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

VA Medical Center in Los Angeles, California
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1. Summary of Why the Investigation Was Initiated

This investigation was initiated after the Department of Veterans Affairs (VA) Office of Inspector General (OIG) received an allegation of in-progress appointment record destruction occurring at the VA Greater Los Angeles Healthcare System's (GLAHS) West Los Angeles Healthcare Center (WLAHC). The activity was described as a "shredding party."

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed three senior VA Medical Center (VAMC) employees.

- **Records Reviewed:** VA OIG reviewed a YouTube audio clip, an article posted about the YouTube audio clip, and canceled pending magnetic resonance imaging (MRI) orders.

3. Summary of the Evidence Obtained From the Investigation

On May 4, 2014, a VA OIG investigator contacted hospital management, obtained a description of how GLAHS handled its appointment process, and physically inspected clinics. When he arrived at GLAHS, the investigator observed activity in the Patient Eligibility Department. He found that a Health Administration Service (HAS) supervisor and a dozen employees had been working to resolve an extensive list of open consults. The HAS supervisor stated that the group was currently resolving an estimated 8,000 open consults for the Surgery Department and that this had been ongoing for months. The HAS supervisor added that all of the consults were listed and updated daily in the HAS SharePoint and no "off the books" record system was being used.

Following the investigator's observation of activity in Patient Eligibility, the OIG investigator met with VAMC senior leader 1 and discussed the open consult issue. VAMC senior leader 1 stated that this was a known problem her staff had been working on diligently for 9 months. She recalled the latest figure to be 5,000 open consults awaiting resolution and conceded that some clinics had unacceptably long wait times, but she insisted there was no effort to hide the issue of wait times by keeping off-the-books records or destroying records. She identified two subordinates who could further advise on the patient appointment-making system.

After speaking with VAMC senior leader 1, the investigator performed a physical inspection of the Gastroenterology (GI) and Radiology Departments, as he was told that shredding was

allegedly occurring in these two departments. He found GI to be unstaffed and in a locked state with no activity. He found the Radiology Department to be open but with no activity. The Radiology administrative offices were locked and unstaffed.

Interviews Conducted

- VAMC senior leader 2 stated that she was the medical department head assigned to work on the open consult issue. She explained that the open consult issue had been ongoing for at least 2 years and that management was fully aware of the issue. She showed the investigator a GLAHS portal that provided her with consult metrics daily. She stated that the GI and Radiology Departments were not keeping unofficial records nor were they misreporting or mishandling appointments. She stressed the differences between appointments for patient care, orders, and consults. Specifically: appointments are scheduled meetings between patients and care providers; orders are requests from care providers for tasks to be performed by support functions, such as an x-ray or lab analysis; and consults are requests for "consultations" between care providers. She added that each of these tasks was handled by a different information/communication system and that GLAHS relied on the consult system to perform many intra-tasks, including requests for MRIs, because the system was more robust and allowed for a richer and more flexible communication. In addition, she stated that no records were destroyed or deleted and that the consult requests and their return to the care providers were all still documented in the system.

- VAMC senior leader 3 and an HAS manager were interviewed jointly. The pair stated that they had been working on the consult issue for months and that management at the Veterans Integrated Service Network (VISN) and VA Central Office were fully aware of the current state of open consults. The HAS manager stated that new patients received immediate care when they sought medical assistance and added that the consult process faced challenges that caused open consults to linger in the system. Both denied any off-the-books appointment-keeping system or any effort to manipulate the metrics.

Records Reviewed

- On July 8, 2013, an individual published a YouTube audio clip. The audio clip sounds like a recording of a hospital administration meeting that the poster attributes to VA and in which cancellations and "mass purging" are contemplated. After listening to the audio recording, the investigator determined that if someone were to listen to the recording without the background knowledge the VA OIG now possessed, the recording could give the impression that VA was at least considering arbitrary cancellation of some kind of medical appointments. Understanding the context in which consults were handled both nationally and at GLAHS at the time, the investigator determined that the conversation was a forthright discussion of sanctioned tasks necessary and in the best interest of the patients. It also appears that on February 26, 2014, the same individual re-posted an article on his Blog.com page titled *VA Defends Deleting Veteran Medical Appointments*. The article was attributed to Bryant Jordan courtesy of *Military Times* - 2/26/2014. (http://www.military.com/aily-news/2014/02/26/va-defends-deleting-veteran-medical-appointments.html)

- In response to the media interest, the OIG was asked by several members of Congress to investigate. The VA OIG Office of Healthcare Inspections (OHI) conducted a comprehensive inspection of the issue. OHI did not find that patients suffered adverse or significant clinical consequences from canceled pending MRI orders; however, it documented two examples in which a timelier MRI could have reduced the risk of serious harm to patients. The electronic health records OHI reviewed contained sufficient evidence to support that the cancellation of pending MRI orders did not impact patients' health care management. OHI did not substantiate that pending MRI orders were deleted or mass purged or that records were destroyed. OHI issued a final report on June 11, 2015, *Healthcare Inspection: Alleged Magnetic Resonance Imaging Order Deletion and Record Destruction VA Greater Los Angeles Healthcare System Los Angeles, CA* (Report No. 14-02195-381).

4. Conclusion

The investigation did not uncover evidence of a shredding party. The investigation found no indication that any manager or employee was actively engaged in malicious behavior to alter, destroy, or manipulate records associated with patient appointments. The investigation disclosed evidence of a long-standing issue of unresolved consults that had been occurring since 2006. However, the investigation did not find any evidence that destruction related to consults had occurred nor did it find that management concealed, altered, or otherwise misreported the state of overdue consults. OHI performed a similar review with similar results and published a report of its findings.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on October 12, 2016.

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