Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00268-66

Healthcare Inspection

Eye Care Concerns
Eastern Kansas Health Care System
Topeka and Leavenworth, Kansas

December 22, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the validity of allegations concerning eye care at the Topeka and Leavenworth, KS, divisions of the Eastern Kansas Health Care System (system).

We substantiated the allegation that Leavenworth VA Medical Center (VAMC) Eye Clinic staff used an unapproved wait list for patients awaiting cataract surgery and determined that system leadership did not ensure the staff were adequately trained to use the required surgical scheduling software package. We did not substantiate that the unapproved wait list was created to falsify cataract surgery wait times because the Veterans Health Administration (VHA) does not track surgery wait times for this specific procedure.

We learned the system had a 6-month wait for cataract surgery at the time of the complaint on September 18, 2014. However, at the time of our onsite visit on November 19, 2014, system leadership had instructed staff to reduce the cataract surgery wait time to no more than 90 days and, to achieve this, had been authorizing Non-VA Care more frequently.

We substantiated that providers did not consistently enter eye care requests for new Leavenworth VAMC and Topeka VAMC Eye Clinic patients using the consult referral process as required. However, we could not substantiate the allegation that the providers did not follow the required consult process in an attempt to falsify wait times.

We did not substantiate that cataract surgeries were completed unnecessarily for the two identified patients nor that patients were harmed while awaiting surgery.

We substantiated the allegation that ophthalmologists' productivity was below expected thresholds. The system ranks in the lowest 25th percentile for ophthalmologists' productivity among VHA facilities of similar complexity. We determined that improved productivity may reduce cataract surgery wait times.

We found intra-departmental discord and poor communication at the Topeka VAMC and Leavenworth VAMC Eye Clinics and learned both Eye Clinics had not had a chief for 6 years.

We recommended that the System Director ensure Eye Clinic Leavenworth VAMC staff use only an approved cataract surgery wait list, that providers use the Computerized Patient Records System for eye care consults, and that system leadership explore and implement measures to improve communication and operations.

Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes B and C,

pages 9–13 for the Directors' comments.) We will follow up on the planned actions until they are completed.

We disagree with the Directors' characterization of the list of patients waiting to be scheduled for eye surgery as a checklist rather than a wait list. We maintain that the system used this list to track patients awaiting cataract surgery, in lieu of the electronic wait list. We agree that the cataract surgery wait list contains more information than a typical wait list and may serve to ensure patients are tracked through pre- and post-operative appointments. However, we focused on the portion of the list that was specific to patients waiting for cataract surgery. The Veterans Integrated Service Network and System Directors state, "The checklist listed Veterans that had been seen by ophthalmology and needing to be scheduled for cataract surgery." Many of the patients awaiting surgery had been on this list for several months. We interpret this use of a list as a wait list. Furthermore, documents we obtained from system staff during our review referred to the list at issue as a wait list.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the validity of allegations concerning eye care access and quality of eye care at the Topeka, KS, and Leavenworth, KS, divisions of the VA Eastern Kansas Health Care System (system).

Background

In 1998, the Dwight D. Eisenhower VA Medical Center (VAMC) located in Leavenworth, KS, (Leavenworth VAMC), and the Colmery-O'Neil VAMC located in Topeka, KS, (Topeka VAMC), were integrated to form the system. The Topeka and Leavenworth VAMCs are approximately 65 miles apart and governed by one executive leadership team.

The system is part of Veterans Integrated Service Network (VISN) 15. It provides a broad range of inpatient and outpatient health care services and serves a veteran population of about 102,500 throughout 37 counties in Kansas and Missouri.

Eye clinics in the Veterans Health Administration (VHA) are specialty clinics that provide the full spectrum of primary, secondary, and tertiary eye care services. The system offers eye care services at the Leavenworth VAMC and Topeka VAMC. Although at different locations, the eye clinics are considered one service. The Leavenworth VAMC Eye Clinic employed two ophthalmologists, one optometrist, three health technicians, and one medical support assistant. The Topeka VAMC Eye Clinic employed two optometrists, two health technicians, and one medical support assistant. All system cataract surgeries were performed at the Leavenworth VAMC by one of the two system ophthalmologists. The direct supervisor for the Topeka and Leavenworth VAMC Eye Clinic staff was the associate chief of surgery.

Allegations. The OIG received a confidential complaint concerning multiple system Eye Clinic concerns, which are summarized below.

- Leavenworth staff used a "parallel" electronic cataract surgery wait list to purposely falsify wait times.
- System providers did not enter eye care consults, as required, to purposely falsify wait times.
- A system ophthalmologist performed unnecessary cataract surgeries.
- Delayed cataract surgeries harmed patients.
- A system ophthalmologist's productivity was less than expected.

Scope and Methodology

The period of our review was October 2014 through March 2015. We conducted site visits at the Leavenworth and Topeka VAMCs on November 19 and 20 and December 4, 2014. We interviewed system leadership; Leavenworth VAMC and Topeka VAMC Eye Clinic ophthalmologists, optometrists, clinical and support staff; and current and past Eye Clinic leaders.

We examined system policies, VA and VHA handbooks and directives, and other related documents. We reviewed the electronic health records (EHRs) of 13 patients whose names were provided to us by the complainant. We also reviewed emails provided to us and the Eye Clinic electronic spreadsheet that contained the names of patients who needed to be scheduled for surgery.

We reviewed peer review findings and patient advocate complaints. We also evaluated provider productivity, clinic access, and wait times data from VHA's Office of Productivity, Efficiency, and Staffing (OPES).[1]

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

[1] Office of Productivity, Efficiency, and Staffing, *Specialty Productivity- Access Report and Quadrant Tool (SPARQ)*, Fiscal year 2014

Inspection Results

Issue 1: Unapproved Wait List

We substantiated that Leavenworth VAMC Eye Clinic staff used an unapproved cataract surgery wait list to track referrals. However, we found no evidence of intent to falsify wait time data.

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 2010, requires the use of an electronic wait list (EWL) for new patients waiting to be scheduled or waiting for a panel assignment. A Deputy Undersecretary for Health for Operations and Management Memorandum, *Inappropriate Scheduling Practices*, dated April 26, 2010, specifically called for immediate elimination of all inappropriate scheduling practices. The Memorandum identified 17 inappropriate scheduling practices, including the use of a manual system instead of the EWL.

We found that Leavenworth VAMC Eye Clinic scheduling staff created and used an unapproved wait list spreadsheet for patients referred for cataract surgery. The wait list was kept on a secure drive accessible to scheduling staff. The wait list spreadsheet was created in 2006 to track cataract surgery referrals and was never discontinued. During our interviews, we learned staff lacked training regarding the EWL feature in the surgical scheduling software package. Staff indicated they did not understand how to use the surgical scheduling software package EWL, which is different from the EWL associated with the clinic and specialty scheduling package. We were unable to identify any staff, supervisors, or managers who understood or had been trained to use the surgical scheduling package EWL function. Staff aware of the tracking spreadsheet did not believe the wait list spreadsheet violated VHA policy. We determined the purpose for the unapproved list was not to falsify wait time data because VHA does not currently track or collect data specifically for cataract surgery wait times.

System leaders informed us they planned to implement training and use of the surgical scheduling software package. However, as of the last day of our onsite visit on December 4, 2014, they had not yet taken action.

Issue 2: Eye Care Consults

We substantiated that system providers did not consistently enter eye care consults through the consult feature in the Computerized Patient Record System (CPRS)[2] as required. We could not substantiate if these practices were purposefully done in an attempt to falsify wait times.

VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011, and local policy requires that all new eye care patients be referred through the CPRS consult feature.

[2] CPRS is VHA's electronic health record.

The complainant alleged that system providers made eye care referrals via the physician orders function within CPRS, and not through the consult feature, intending to falsify wait time data. To evaluate this complaint, we interviewed staff and reviewed the EHRs of 11 patients identified by the complainant, the Leavenworth VAMC and Topeka VAMC Eye Clinic consult list for calendar year 2014, VISN Support Services Center wait time data, and the system's Eye Clinic Action Plan.

Various primary care providers had referred the 11 identified patients for new eye clinic services during the month of March 2014. Our EHR review showed that 9 of the 11 patients had physician orders rather than consults for new Eye Clinic service. The remaining two had both a consult and a physician order.

The Leavenworth VAMC and Topeka VAMC Eye Clinic consult list reflected 4,765 consults that were appropriately placed during 2014. For the month of March, 974 consults were appropriately placed for Eye Clinic services at both locations. During staff interviews, we learned that the referral process for new patients had been inconsistent. Staff indicated physician orders for new Eye Clinic services had been used in lieu of, or in conjunction with, a consult. System leaders told us the process had been clarified and only consults were used to refer patients for new Eye Clinic services.

We determined system providers used various referral processes for patients to access the Eye Clinic in 2014. We also determined the system identified issues regarding accessing Eye Clinic services and took corrective steps. We could not substantiate whether inconsistent referral practices occurred to purposely falsify wait times; however, we found that more than 4,700 consults were placed appropriately in fiscal year (FY) 2014. Regardless, staff described a lack of system guidance regarding consult management, and wait times were not improved.

Issue 3: Unnecessary Cataract Surgeries

We did not substantiate the allegation that an ophthalmologist conducted "needless and unnecessary" cataract surgeries. We reviewed relevant internal documents and found no specific instances to support the allegation. In addition, we reviewed patient advocate and compliance officer complaints and found no concerns about the quality or appropriateness of cataract surgeries. We also reviewed the EHRs of two patients identified by the complainant as allegedly undergoing unnecessary surgery and did not find evidence of needless procedures.

Issue 4: Patient Harm Due to Cataract Surgery Wait Times

We did not substantiate the allegation that patients were harmed due to excessive cataract surgery wait times. We found the system had a 6-month wait for cataract surgery at the time of the complaint. However, all the cataract surgeries were identified as elective and not emergent. During an interview, the complainant withdrew this allegation stating, "No direct medical harm has come from a cataract surgery." We reviewed relevant internal documents and found no data to support the allegation. In

addition, we reviewed patient advocate complaints and found no concerns regarding harm to cataract surgery patients.

Prior to our onsite review, system leadership identified and responded to the 6-month cataract surgery wait time, setting a 90-day goal. Additionally, Non-VA Care was increasingly utilized to help meet the goal of timely cataract surgery.

Issue 5: Less Than Expected Ophthalmologists' Productivity

We substantiated the allegation that the system ophthalmologists' productivity was less than expected. According to VHA Eye Care Handbook 1121.01, ophthalmologists' productivity expectations are specified by utilizing relative value units (RVUs). VHA uses a RVU-based model for measuring productivity of specialty providers and providing staffing guidance for specialty services. Provider productivity data is available via the OPES website.

VHA ophthalmology providers have expected performance thresholds dependent on facility complexity.[3] The system is a 1c-complexity facility. Our review of ophthalmologist productivity data revealed the system placed in the lowest quarterly percentile, which is considered inefficient by VHA standards. As displayed in Appendix A, overall ophthalmologist productivity at the system lags that of other VHA 1c-complexity facilities. The system reported an average of eight cataract surgeries per week. However, from October 1, 2013, through September 30, 2014, the system had an average of five cataract surgeries performed per week.

We determined that improving ophthalmologists' productivity might reduce cataract surgery wait times and the number of Non-VA Care authorizations for cataract surgery consults.

Issue 6: Intra-Departmental Discord and Lack of "Hands-on" Leadership

During our interviews and review of documents starting on November 20, 2014, we found two additional opportunities for improvement. We learned that the Leavenworth VAMC and Topeka VAMC Eye Clinics have had a history of poor communication and negative relationships between some staff.

Staff provided consistent examples of poor communication between Eye Clinic staff at the Leavenworth and Topeka VAMCs. Additionally, staff identified and providers told us about discord among some providers within the Topeka Eye Clinic and between the two Eye Clinics and that the relational issues were long-standing. We learned of instances of reassignment requests due to conflict, individuals working in close proximity but not speaking to one another for years, and talking negatively about each other to patients.

[3] Facilities are categorized according to complexity level which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions and administrative complexity. A Level 1 facility represents the highest complexity level.

In the May 30, 2014, Eye Clinic Workgroup Recommendation report, the system identified "serious conflicts and issues" within the Eye Clinics.

We also found that the Eye Clinics' leadership position has been vacant since 2009 when the Eye Clinic Chief stepped down and the position was not subsequently filled. The Chief managed the Leavenworth VAMC and Topeka VAMC Eye Clinics. Other system leaders have assumed managerial oversight of the Eye Clinics for the past 6 years. Several staff we interviewed were unable to name their direct supervisor and were unclear regarding the chain of command. We determined that a lack of leadership over the Topeka VAMC and Leavenworth VAMC eye clinics may have contributed to unresolved and ongoing clinic discord.

Conclusions

We substantiated the allegations that Leavenworth VAMC Eye Clinic staff used an unapproved wait list for scheduling cataract surgery patients and that the required eye care consult process was inconsistently followed. We did not substantiate that the surgery wait list was used to falsify wait time data, as cataract surgery wait times are not monitored.

We could not substantiate whether inconsistent eye care consult practices were done in an attempt to falsify wait time data although we did find more than 4,700 eye care consults were used appropriately in FY 2014. Regardless, staff described a lack of system guidance regarding consult management, and wait times were not improved.

We did not substantiate that patients were harmed due to cataract surgery wait times or that medically unnecessary cataract surgeries were performed for identified patients. We substantiated that the system ophthalmologists' productivity is low relative to peers at comparable facilities. Further, we learned both Eye Clinics lacked leadership, which may have allowed negative relational dynamics to persist among staff.

Recommendations

1. We recommended that the Eastern Kansas Health Care System Director ensure all system staff use only approved wait lists for scheduling cataract surgeries as required by VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 2010.

2. We recommended that the Eastern Kansas Health Care System Director ensure that providers use the consultation package in the Computerized Patient Records System for all eye care referrals as required by VHA Handbook 1121.01, *VHA Eye Care*, March 10, 2011.

3. We recommended that the Eastern Kansas Health Care System Director take actions to increase ophthalmologists' productivity.

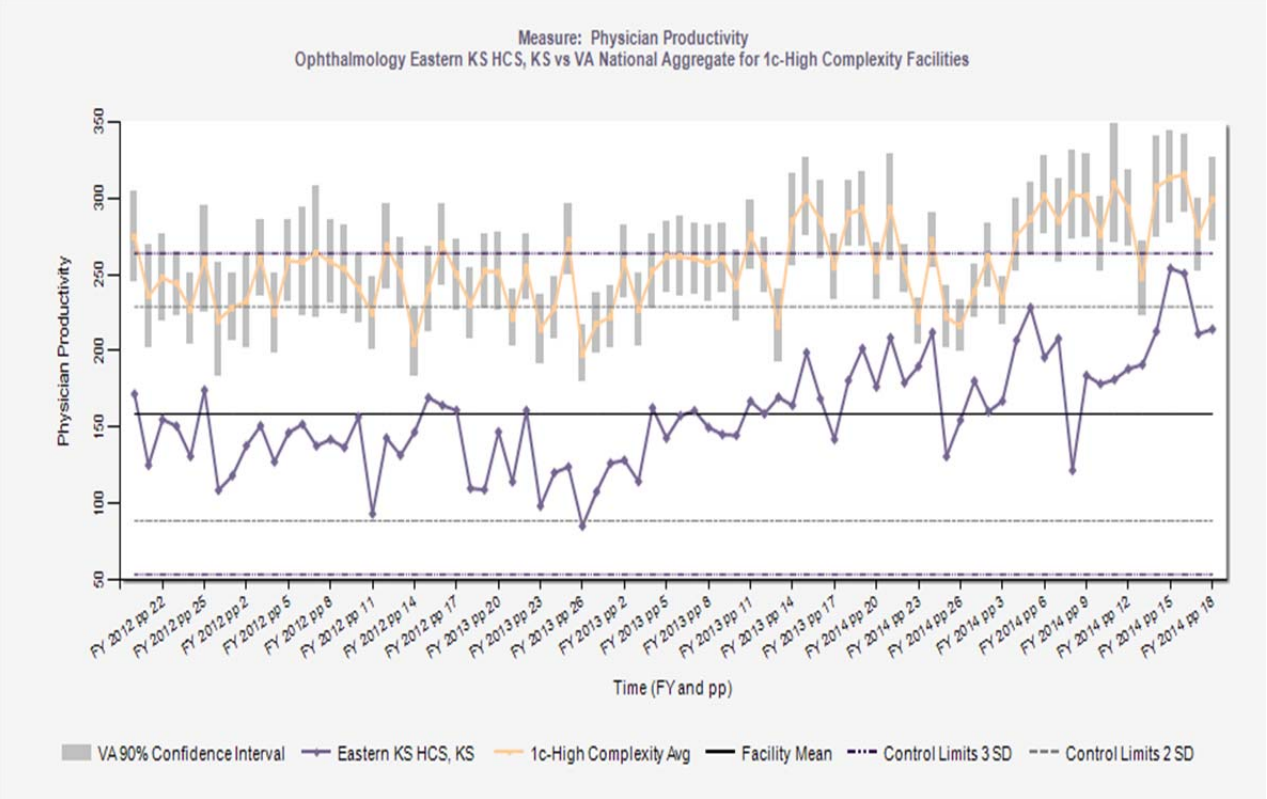
4. We recommended that the Eastern Kansas Health Care System Director explore and implement measures to improve communication, interpersonal dynamics, and operations within and between both Eye Clinics.

Appendix A

Ophthalmology Productivity

The graph below shows the productivity of ophthalmologists at the Leavenworth VAMC and Topeka VAMC Eye Clinics compared to overall productivity of all ophthalmologists in similarly complex VHA facilities. Physician productivity is based on RVUs, and the time frames are based on fiscal year pay periods for VA employees.

Figure 1: Ophthalmologist Productivity at the Eastern Kansas Health Care System versus Other VHA 1c-Complexity Facilities



Source: OPES, SPARQ Report

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: September 17, 2015

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Healthcare Inspection – Alleged Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, KS

To: Director, Kansas City Office of Healthcare Inspections (54KC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the report of the Healthcare Inspection—Healthcare Inspection – Alleged Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, KS. I concur with the facility's statement that this was a checklist and not waitlist. I also concur with the responses and action plans developed by the facility.

2. If you have any questions or require additional information, please contact Mary O'Shea, VISN 15 Quality Management Officer.

William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: September 17, 2015

From: Director, Eastern Kansas Health Care System (589A6/00)

Subj: Healthcare Inspection—Healthcare Inspection – Alleged Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, KS

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review the report from the Office of Inspector General (OIG) Healthcare Inspection—Alleged Eye Care Concerns of the VA Eastern Kansas Health Care System (VAEKHCS).

2. I have reviewed the document and attached the facility's responses to the recommendations. Prior to the OIG visit, VAEKHCS had initiated improvement plans within the eye clinic as determined by employees through completion of a System Redesign Project. VAEKHCS leadership had instructed staff to increase the frequency of completing cataract surgery procedures in June 2014.

3. The Eye Clinic maintained an electronic checklist to ensure Veterans received the appropriate and necessary pre-surgical work-up prior to cataract surgery. The checklist listed Veterans that had been seen by ophthalmology and needing to be scheduled for cataract surgery. The information included the patient's name, last four of social security number, city address, age, visual acuity, which eye was affected, the campus location, notes about work-up/tests needed, subsequent future care with ophthalmologist. This tracking mechanism followed multiple facets of care including progress of clinical work-up through clinical disposition. The electronic checklist was maintained at the local facility as no VHA mechanism was available that met the specific needs of the eye clinic procedures. Please note this was not a wait list.

4. If you have any questions or need further information, please contact Mary Weier, Chief Quality Management at 913-682-2000, extension 52146.

A. Rudy Klopfer, FACHE, VHA-CM
Director, VA Eastern Kansas Health Care System

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 Eastern Kansas Health Care System Director ensure all system staff use only approved wait lists for scheduling cataract surgeries as required by Veterans Health Administration Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 2010.

Concur

Target date for completion: Completed

Facility response: The Eye Clinic maintained an electronic checklist to ensure Veterans received the appropriate and necessary pre-surgical work-up prior to cataract surgery. The checklist listed Veterans that had been seen by ophthalmology and needing to be scheduled for cataract surgery. The information included the patient's name, last four of social security number, city address, age, visual acuity, which eye was affected, the campus location, notes about work-up/tests needed, subsequent future care with ophthalmologist. This tracking mechanism followed multiple facets of care including progress of clinical work-up through clinical disposition. The electronic checklist was maintained at the local facility as no VHA mechanism was available that met the specific needs of the eye clinic procedures. Please note this was not a wait list. VAEKHCS is using only approved lists for scheduling cataract surgeries. Eye Clinic staff who utilize scheduling functions have been educated on the Vista scheduling package for surgical consults.

Recommendation 2. We recommended that the Eastern Kansas Health Care System Director ensure that providers use the consultation package in the Computerized Patient Records System for all eye care referrals as required by Veterans Health Administration Handbook 1121.01, *VHA Eye Care*, March 10, 2011.

Concur

Target date for completion: December 31, 2015

Facility response: EKHCS will use the consultation package in the Computerized Patient Records System (CPRS) for eye care referrals. Clinical Care providers who submit clinical consults will receive training from the respective Service Line Management on their proper use.

Recommendation 3. We recommended that the Eastern Kansas Health Care System Director take actions to increase ophthalmologists' productivity.

Concur

Target date for completion: Completed

Facility response: To increase productivity, the ophthalmologists were provided additional time in the Operating Rooms to complete more surgical procedures. Cataract surgery completions increased by approximately 100% since the System Redesign project identified the opportunity for improvement in May 2014. New Surgery Service Leadership started in September 2014. The new leadership team continues to review and maximize clinical and surgical availability and productivity.

Recommendation 4. We recommended that the Eastern Kansas Health Care System Director explore and implement measures to improve communication, interpersonal dynamics, and operations within and between both Eye Clinics.

Concur

Target date for completion: Completed

Facility response: New Surgery Service Leadership began in September 2014 and has improved interpersonal communication among and within Surgery Service including the Eye Clinics across both Topeka and Leavenworth campuses. New staff have been hired to fill vacancies caused through several retirements. Eye clinics at both campuses hold quarterly staff meetings to discuss work related issues and to help facilitate dual-campus cooperation in handling of patient issues.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Laura Tovar, LICSW, Team Leader Stephanie Hensel, RN Thomas Jamieson, MD

Appendix E

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