onset of chemotherapy was 28 days, diagnosis to onset of radiation therapy was 33 days, and diagnosis to surgical treatment was 50 days. Facility data on these metrics were not available.

We found that 28 of the 82 patients diagnosed with lung cancer in 2010 either did not ultimately receive cancer treatment or did not receive their treatment through the VA.

The reasons for this included:

- Choice of the patient
- Cancer was diagnosed at an advanced stage and the patient was referred for hospice care

[2] Cyberknife Robotic Radiosurgery System is a non-invasive alternative to surgery by delivering beams of high dose radiation to tumors.
[3] VHA Directive 2003-034, *National Cancer Strategy*, June 23, 2003.

- Patient pursued treatment outside of the VA
- Other medical conditions precluded treatment
- Further work-up was negative for malignancy

We evaluated the timeliness of care for 47 of the remaining 54 patients. These 47 patients had a confirmed diagnosis of lung cancer prior to initiation of treatment. The median timeframes from confirmed diagnosis to initiation of treatment are shown in Table 1 below.

Table 1. Timeframes from Lung Cancer Diagnosis to Treatment.

Diagnosis to Treatment: All Modalities	Diagnosis to Treatment: Radiation	Diagnosis to Treatment: Chemotherapy	Diagnosis to Treatment: Radiation/Chemotherapy Combined	Diagnosis to Treatment: Surgery
28.8 days	26.8 days	35.6 days	24 days	39.3 days
47 patients	26 patients	9 patients	9 patients	3 patients

These timeframes compare favorably to the VHA median timeframes reported in the 2010 report on timeliness of lung cancer care.

Renal Cancer

The TN who follows lung cancer patients is also tasked with following renal cancer patients. However, we were told that this provider is often detailed to other areas and does not have adequate time to closely follow this population. The facility could not provide a tracking spreadsheet for renal cancer where milestones in the treatment continuum are recorded. Because cycle times could not be calculated, the overall timeliness of care for renal cancer patients was not reviewed by the Cancer Committee, and delays in treatment were not identified.

Patients with renal cancer are reviewed in the inter-disciplinary Renal Case Conference, scheduled on a monthly basis. Services often involved in the treatment of renal cancer are urology and oncology. There were 10 patients diagnosed with renal cancer at the facility during 2010. We reviewed the medical records of these 10 patients to determine the timeliness of their cancer care. We found that 5 of the 10 patients did not pursue further treatment from the VA for their cancer. Treatment was completed for four of the remaining five patients; treatment is still pending for one patient.

Four of the 10 patients diagnosed with renal cancer in 2010 were referred to urology (the remaining patients diagnosed with renal cancer were already being followed by urology). The median wait for a new renal cancer patient to be seen was 11.75 days. Three of the 10 newly diagnosed renal cancer cases were referred to outpatient oncology. The median wait for a new renal cancer patient to be seen by oncology was 11.7 days.

Per National Cancer Institute clinical practice guidelines,[4] the treatment of choice for renal cancer is nephrectomy,[5] a surgical procedure performed by a urologist. As with lung cancer, the VHA clinical practice guidelines for renal cancer do not specify time frames for surgical treatment. The National Cancer Institute guidelines are clear; however, that early surgical treatment is desirable as the survival rate declines sharply if the cancer has time to spread.

Of the five patients who received their treatment through the VA, two patients had their surgery at the facility. Only one of these two patients had a confirmed diagnosis prior to surgery. The time from diagnosis to surgery was 35 days.

The remaining three patients were referred to the Miami VAMC for procedures not available at the facility. Patient 1 had a nephrectomy at the Miami VAMC 113 days after receiving a confirmed diagnosis of renal cancer. Patient 2 opted for computed tomography guided radio frequency ablation (CT Guided RFA), an interventional radiology procedure. This procedure was performed 107 days after diagnosis. Patient 3 was approved for a nephrectomy at the Miami VAMC, but is still waiting for this surgery. His scheduled surgery (May 2011) will be 155 days from the date of diagnosis. There is a significantly longer wait time for treatment for those patients who were referred to the Miami VAMC. Table 2 below illustrates the cycle times for these three patients.

Table 2. Timeframes from Renal Cancer Diagnosis to Treatment at Miami VAMC.

	Time from Diagnosis to Referral	Time from Referral to Treatment	Total Time from Diagnosis to Treatment
Patient 1	21 days	92 days	113 days
Patient 2	4 days	103 days	107 days
Patient 3	18 days	137 days*	155 days*

*Based on date of scheduled treatment; treatment is pending.

On March 22, 2011, we spoke with the Associate Chief of Staff (ACOS), the Chief of Surgery, and a urologist at the facility who concurred that these timeframes for treatment of renal cancer were "unacceptable" and told us they were unaware of this issue. The urologist told us that these cases should "definitely have been treated as urgent." However, medical record documentation revealed that all three of these consults to Miami VAMC were sent with "routine urgency." We found no documentation to

[4] National Library of Medicine, National Cancer Institute, Physicians Data Query (PDQ), http://www.cancer.gov/cancertopics/pdq/treatment/renalcell/HealthProfessional, accessed February 7, 2011.
[5] Nephrectomy is the partial or complete removal of a kidney.

indicate that the referring providers called to speak to the Miami VAMC providers about the referred patients.

We were told that there is no service agreement or other memorandum that delineates how facility patients should be managed when referred to another VA Medical Center. There was no process in place at the facility to track and monitor the progress of those patients who were referred to the Miami VAMC for treatment. We also found that there was no process in place to notify the referring provider that the procedure had been scheduled. Had providers been aware of the protracted wait times for treatment, they could have discussed other treatment options with the patients, referred them to another facility, or sought Fee Basis authorization for non-VA treatment in the community.

Issue 2: Delays in Obtaining Cardiology Clearance for Surgery

We did not substantiate the allegation that there were delays in obtaining cardiology pre-operative risk assessment (hereafter referred to as "clearance") for surgery. We found that cardiology consults were responded to in a timely manner for the seven patients with lung cancer who were referred for cardiology clearance. We found that six of seven consults were answered within the requested timeframe. We also found that six of seven consults had documentation of a clearance statement written on or attached to the consult note. On average, these patients were seen by cardiology within 14 days of the consult request, and the statement that the patient was "cleared" for surgery was documented within 25 days of the request. None of the patients with renal cancer in our sample were referred to cardiology for clearance.

Issue 3: Management Responsiveness

We substantiated the allegation that managers were aware of delays in renal cancer care for one patient, but made no efforts to follow up on this. We did not identify significant delays in lung cancer care. Managers told us that prior to our February site visit, they were unaware of problems with timely renal cancer care. Although we discussed this issue with the ACOS, the Chief of Surgery, and the urologist on March 22, 2010, and the urologist again on April 25, no action was taken to expedite care for one patient still awaiting treatment—at that time, 126 days since confirmed diagnosis.

On March 22, we conducted a telephone interview with the ACOS, the Chief of Surgery, and the urologist to discuss delays in care for patients referred to the Miami VAMC. We informed them that two patients referred to the Miami VAMC had waited 107 and 113 days for surgery following confirmed diagnosis of renal cancer, and that a third patient was still awaiting surgery which was scheduled to occur 155 days post diagnosis. The ACOS told us that had he been informed of the long waits faced by patients referred to the Miami VAMC for surgical treatment of their renal cancer, these patients would have been approved for Fee Basis treatment. He also told us that he was aware that the TN

was frequently tasked with duties in other clinical areas and did not have dedicated time to follow or track the renal cancer patients at the facility.

The Chief of Surgery and the Urologist told us that they were also unaware of these long delays. We informed them that Patient 3 was still awaiting treatment, because the surgery was scheduled for late May 2010. These clinical leaders responded that this cycle time of 155 days was unacceptably long, especially because this patient's work up for suspected renal cancer had initially begun in June 2010.

On April 25, 4 weeks after we first discussed this with the facility, we reviewed Patient 3's medical record to see if any action had been taken. We found no evidence that anyone from the facility had contacted the Miami VAMC or the patient about his surgery date. There was no documentation of any effort to arrange Fee Basis treatment. We found documentation that Patient 3 had presented to the Medical Center's Emergency Department with pain (described by the treating provider as "cancer pain") in late April. He was given morphine and instructed to keep appointments as scheduled with the Miami VAMC.

On April 25, we again interviewed the urologist. He was unaware of the patient's recent visit to the Emergency Department and confirmed that there had been no attempt to expedite treatment for this patient. The patient's surgery was still scheduled for late May at the Miami VAMC, 350 days from first suspicion of renal cancer and 155 days from confirmed diagnosis.

Conclusions

While we found no pattern of delays in care for those patients diagnosed with lung cancer, we substantiated the allegation that there were delays in treatment for patients diagnosed with renal cancer.

We found that renal cancer patients referred to the Miami VAMC waited between 3 and 5 months from confirmed diagnosis for their treatment. Facility providers sent consults to the Miami VAMC on these cancer patients with routine urgency, and there was no mechanism in place to follow their progress and verify that treatment was provided.

We substantiated the allegation that facility management was aware of problems with timely renal cancer care for one patient, but made no effort to follow up on this. We did not substantiate the allegation that there were delays in obtaining cardiology risk assessments for lung and renal cancer patients scheduled for surgery at the facility.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that formal processes are strengthened for tracking the timeliness of cancer care through the ongoing use of metrics and milestones.

Recommendation 2. We recommended that the Medical Center Director ensure that processes are implemented to improve the coordination of care for patients referred to other VA Medical Centers for cancer treatment.

Recommendation 3. We recommended that the VISN Director require a review of surgical wait times for cancer patients at the Miami VAMC.

Comments

The VISN and Medical Center Directors agreed with our findings and recommendations and provided acceptable action plans. See Appendixes A and B (pages 9–14) for the full text of the Directors' comments. We will follow up on the proposed actions through completion.

(original signed by:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 2, 2011

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Healthcare Inspection – Delays in Cancer Care, West Palm Beach VA Medical Center, West Palm Beach, Florida**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

Thru: Director, VHA Management Review Service (10A4A4)

I have reviewed and concur with the conclusions presented by the Office of the Inspector General in the Healthcare Inspection – Delays in Cancer Care, West Palm Beach VA Medical Center, West Palm Beach, Florida.

(*original signed by*:)
Nevin M. Weaver, FACHE
Director, VA Sunshine Healthcare Network (10N8)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 25, 2011

From: Director, West Palm Beach VA Medical Center (548/00)

Subject: **Healthcare Inspection – Delays in Cancer Care, West Palm Beach VA Medical Center, West Palm Beach, Florida**

To: Director, VA Sunshine Healthcare Network (10N8)

Thank you for your comprehensive report on renal cancer tracking when patients are referred to a Medical Center outside West Palm Beach VA.

(*original signed by*:)
Charleen R Szabo, FACHE
Director, West Palm Beach VA Medical Center (548/00)

Directors' Comments to Office of Inspector General's Report

The following Directors' comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that formal processes are strengthened for tracking the timeliness of cancer care through the ongoing use of metrics and milestones.

Concur **Target Completion Date: June 30, 2011**

Facility's Response:

1. The consult entitled "Referrals Outside West Pam Beach (WPB)" has been reviewed and the following mandatory field has been added:

   "Is this request for cancer treatment or evaluation?" Yes or No

   When the response is "Yes", the referral title changes to "Referrals Outside WPB-CANCER" and the consult will print on the WPB Transfer Coordinator's printer. When the response is "Yes", the urgency of the consult automatically changes from "Routine" to "Within 2 Weeks."

2. The new consult entitled "Referrals Outside WPB-CANCER" asks if the WPB provider spoke to a point of contact person (POC) in Miami and if so, the name of the POC.

3. WPB Urology providers have been instructed to ensure all pulmonary and cardiac work-ups, if required, are completed prior to placing the consult. A third question was added to the consult for non-emergent cases requiring the urology provider to document the patient is optimized for surgery.

4. All hand off communication between WPB and Miami providers will be clearly documented in the electronic medical record (EMR).

5. The WPB Transfer Coordinator will hand off all consults for Referrals Outside WPB-CANCER to the WPB Tumor Navigator.

6. All renal cancer patient consults will be coded "90" and an alert to identify the renal patients will be sent to the WPB Tumor Navigator and Physician Assistant.

7. The WPB Tumor Navigator will enter all consults for radiology code "90" renal cancer into a spreadsheet.

8. A Physician Assistant in WPB Urology has been identified as the POC for all urology cases consulted out to other VAs or as a result of Fee Basis.

9. A Nursing Coordinator dedicated to Miami Urology has been identified and will be the POC for WPB Physician Assistant.

10. The WPB Physician Assistant will have access on the U-drive to the WPB Tumor Navigator spreadsheet.

11. The WPB Transfer Coordinator, WPB Physician Assistant and WPB Tumor Navigator will meet monthly to discuss plan of care timeline progression and the Physician Assistant will facilitate treatments/procedures as required.

12. The WPB Physician Assistant will follow up when delays are identified with the Miami POC to ensure renal patients are seen within 3 weeks as requested. Any patient not seen within 3 weeks will be identified and the Chief of Surgery and the Section Chief for Urology at WPB will be notified by the WPB Physician Assistant.

13. During the weekly follow-up the WPB Physician Assistant will identify patients that have completed WPB work-up and report to Miami Urology Nurse Coordinator to ensure renal patients are then scheduled to see Miami Urology Surgery timely.

14. The WPB Transfer Coordinator and the Physician Assistant will review all "Plans for Care" after the patients are seen at the referred Medical Center and will ensure all treatment/procedures required that are to be completed at WPB will be ordered and completed timely.

15. Timeliness of care cycle times will be calculated and analyzed and will be compared to the national average from "confirmed diagnosis to treatment." The data will be tracked and trended and will be reported quarterly by the WPB Tumor Navigator to the Cancer Committee up to the Clinical Executive Board semi-annually (January and July).

Status: Pending full implementation

Recommendation 2. We recommended that the Medical Center Director ensure that processes are implemented to improve the coordination of care for patients referred to other VA Medical Centers for cancer treatment.

Concur **Target Completion Date: June 30, 2011**

Facility's Response:

1. The WPB ARNP Tumor Navigator, on an ongoing basis, will track cancer case treatment progress internally and externally to ensure timely treatment.

2. The WPB Transfer Coordinator and Physician Assistant will ensure all required tests and procedures recommended by the referral facility to be performed at WPB are ordered and completed timely.

3. The WPB Transfer Coordinator will report testing/procedures required with the scheduled date to the WPB Physician Assistant.

4. The WPB Physician Assistant will track test/procedures completed as scheduled and will identify all timeliness in care issues when identified. WPB Physician Assistant will then discuss issues with the referral POC to identify timely resolution.

5. All timeliness in care issues that cannot be facilitated will be identified by the WPB Physician Assistant and reported when identified to the WPB Tumor Navigator, the WPB Chief of the Surgery and the WPB Urology Department Section Chief.

6. All timeliness in care issues identified to the WPB Chief of Surgery and POC Urologist will be discussed when identified with Miami POC Urologist. The updated plan of care will be documented in the EMR at both facilities.

7. During this collaborative meeting, if timeliness of care issues dictates, a Fee Basis Consult will be considered and the justification for the decision will be documented in the EMR.

Status: Pending full implementation

Recommendation 3. We recommended that the VISN Director require a review of surgical wait times for cancer patients at the Miami VAMC.

Concur **Target Completion Date: June 2, 2011**

Facility's Response:

The Chief of Surgery at the Miami VAMC conducted a review of urology and thoracic cancer surgery cases to identify potential delays in care. After the review and analysis of the cases, no issues were identified regarding delays in the thoracic surgery cancer cases. A few patients with urological cancers where identified where timeliness may have been an issue. However, the disease process was very different in those cases. To effect a change in care, the Miami VAMC has determined that all patients with kidney or bladder cancer identified in the consults will be seen within 3 weeks of referral.

Status: Complete

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Christa Sisterhen, MCD, Regional Director, Project Leader Karen McGoff-Yost, LCSW, Team Leader Michael Shepherd, MD

Appendix D

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