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

Radiology Service at VA Medical Center in Temple, Texas
March 8, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated in response to a complaint to the Department of Veterans (VA) Office of Inspector General (OIG) Hotline by a former VA Medical Center Temple employee who was working at another facility in the Central Texas Veterans Health Care System (CTVHCS). The employee stated that he had witnessed manipulation of radiology consults by the chief of Imaging Service for the CTVHCS. According to the complainant, this involved the Imaging Service Chief asking or ordering CTVHCS physicians to move the desired dates of requested imaging procedures out beyond 30 days, so that the procedures could be shown to have been completed within 30 days of the desired dates listed on the original orders. This was allegedly done by sending out memos to physicians indicating that there were backlogs in the Radiology Department, and by asking that the physicians cooperate by ordering radiological studies within time frames in excess of 30 days, when clinically appropriate.

The complainant did not allege that the Imaging Service Chief ever falsified data; rather, the complainant indicated that the Imaging Service Chief regularly reported on these backlogs via widely distributed email messages. The complainant further indicated that the Imaging Service Chief documented the cancellation (or discontinuation) of imaging consults in the Computerized Patient Record System (CPRS) and suggested that since all of this activity was done through the CPRS, the activity could therefore be tracked. The complainant specifically alleged that one veteran patient was directly affected by delays in radiology procedures. The complainant alleged that he submitted an urgent order requesting that an ultrasound be completed within 1 week. Instead, it took 2 or 3 weeks for the ultrasound to be completed.

On May 30, 2014, during the VA OIG investigation, the U.S. Office of Special Counsel (OSC) sent a letter to the VA Acting Secretary, outlining the following related allegations received from an anonymous complainant:

Radiology appointments at the Temple medical center were scheduled and canceled improperly, specifically:

- The Radiology Chief regularly canceled and rescheduled appointments that would have otherwise shown an extended wait time.

- The Radiology Chief directed radiologists to cancel and reschedule appointments in a similar fashion when he was unavailable.

The investigation did reveal that the OSC complaint in fact pertained to discontinuation of imaging consults. Imaging consults were not sent to schedulers until after the screening

process referenced in the OSC complaint had already been completed.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** The OIG investigators interviewed the Hotline complainant, the chief of Imaging Service, the Chief Technologist, the CTVHCS Director, and seven staff radiologists.

- **Records Reviewed:** Performance plans, appraisals, and awards for the Chief for fiscal years (FY) 2011 through 2013; a random sample of discontinued Radiology consults spanning the period of time from January 2010 to July 2014, and email accounts of the Chief and the Chief Technologist. The investigation also included a review of medical records relating to the care of a specific patient identified by the former employee.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

A summary of the interview with the complainant is included in paragraphs 1 and 2 above.

- The Chief Technologist explained that the CTVHCS Imaging Service bases the "desired date" on what the physician puts in the order, which in many cases is simply a default date resulting from the physician hitting [enter] without actually selecting a desired date. In this case, the desired date would default to the date on which the order was entered.

  With regard to the email exchange published by *The Daily Beast*, which included an email sent by the Chief Technologist on November 1, 2011, he acknowledged that he did in fact send the email. The purpose of the email was to advise physicians of the next available dates for annual screening mammograms. At the time, patients were not being asked to provide a desired date, so the email was intended to provide guidance to physicians when selecting the desired date of a procedure. He indicated that after receiving a response from the CTVHCS Chief of Staff (stating "You cannot do this!!!!"), the practice of sending these emails in regard to the desired dates was discontinued.

  He stated that no one has ever instructed Radiology schedulers to change the desired dates of orders that have already been entered, and he indicated that he is not aware of any orders that have been canceled and re-entered solely for the purpose of changing the desired date. He stated that if a patient cannot be accommodated within a 30-day period, then the patient will be scheduled as soon as feasible. He also mentioned the VA Outpatient Clinic in Austin as an example and explained that this facility has experienced significant backlogs for routine ultrasound procedures.

- During his interview, the Imaging Service Chief indicated that the desired dates on Radiology orders are normally determined by the ordering physicians. Several years ago (exact time frame unspecified), there were significant backlogs for radiological exams, in part caused by providers who were not selecting appropriate time frames for the exams to be conducted. During this time period, in certain instances, he would discontinue some orders and "flag the provider back" with a note stating that, based on the patient's clinical

history, they should consider selecting a different desired date, which might be 1 or 2 weeks in the future.

He further stated that during an unspecified period of time, beginning approximately in 2007, the Chief Technologist began sending out periodic emails to all CTVHCS doctors explaining when the first available slots were open for certain modalities. The providers were asked to use that information, along with the patient's clinical history, to guide them in their selection of desired dates. These emails were sent out with the full knowledge of both the Imaging Service Chief and the Chief of Staff. These emails are no longer sent out, since the backlog in Radiology is now under control and physicians are now using better ordering practices.

When re-interviewed, he acknowledged that, on occasion, he has canceled and re-ordered imaging studies, but stated that he has only done this in cases when patients had canceled their appointments and had asked to be seen on a later date. He explained that the scheduling package used by the Imaging Service does not allow schedulers to change the desired date of patient appointments when patients ask to be re-scheduled. Therefore, in order to capture the new desired date provided by the patient, he must cancel the existing order, re-input the order with the new desired date, and send the new order to the schedulers. He has never done this without the patient having requested the change and indicated that he always places notes in the computer system specifying what the patient has requested. He acknowledged that, on occasion, he may have asked other radiologists to follow this same procedure when they were serving in his place as the acting chief.

He denied ever having canceled and re-ordered imaging studies, simply to make it appear that those studies had been pending for a shorter period of time, or when that was not what the veteran actually wanted. He also denied ever instructing other radiologists to cancel and re-order imaging studies, simply to make it appear that those studies had been pending for a shorter period of time or when that was not what the veteran actually wanted. He gives appropriate clinical review to new imaging consults, including those that he changes or discontinues and he insists that other radiologists in his section do the same. He described the process that he uses to screen new consults by reviewing the orders, looking at patient medical records, and separating the incoming consults according to their level of urgency. He further denied ever having discontinued pending consults without appropriate clinical review and denied instructing other radiologists to cancel pending consults without appropriate clinical review. He denied ever having engaged in any strategy to manipulate wait times or "game the system" in any way and indicated that he has always followed what he believes to be correct procedure.

- Four radiologists described the process by which they screened new imaging consults and provided clinical review, while serving as acting chief of Imaging Service during periods of the Imaging Service Chief's absence. All four denied ever having discontinued imaging consults without conducting the proper clinical review and denied ever having discontinued imaging consults when there was no clinical reason to do so. All four physicians stated that they were never instructed to discontinue consults when an imaging study could not be completed within a certain number of days, simply to make it appear that there were fewer consults pending.

- Another staff radiologist described the process by which he screened new imaging consults, and provided clinical review, while serving as acting chief of Imaging Service during periods of the Imaging Service Chief's absence. When asked if he had ever discontinued consults without doing the appropriate clinical review, he responded that in 2010 or 2011, on two or three separate occasions, the Imaging Service Chief gave him a folder of "exams to be cancelled," which contained a list of patients, and instructed him to cancel and re-order those imaging studies on behalf of the requesting clinicians. The radiologist clarified that he did not change the desired dates on the orders and that the original orders continued to be reflected in the computer system. He was never instructed by anyone to alter data or to modify information pertaining to pending consults, nor would he know how to do that.

  He no longer remembers the specific justification that the Imaging Service Chief gave for canceling these consults; however, he was not then under the impression that the cancellations were in any way related to wait times or performance measures. He did not give clinical review to the consults in the folders since he had been directly instructed by the Imaging Service Chief as to what action to take. He further indicated that it was possible that the Imaging Service Chief had already given clinical review to these consults; however, he could not say definitively that this took place. The Imaging Service Chief never asked him to cancel consults again after 2011 and, to his knowledge, this is no longer taking place. He was never instructed to discontinue consults when an imaging study could not be completed within a certain number of days, simply to make it appear that there were fewer consults pending.

- Two other radiologists described the process by which they screened new imaging consults and provided clinical review, while serving as acting chief of Imaging Service during periods of the Imaging Service Chief's absence. Both denied ever having discontinued imaging consults without conducting the proper clinical review and denied ever having discontinued imaging consults when there was no clinical reason to do so. Both physicians stated that they were never instructed to discontinue consults when an imaging study could not be completed within a certain number of days, simply to make it appear that there were fewer consults pending. Both physicians stated that they were never given folders by the Imaging Service Chief containing pending consults that needed to be canceled, nor were they ever aware of such a practice.

Records Reviewed

- The review of the Imaging Service Chief's performance plans, appraisals, and award showed that his 2011 performance rating was partially dependent on patient wait times; however, nothing additional of evidentiary value was disclosed. His FY 2012 and FY 2013 performance plans and performance appraisals make no mention of patient wait times or desired dates.

- The analysis of the random sample of discontinued radiological consults was inconclusive and did not produce anything of evidentiary value, due to the fact that it was not possible to determine the reason for the discontinuations.

- The review of email accounts did not disclose any evidence that the Imaging Service Chief or the Chief Technologist ever instructed employees or providers to modify the desired dates of imaging procedures. It was also noted that search terms, such as "desired date," "date desired," and "wait time," did not produce any relevant emails dated before March 2014.

4. Conclusion

The allegation was not substantiated. Veterans Health Administration (VHA) Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, defines "Desired Date" as follows: "The desired appointment date is the date on which the patient or **provider** wants the patient to be seen" (emphasis added). There is no evidence to suggest that the Imaging Service Chief ever canceled imaging consults without appropriate clinical review and there is no evidence to suggest that subordinate radiologists ever canceled imaging consults without appropriate clinical review. The conduct disclosed by the investigation (suggesting desired dates for imaging studies based upon the urgency of the procedure and the patient's clinical history, determining the desired dates of procedures following the clinical review of imaging consults, or requesting that the desired dates of imaging studies be modified based upon clinical review) does not constitute a Federal crime, nor does it appear to violate the referenced scheduling directive. In addition, a VA Medical Center staff radiologist in Houston reviewed the medical records of the patient identified by the OIG Hotline complainant and determined that, given the patient's clinical history, all imaging procedures were performed within a reasonable period of time.

The OIG referred the Memorandum for Record to VA's Office of Accountability Review on November 16, 2015.

QUENTIN G. AUCOIN
Assistant Inspector General
for Investigations

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