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

VA Medical Center in Fayetteville, North Carolina
November 8, 2017

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) began an investigation in 2014 pursuant to an anonymous complaint received by the OIG Hotline. The complainant alleged that 1,400 Dermatology Clinic appointments were canceled from 2011 through 2012 at the VA Medical Center (VAMC) Fayetteville, NC. In addition, it was alleged that senior leader 1 and senior leader 2 improperly instructed staff to delete the appointments and consults without regard for whether the patients still required the tests or services. In mid-2014, another anonymous complaint was received by the VA OIG, Office of Healthcare Inspections (OHI), in which the complainant indicated Radiology Clinic staff at VAMC Fayetteville deleted several old imaging studies with no concern as to whether the patients ever received the needed care. While the OIG seeks to complete each investigation in a timely manner, this investigation took longer than customary due to a number of reasons, including that the initial complaints were made anonymously; the complexity of the issues required work by multiple OIG directorates; and facility leadership took an extended period of time before providing an acceptable action plan to the recommendations made by OIG.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 11 VA employees.
- **Records Reviewed:** VA OIG reviewed Dermatology and Radiology records.

3. Summary of the Evidence Obtained From the Investigation

Dermatology

Interviews Conducted

- Senior leader 3 stated that in 2011, the Dermatology Clinic did not have a VA staff dermatologist and that veterans were being treated by dermatologists and dermatology fellows who were contracted by VAMC Fayetteville. He stated that VAMC Fayetteville used fee-basis dermatologists in an attempt to fill the gaps in treatment in the Dermatology Clinic.
- VA employee 1 stated that she reviewed, and had her staff review, consults that came to the Dermatology Clinic from other clinics at VAMC Fayetteville. She explained that consults were canceled or discontinued based on clinical reviews; however, she said

senior leader 2 and senior leader 4 told her to discontinue or cancel consults without clinical reviews. She stated that this occurred during a meeting but she did not provide the names of anyone else present at this meeting, nor was she able to provide a definitive date of the meeting. She said she believed senior leader 1 was aware of what senior leader 2 and senior leader 4 were asking staff to do; however, she was not able to provide any evidence, such as names, emails, or written documentation, supporting her assertion.

- VA employee 2 stated that she was an employee in the Specialty Care Clinics, VAMC Fayetteville. She said she was part of a group of VA staff tasked to work on consults from the Non-VA Care Coordination (NVCC) Program. She added that the staff updated information on consults and did not close or discontinue any consults.

- VA employee 3 stated that she was assigned to the Tele-Dermatology Program. She said she was assigned with other nurses to participate in the consult cleanup for NVCC because there was intermittent dermatology service at VAMC Fayetteville. She said she had some freedom to adjust consults if there were minor errors or omissions; any other issues, such as closing or discontinuing consults, would have to be discussed with the health care provider.

- VA employee 4 said she worked in the NVCC Program. She said she was tasked to participate in the consult cleanup. She stated that she was told by Veterans Integrated Service Network (VISN) 6 staff (no names were provided) that people working on the consult cleanup at VAMC Fayetteville had closed approximately 600 consults incorrectly and the patients involved had to be contacted. She reported that NVCC staff were incorrectly closing consults if the patient had not used the consult during the authorization period or been seen. She said there was no clinical review or patient contact. She stated that they would check the Veterans Information System and Technology Architecture (VistA) to see if any bills were paid to vendors, and if so, they would contact the vendors to get the documentation. She said she was not sure if patients were contacted by phone; however, she was told by VAMC Fayetteville staff (no names were provided) that letters had been sent to the patients to follow up on the closed consults.

- A VA physician stated that he was the only dermatologist for the health care facilities associated with VAMC Fayetteville. He stated that before seeing patients, he was reviewing NVCC consults and dermatology consults for appropriateness and to approve extension of services. He said he was not sure who currently reviewed dermatology consults at the medical center but believed it would be a nurse practitioner or a physician's assistant. He stated that for the consults he received, he would discontinue or cancel them if the patient needed specialty care that he could not provide. He stated that in those instances, he would cancel or discontinue the consult and then enter an NVCC consult. He said both he and the primary care providers were alerted on the status of the NVCC consults. He stated that the primary care provider was required to sign off on the NVCC consult and the NVCC staff would then close consults. He added that NVCC consults remained open until all services were completed.

Records Reviewed

- OHI reviewed records regarding dermatology appointments and consults that were canceled or discontinued in 2011 and 2012. OHI substantiated that 1,993 Dermatology Clinic appointments were canceled by the clinic between January 2011 and December 2012. OHI reviewed 344 randomly selected patient electronic health records (EHR) and found that about 86 percent of the 316 patients who still required appointments were rescheduled and seen by dermatology providers. However, more than 30 percent of the rescheduled patients waited more than three months to be seen by dermatology providers, and some waited more than one year. OHI found no evidence that 45 patients received dermatologic care after their appointments were canceled, nor did it find that the patients' EHRs contained documentation showing the appointments were no longer needed.

- OHI substantiated that 3,272 dermatology consults were canceled or discontinued from January 2011 through December 2012. OHI reviewed 299 randomly selected EHRs and found that about 65 percent of the 253 patients who still required appointments received dermatologic care subsequent to the consult cancellation; the average wait time for care provision was about 13 months. OHI identified 89 patients who did not receive dermatologic evaluation or care after the consults were canceled or discontinued. OHI provided those cases to the facility director for review and disposition. OHI's review of patients with diagnosed skin malignancies did not disclose cases in which canceled or discontinued dermatology consults in 2011–2012 may have negatively affected these patients' subsequent diagnoses or treatment plans. OHI found nine cases, however, in which the EHRs did not contain evidence of follow-up after the canceled or discontinued consults.

- OHI concluded that although some patients were not seen by dermatology providers in a timely manner due to canceled appointments and/or consults, it did not identify instances in which patients experienced clinically significant delays in diagnosis or treatment for the cases reviewed. OHI found that a shortage of dermatologists at the facility in 2011–2012 contributed to the appointment scheduling and consult completion delays. The facility has since hired additional dermatology providers in its Wilmington location and continues to use Tele-Dermatology and NVCC to meet demand.

- OHI provided two recommendations to VAMC Fayetteville management for review and disposition:

    - OHI recommended that the facility follow up on the 143 patients referenced in the report who did not receive dermatology care after their appointments or consults were canceled, and take appropriate action.

    - OHI recommended that the facility follow up on all the patients with canceled dermatology appointments and consultations in 2011–2012 who were not subsequently seen by a dermatology provider to determine whether the requested evaluation and/or care was still needed.

- VAMC Fayetteville management provided documentation that indicated the 143 patients identified in the recommendations as having canceled appointments or consults received care as necessary. It also provided documented evidence that VAMC Fayetteville staff reviewed all of the canceled dermatology appointments and consultations from 2011 and 2012, and ensured that the patients who needed dermatologic care received it.

- OHI published its report regarding the alleged improper management of dermatology requests at VAMC Fayetteville.[1]

Radiology

Interviews Conducted

- VA employee 5 at the Radiology Clinic in VAMC Fayetteville stated that she did not directly handle scheduling or review consults; however, she supervised technicians who did. She stated that as far as she knew, the administration at the medical center (senior leader 1, senior leader 2, and senior leader 3) was following directions given by VA Central Office staff on the disposal of obsolete orders or consults.

Records Reviewed

- OHI reviewed the Radiology Clinic's records and found that VAMC Fayetteville staff canceled more than 18,000 radiology orders over a two-year period starting in 2012. In the past, when a radiology exam was performed, the order was completed and removed from the "order list." However, if a patient was not present for the exam, that order remained active, sometimes for years. In general, the facility considered radiology orders obsolete if they exceeded 180 days. Of the 18,184 radiology orders that were canceled from January 2, 2012, through January 27, 2014, 11,429 were greater than 180 days old and, in accordance with routine administrative practices at the facility, could have been canceled because they were considered obsolete. In those cases, the ordering health care providers should have received notification of the cancellation, so they could re-enter the order if the exam was still required. The remaining 6,755 canceled orders were 180 days old or less. OHI reviewed a random selection of 230 EHR (of the 6,755). OHI's review found evidence of clinical review, alternate care provision, or other explanatory documentation. OHI's review also found that patients in the OHI sample who still required radiology tests routinely received those services. OHI did not substantiate a mass deletion of old radiology orders. (No formal report was published.)

Senior Management Interviews

- At the time of her interview in mid-2015, senior leader 1 stated that her staff had been working on the consult cleanup process. She said there was no backlog for consults/orders in radiology in 2011–2012 because the facility used a contract with community resources to meet the patient demand. However, she said there were concerns in the Dermatology Clinic because there was no onsite dermatologist. Senior

[1] *Healthcare Inspection–Alleged Improper Management of Dermatology Requests Fayetteville VA Medical Center Fayetteville, North Carolina*, Report No. 14-02890-286, May 3, 2016.

leader 1 stated that during the consult cleanup, she had had her staff verify that the issue noted on the consult had been addressed. She added that if the issue had been addressed through NVCC or another VAMC, then it was okay to close out the consult. If the issue had not been addressed or was unclear, then staff would need to contact the patient to determine resolution. If the patient confirmed the issue had been addressed, then staff would close the consult; if not, then staff would contact the provider to see whether the service/procedure was still necessary. She stated that no staff were ever directed to discontinue, delete, or cancel any consults without following policy.

When reinterviewed, senior leader 1 explained the process for the Radiology and Dermatology Clinics and stated that she was aware of the significant consult backlog in the Dermatology Clinic. She said the Radiology Clinic was on task. She further stated that she did not advise any VA staff to delete, discontinue, or cancel consults without a clinical review and that she was not aware of any VA staff giving directions that would be in direct conflict with VA's policies.

- Senior leader 2 stated that she was never directed to discontinue, delete, or cancel consults or appointments and that she did not direct any VAMC Fayetteville staff to do so. She further stated that she could not recollect any major issues with Dermatology or Radiology; however, she said that if there were, she would have addressed the issues at that time.

  When reinterviewed, senior leader 2 stated that she was not aware of the significant consult backlog in the Dermatology Clinic or in the Radiology Clinic. She further stated that she did not advise any VA staff to delete, discontinue, or cancel consults without a clinical review. She added that she was not aware of any VA staff giving the aforementioned directions.

- Senior leader 4 stated that he did not advise any VA staff to delete, discontinue, or cancel consults without a clinical review. He further stated that he was not aware of any VA staff giving the aforementioned directions.

- Senior leader 5 stated that he was familiar with the backlog of consults in the Dermatology Clinic at VAMC Fayetteville because senior leader 1 kept him apprised of the situation. He said he did not advise any VA staff to delete, discontinue, or cancel consults without a clinical review. He further stated that he was not aware of any VA staff giving the aforementioned directions.

4. Conclusion

Our investigation found that some patients, whose dermatology appointments or consultations had been canceled in 2011 and 2012, were not seen by a dermatology provider to assess whether the requested evaluation and/or care was still needed. We substantiated that 143 patients did not receive dermatology care; more specifically, 45 patients' appointments were canceled, 89 patients' consults were canceled or discontinued, and nine patients did not receive any follow-up after the canceled or discontinued consults. Although some patients were not seen by dermatology providers in a timely manner due to canceled

appointments and/or consults, there were no instances in which patients experienced clinically significant delays in diagnosis or treatment for the cases reviewed. A shortage of dermatologists at VAMC Fayetteville in 2011 and 2012 contributed to the appointment scheduling and consults completion delays.

VAMC Fayetteville hired additional dermatology providers and continues to use NVCC and Tele-Dermatology.

VA OIG special agents and OHI inspectors interviewed 11 VAMC Fayetteville employees. One employee reported that she had been given improper instructions to cancel appointments and consults. However, the investigation did not disclose any evidence to support this employee's assertion as the other staff members did not tell us they were given improper guidance and the senior leaders denied giving improper instruction. In addition, the investigation did not substantiate that a mass deletion of old radiology orders or old imaging studies ever occurred.

We made recommendations, which are documented on page 3, for senior leader 1 and senior leader 5 to follow up on the issues that were substantiated by OHI. VAMC Fayetteville managment successfully completed the required follow-up on the recommendations. Although we found lapses in documentation and follow-up in some cases, it did not appear that facility leadership played a role in the events discussed in this summary.

VA OIG referred the Report of Investigation to VA's Office of Accountability and Whistleblower Protection on August 16, 2017.

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