STATEMENT OF
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BEFORE THE
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Good Morning, Mr. Chairman. Thank you for the opportunity to share the Radiation Oncology experience at VA New Jersey Health Care System. I will describe for you our 3 year journey that includes how we identified a problem in the quality of care for radiation oncology patients, how we responded, and how we rebuilt our program to make sure that these circumstances would not happen again. Transparency was our constant focus throughout this process, and guided our decisions to ensure we acted in the best interest of our patients. As soon as we determined that specific patients did not receive the quality of care they deserved, we disclosed this information to 53 patients and their families consistent with Veterans Health Administration (VHA) policy. Of the 53 patients, we determined that two patients were harmed. We informed the other 51 patients that they experienced errors that created a risk for future harm. We are following these patients for any subsequent signs of injury resulting from the errors identified.

Prior to December 2006, the East Orange Campus of the VA New Jersey Health Care System's radiation oncology program was accredited by a nationally recognized external reviewing agency. Our patients were satisfied, staff members had no complaints, and all indications suggested our program was delivering quality care. In December 2006, we first heard that two radiation therapy contract technicians unexpectedly were no longer reporting to work at our facility. When we inquired as to why this happened, we learned that they had raised concerns about the quality of care being provided, resulting in conflict with supervisory staff. We immediately initiated a review that included a series of increasingly detailed investigations of the quality of care in radiation oncology. The first review by our quality manager validated that the concerns raised by the technicians were credible. In response, we made the decision to close the program until a thorough review was complete and we were certain our program provided safe, quality care for our Veterans. Patients in need of radiation therapy have received care through fee basis arrangements with local accredited facilities in their communities.

Subsequent reviews by external VHA teams of experts and a final comprehensive review by the American College of Radiology (ACR) confirmed there were deficits in our programs. These included issues with staff qualifications and communication, implementation of new technology without adequate education and training, gaps in procedures for managing patients, and the lack of a robust quality assurance program.

These findings became the framework for rebuilding our radiation oncology program; we needed to be sure we would deliver the highest standard of care possible and implement corrective actions to rectify all deficits identified by the ACR.

During the course of investigation, the clinical staff who had been working in our program resigned. At the same time the contract for radiation therapy technicians and for contract physicists expired; we then made a decision that it would not be renewed. We began improving our program by hiring all new staff members, including a nationally respected, experienced and board certified Chief of Radiation Oncology. We also hired properly trained and credentialed physicists, a dosimetrist, and radiation therapy technicians. As radiation therapy is complex and rapidly changing, we established a program of continuous education for all staff, and a major component of this is initial and ongoing training of new technology and equipment.

We next established policies and procedures to guide patient care and instituted a comprehensive quality management program. Such a program includes meeting the standards established by the American College of Radiology. This entails identifying quality controls for every step of radiation therapy including the dose and technique prescribed, the energy the machine delivers, the dose of radiation the patient receives and how the patient responds to the therapy. We are conducting routine tests of our machines, simulating patient encounters, checking dose calculations, tracking patient outcomes, and instituting routine quality reviews of care, including peer review.

A culture of openness is fundamental to patient safety. This means an environment where all staff members are considered an equal part of the health care team. To this end, we established multi-disciplinary team meetings prior to, during, and after treatment to review all aspects of care. We encourage our staff members at all times to raise questions or concerns about the care being provided. The most important lesson we learned through this process was that staff members must be able to communicate openly, to feel comfortable about raising issues, and to feel confident that leadership will respond to their concerns.

Thank you again for the opportunity to share my experience with you. I am now available to answer your questions.