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

Radiology Department, VA Medical Center in Brooklyn, New York March 15, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based upon information provided by an employee at the Department of Veterans Affairs (VA) Medical Center (VAMC) in Brooklyn, NY, who contacted VA Office of Inspector General (OIG) on June 12, 2014. The complainant alleged that the Radiology Department at VAMC Brooklyn was manipulating patient scheduling and misrepresenting wait times for medical scans.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In addition to the complainant, VA OIG interviewed a lead medical support assistant (LMSA), a medical support assistant (MSA), and the Hematology and Oncology Chief.

- **Records Reviewed:** VA OIG Office of Healthcare Inspections reviewed "no show" cancellations.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant stated that MSAs assigned to the Radiology Department at VAMC Brooklyn are canceling physician's orders for diagnostic testing when the patient is a no-show. According to the complainant, once the MSA cancels the doctor's order, there is no record of the order having existed. The complainant claimed that a former scheduling supervisor, who is no longer with VA, instituted the practice of canceling orders for no-shows.

  In a follow-up interview regarding his allegations of wait list manipulation and misrepresented wait times, the complainant provided no new relevant information pertaining to his original complaint. According to the complainant, all aspects of the scheduling practices that he thought were indicative of wait list manipulation were presented to OIG.

- An LMSA for the Radiology Department at VAMC Brooklyn informed us that MSAs are responsible for scheduling in the Radiology Department. The LMSA explained that the Radiology Department currently follows the 2008 policy recommended by the former VA National Radiology Director regarding no-show appointments. The change was communicated to VAMC Brooklyn Radiology MSAs in 2008 by the former service chief

for VA New York Harbor Healthcare System (NYHHS). The LMSA provided a copy of an email she received in September of 2008 detailing the policy change.

The policy directs that supervisors, or their representatives, check the appointment list at the end of each day to identify any no-shows. Provided there is no inclement weather, and excluding Department of Defense patients, MSAs are directed to cancel the order for testing of any no-show and notify the physician's office that the order was canceled; the physician must then re-order the test.

According to the LMSA, when a patient contacts Radiology to cancel or reschedule an appointment, the original order is maintained in the system as "pending" with the original date the test was ordered. Orders submitted to the Radiology Department are considered valid for 90 days from the date the doctor issues them. After 90 days, orders are considered obsolete and removed from the system. The staff assistant for Radiology at VAMC Brooklyn is responsible for monitoring the department's log of pending appointments and removing obsolete orders from the system.

The LMSA also stated that the MSAs have a monthly rotating duty, which involves reviewing the schedule for the upcoming day, ensuring orders are in place, verifying the patients are scheduled for the correct clinic and time, and identifying and canceling no-shows from the previous day. Anyone with the Radiology package of permissions in the Veterans Health Information Systems and Technology Architecture (VistA) has access to cancel a doctor's order for testing.

- An MSA for the Radiology Department at VAMC Brooklyn confirmed that the Radiology Department's current practice is to cancel testing orders for no-show patients. The MSA explained that when an order is canceled for a no-show, Radiology sends a form letter to the patient explaining that his/her order was canceled and that he/she needs to contact his/her doctor to create a new order. In the event a patient calls to complain about his/her order being canceled, when possible, MSAs will attempt to contact the care provider directly and have a new order created without the patient having to personally contact the doctor.

- The chief of Hematology and Oncology (CHO) at VAMC Brooklyn was interviewed regarding the potential negative effect to patient care due to the Radiology Department's current practice of canceling orders for testing on patients who do not show up ("no show") for their appointments. Prior to meeting with the CHO, we requested that she inquire among her staff if any of the physicians had experienced any negative effect on patient care related to Radiology's scheduling practices. We also requested she provide appropriate contact information for anyone indicating they had an issue. During the interview, the CHO had nothing negative to say about her department's collective experience dealing with Radiology. According to the CHO, when orders for testing were deleted by the Radiology Department, she and her staff were alerted and could re-order the test without requiring the patient to come in for a new visit. On the whole, the Oncology Department had not had issues with accessibility for any type of testing done in Radiology. The CHO indicated that patients under the care of her department were generally being treated for major illnesses and less apt to miss appointments.

- In a briefing with the director of VA NYHHS, we explained the allegation, detailed our investigative steps, and shared our findings. The director appreciated the investigation and the fact that no evidence was uncovered at the VAMC Brooklyn Radiology Department, proving that staff were not engaging in wrongful practices regarding wait times. The director informed us that she expected this outcome because of the availability of supplemental medical services in the New York City area. Specifically, the director cited the working relationship between VA NYHHS and New York University (NYU) Medical School at VAMC Manhattan and the State University of New York (SUNY) Downstate Medical College at VAMC Brooklyn as providing an abundant source of medical personnel and facilities to augment VA's own staff, should the need arise. In addition, the veteran population to which VA NYHHS provides services is either static or slightly decreasing, so resources are not unduly burdened.

  The director also informed us that all directors were mandated by VA Central Office (VACO) to have listening sessions (forum style) with scheduling clerks and also learning sessions during which they go to the clinics and watch/learn the scheduling package first hand from the clerks, asking them for suggestions for improvements. None of the scheduling clerks at these sessions reported any practices that were not in keeping with VA policies. Data entry of the listening session results into a national VA Sharepoint was completed on or around July 31, 2014.

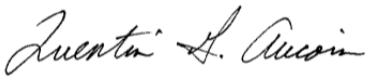
Records Reviewed

VA OIG Office of Healthcare Inspections assisted with the analysis of the cancellations for no shows. The process of canceling Radiology consults for no-show patients, now currently in place at VAMC Brooklyn, is consistent with Veterans Health Administration policy and is similarly applied throughout the United States. As a result, Office of Healthcare Inspections senior staff advised that they would not pursue the matter.

4. Conclusion

The investigation did not substantiate the allegation. The Radiology Department at VAMC Brooklyn currently follows the 2008 policy recommended by the former VA National Radiology director regarding "no-show" appointments. The policy directs that a supervisor, or his/her representative, check the appointment list at the end of each day to identify any no-shows. Provided there is no inclement weather, and excluding Department of Defense patients, MSAs were directed to cancel the order for testing of any no-show and notify the physician's office that the order was canceled; the physician must then re-order the test.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 22, 2014.



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