ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

Radiation Oncology at the VA Medical Center in Dallas, Texas December 20, 2016

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG), South Central Field Office (SCFO) in Dallas, TX, received Hotline Contact 2014-17001, which included the following allegations:

- Severe delays in patient care in the Radiation Oncology Service (ROS) at the VA Medical Center (VAMC) in Dallas, TX
- ROS patients on secret lists
- ROS patients lost to follow-up or never received an appointment at all
- A low number of ROS consults were seen each week
- ROS patients waiting hours past their appointment times
- An ROS provider who directed the ROS Administrative Officer (AO) to manipulate data to cover up delays in ROS patient care
- Management was told to "get rid of anything that shows delays."

During an interview, the complainant provided a list of 55 veterans who allegedly were subject to delays in care. The names were provided to the VA OIG Office of Healthcare Inspections (OHI) for review to determine whether the veterans encountered a delay in receiving ROS care. During the course of the investigation, the complainant provided additional names of patients and other information.

The first five complaints listed were sent to the Veterans Health Administration (VHA) to be addressed. VHA's response was reviewed and accepted by OHI and is discussed at the end of Section 3. The Office of Investigations addressed the remaining complaints.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the complainant, VA OIG interviewed nine employees working in ROS.

- **Records Reviewed:** VA OIG reviewed the audio tape of the May 27, 2014 meeting and the medical records of 80 patients, including the 55 alleged to have been subject to delays in care.

3. Summary of the Evidence Obtained From the Investigation

Issue 1: Allegations Addressed by the Office of Investigations

Interviews Conducted

- A nurse working in ROS said that it was very rare for a patient to wait a long time for his/her initial consultation appointment and often, delays existed because ROS needed previous treatment records or additional information from the patient (or the patient's primary physician). When questioned about the "desired date" versus the "available date," the nurse admitted that he was confused and not sure how to enter the desired date and did not appear to know what role the desired date played. The nurse explained that ROS uses a system called MOSAIQ® Radiation Oncology, which is used to determine the doctor's availability. MOSAIQ® does not interface with Computerized Patient Record System (CPRS) or Veterans Health Information Systems and Technology Architecture (VistA). The nurse did not specifically remember attending the mandatory monthly staff meeting on May 27, 2014. He had never seen or heard of a separate "secret list" denoting troubled patients who may have received delayed care. He also was not aware of any situation in which a patient died because of lack or delay of care. He stated that he was never instructed by anyone to alter patient information and scheduling to show the process in a more favorable light.

- An ROS Medical Support Assistant was asked about the monthly staff meeting on May 27, 2014. She stated that the provider was upset about scheduling, but she "couldn't remember what started it." She recalled that an ROS employee gave the group some statistical information regarding patient wait times, which caused that employee and the provider to go "back and forth" regarding acceptable wait-time periods and how they should be calculated, in addition to the definition of desired date. She also stated that the meeting was audio recorded by another staff member. She was not aware of a secret list in which troubled patients were documented. She did not know of any delays in care, treatment, or consultations that resulted in harm to any patients.

- A manager in Outpatient Services and an employee in the VAMC's Office of Public Affairs were asked about the ROS "Dashboard," which is a Microsoft Excel spreadsheet of data related to various metrics, including wait times, missed opportunities, and so forth. They explained that VAMC Dallas was using the creation date of the appointment as the starting point in ROS with regard to VA's since-rescinded goal of having patients seen within 14 days of their desired date. The manager provided the ROS Dashboard via email.

- An administrative employee in ROS explained that every service has a Dashboard, which is overseen by VAMC Quality Management. The Dashboard is a Microsoft Excel spreadsheet summary of performance measurements that is updated every month and reported at "Morning Meetings." She stated that she was responsible for maintaining the ROS Dashboard.

When questioned about the May 27, 2014 meeting, she stated that staff meetings were common and were always audio recorded. When asked about her reported altercation with the provider, she explained that the day the ROS nurse/case manager scheduled the patient for an appointment was considered the "create date" within the Dashboard. The Dashboard tracks the number of days from the create date to the actual consult appointment date and it was supposed to be less than 14 days. The provider disagreed with that method and believed that the measurement should be from the desired date to the actual appointment date. She stated that the provider explained in the meeting that the term desired date could denote either the patient's desired date or the doctor's desired date. Her dispute with the provider was about his definition of desired date. She stated that she did not feel she was being threatened or attacked by the provider; they merely had "a difference of opinion." She further explained that she received her guidance from the VAMC Executive Office. She also stated that she and the provider had discussed the new patient 14-day performance measurement on several occasions before the May 27, 2014 meeting. Because the provider did not believe that it was an accurate measurement, he wanted it removed from the Dashboard. She said that she told the provider that whether or not they agreed on the new patient 14-day performance measurement, it had to stay on the Dashboard. She did not feel delays in care, treatment, or consultations had harmed any patients. She also provided a copy of the recording for the May 27, 2014 meeting.

- A medical dosimetrist stated that when there were only two ROS doctors, patients could go as long as 6 weeks between being diagnosed with cancer and seeing a doctor for their initial consultations.[1] She stated that these wait times had been reduced dramatically once the problem of extended wait times had been exposed by the media and conceded that, often, treatment is delayed because additional information or tests must be obtained from the patient or their primary doctor. She reported that the providers always wanted their nurses, who schedule patients, to make sure they list the actual appointment date as the desired date, ensuring there is no appearance a patient waited an extended period of time to see the doctor. She has never seen or heard of a separate secret list showing troubled patients who might have received delayed care.

- Another ROS nurse stated that she asks the patient for a desired date, checks for the "next available date," and then enters both dates in VistA/CPRS; however, this change occurred recently. She noted that she had always scheduled patients as early as possible, but before the recent change, she entered the desired date as the next available date. She explained that this was just "how things were done," and it was not done to deceive anyone. She said that it was confusing because of the "conflicting guidance" within VA. She was not aware of any secret lists kept by staff and was not aware of any lists kept to keep track of problem patients. She further said that ROS treated patients as quickly as

[1] According to the American Association of Medical Dosimetrists, a dosimetrist is a member of the radiation oncology team who has knowledge of the overall characteristics and clinical relevance of radiation oncology treatment machines and equipment, is cognizant of procedures commonly used in brachytherapy and has the education and expertise necessary to generate radiation treatment. According to the Cancer Treatment Centers of America, brachytherapy is an advanced cancer therapy involving use of radioactive seeds or sources.

possible and that delays were usually the result of the patient not being "staged" completely. She explained that sometimes, the patient must undergo, or finish healing from, some other necessary medical procedure before treatment could begin. She further explained that sometimes delays arose because previous treatment records were needed. She stated that the doctors did not purposely slow down their work or cause delays that may harm patients. She reported that she attended a mandatory monthly staff meeting on May 27, 2014. She recalled a debate between the provider and the ROS employee concerning scheduling patients and how the appointments were documented. She did not feel that the provider was trying to manipulate the process or cover up delays within ROS. She felt there was simple confusion regarding scheduling patients and how the appointments are documented for performance purposes.

- Another provider was asked about how he was held accountable for the 14-day requirement and how it affected ROS. He stated, "I'm not sure how to answer this one" and explained that the 14-day requirement changed over time. In the end, he said, "The answer is, we get people in as fast as we can." He denied ever instructing ROS nurses/case managers to respond to scheduling questions in any particular way and added that until recently, he was unaware that the system required information about desired dates or appointment dates. He also denied ever instructing anyone to make ROS performance numbers look better than they actually were. He noted, "I don't have time to manipulate the system."

  When questioned about severe delays in patient care, he responded that in some cases, a patient would be treated faster under his care than in the private medical sector. He further stated that patients often needed other medical treatments before starting cancer therapy. He gave the example of a patient with head or neck cancer who must have a dental evaluation before starting a cancer treatment. Often, patients will refuse to receive these early treatments, thus prolonging their initial cancer treatment. He considered ROS patient care to be "quick" and noted that he would like the "turnaround time" to be even faster, but attributed that to the lack of staffing.

  He denied the existence of a secret list regarding difficult patients. He also denied any involvement in preventing patients from receiving care. To his knowledge, a patient had never been "lost" purposefully. (In this case, the word "lost" as originally used by the complainant was meant to convey that patient follow-up appointments were not being completed due to clerical errors and/or administrative bureaucracy.) However, he did concede that the VA system was cumbersome and complicated and it would be possible for a patient to be lost due to administrative errors.

  He said that the number of consults seen by him weekly would vary. He sets aside 2 days a week to see new patients and 2 days a week for administrative duties. However, this schedule is only set "in theory" and he often sees new patients on days set aside for administrative duties. He stated that he "generally sees more than three new patients a week" and had "seen five new patients" on the previous day. He further stated that his patients do not wait more than 30 minutes for their appointment. He reported that there are often circumstances when he has to reprioritize his schedule because of the nature of his patients' conditions. Some patients may require more time than expected. He also

pointed out that patients often show up late and he has to "try to fit them in" to the remainder of the schedule.

Regarding the May 27, 2014 staff meeting, he did not consider the discussion between the provider and the ROS employee to be an argument. He stated that the provider is a "smart guy," but "can get excited." He further noted that the provider had no authority to make changes and was just giving his opinion as to what they should document when indicating the patients' desired date versus their actual appointment date. The provider was not telling anyone what to do specifically because he did not have that authority.

With regard to backdating patient notes, he said that it would be impossible to add notes to a patient's electronic file without the date being noted in the system. Therefore, it would be impossible to add or change information in a patient's file to make his work appear in a more favorable light.[2]

Records Reviewed

- The recording of the May 27, 2014 meeting did not substantiate the allegation that the provider ordered an administrative employee in ROS to manipulate data in order to cover up delays in ROS patient care. In fact, the recording contradicted the allegation.

- A review by OHI of medical records relating to the 83 ROS patients identified by the complainant did not find that patients suffered harm and/or death, as alleged, because of any delay in scheduling.

Issue 2: Allegations Addressed by VHA

VA OIG sent the unaddressed allegations made by the Office of Investigations to VHA, which reviewed them and provided responses. The responses, discussed below, were subsequently reviewed and approved by OHI.

Allegation: It was alleged that there were severe delays in patient care, patients on secret wait lists, and patients lost to follow-up or who had never received an appointment.

VHA Response: A complete review of all patients who were referred to the Radiation Oncology Service in the last 15 months (January 2014–March 2015) was conducted. The average wait time from the date the consult was received to the date the patients were seen was 23.5 days. Patients waited no longer than 15 days to start treatment from the date that treatment planning started. There were no secret wait lists located in the Radiation Oncology Service. The only list of patients in Radiation Oncology is in the treatment system, MOSAIQ®. All patients who were referred to the service were either seen by a physician or canceled by the requesting service, or the patient requested not to be seen when contacted for an appointment.

[2] Although this may appear to be true from the perspective of a user with normal application package privileges, such changes can be made by a small group of VA Office of Information and Technology users with elevated application package privileges.

Allegation: Three consults were seen per week for the past 2 years, then patients were delayed again, and must wait weeks to months in some cases before they were able to start treatment for their cancer.

VHA Response: A complete review of consults scheduled from January 2013 to December 2014 showed an average of nine consults per week scheduled for the year 2013 and 10 consults per week scheduled for the year 2014. The only reason patients were delayed was because the patients were not clinically stable and/or ready for treatment.

Allegation: It was alleged that veterans waited hours past their appointment times.

VHA Response: The service had no documented cases of veterans waiting hours past their appointment times. All veterans were seen within 30 minutes of their appointment time. Radiation Oncology had not received any patient complaints regarding this issue.

In addition to the allegations received through the OIG Hotline, VHA was requested to address the following two questions:

Question 1: What steps, apart from the Veterans Choice Act, have you used to increase access?

VHA Response: Patients are sent to non-VA care for referral to the community if the service is unable to see the patient within 30 days. Radiation Oncology and Hematology Oncology work together to coordinate a patient's care, so that if combined radiation therapy and chemotherapy are needed, both are given in the community.

Question 2: What are the current wait times for this service?

VHA Response: The current wait time cannot be found in the scheduling package; however, the next appointment available is within 18 days for new consultations and within 25 days for follow-ups.

OHI reviewed VHA's responses and determined them to be adequate. OHI recommended case closure; OIG Hotline staff closed this portion of the complaint and recorded it as unfounded.

4. Conclusion

There is no evidence that an ROS provider directed the ROS AO to manipulate data to cover up delays in ROS patient care, and there is no evidence that management was told to "get rid of anything that shows delays." There is contradicting testimony that delays even existed; however, the witnesses who spoke of delays conceded that delays were caused by the fact that ROS needed previous treatment records or additional information from patients (or the patients' Primary Care physicians). Most importantly, OHI reviewed more than 80 patient records, which were identified by the complainant, and did not find that patients suffered harm and/or death as a direct result of any scheduling or treatment delays. During interviews, it was determined that both ROS nurses used "next available" as the desired date. However, nothing was found to indicate that this was done specifically to manipulate VA's

since-rescinded goal of having patients seen within 14 days of their desired date. In fact, the investigation found that using next available as the desired date had no effect on the 14-day performance measure because VAMC Dallas was using the creation date of the appointment, not the desired date, as the starting point for measuring wait times.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on February 27, 2016.

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For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.