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

VA Medical Center in Palo Alto, California
March 30, 2016

1. Summary of Why the Investigation Was Initiated

On February 25, 2015, a House Committee on Veterans' Affairs staffer notified the Department of Veterans Affairs (VA) Office of Inspector General (OIG) of the existence of several allegations and issues raised by the committee members from California regarding the VA Medical Center (VAMC) Palo Alto and Stanford University. One of the allegations claimed that there were three lists for scheduling Gastroenterology (GI) Clinic appointments for patients. The first list was described as a "legal" list of patients waiting for doctors' appointments. The second list was described as an "illegal list of patients that was created in order to make the waiting time with the required performance measures." The third list was described as a "List of patients who are scheduled to have substandard test or care in order to make the first list meeting the performance measures." This allegation was reviewed separately by the VA OIG's Office of Healthcare Inspections. The report, *Healthcare Inspection: Alleged Colorectal Cancer Screening and Administrative Issues VA Palo Alto Health Care System Palo Alto, California*, detailed its findings.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed seven current employees, including those with scheduling responsibilities; a former provider; two union officials; and a service chief.

- **Records Reviewed:** VA OIG reviewed appointment data for the GI Clinic at the Palo Alto Division (PAD).

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A senior leader for the VA Palo Alto Health Care System (VAPAHCS), who was also serving as the acting chief of the PAD GI Clinic, was not aware of any secondary or hidden lists of patients. He explained that the GI Clinic at the PAD had not been in a situation in which patients could not be seen within 90 days of their "desired date." Due to the increased availability, there had been no need to use the Electronic Wait List (EWL). Moreover, he stated that the GI Clinic also had the capacity to provide patients with appointments very close to the date the patient requested.

- A provider in the GI Clinic stated that when a patient is referred to the GI Clinic, a consult is electronically generated in the Computerized Patient Record System (CPRS), which is then routed to the GI Clinic. She reviewed incoming consults for the GI Clinic and assessed each patient's needs. After she triaged the incoming consults, an

electronically generated letter was mailed to the veterans notifying them to contact the GI Clinic scheduler. The letter included the direct phone number for the primary GI Clinic patient scheduler. She was not aware of any hidden lists of patients. She was only aware of the consults in Veterans Health Information Systems and Technology Architecture (VistA) and the patients who had been scheduled for an appointment.

- One of the PAD GI Clinic's schedulers responsible for the majority of the patient scheduling stated that the letters that were mailed to patients provided a direct phone number to contact her. When contacted, she scheduled the patient for an appointment based upon the patient's desired date. She stated that the GI Clinic did not have a waiting list. The only list that she worked with was the list of consults that had already been reviewed. Once she received the consults, the patient was contacted and scheduled for an appointment. She believed that approximately 90 percent of the time, she was able to schedule patients' appointments on their actual desired date. Regardless of the date of the appointment, she always recorded the patient's desired date into the VA scheduling system. She was not aware of any secondary or hidden lists of patients.

- A registered nurse in the GI Clinic who coordinated scheduling stated that she was not the primary patient scheduler but did occasionally schedule patients. She added that, normally, the GI Clinic was able to schedule the patient exactly on the desired date or very close to the desired date and that the GI Clinic did not keep any waiting lists. She stated that everything was in CPRS, including all patient interactions while trying to contact the patient for scheduling. There were enough doctors in the GI Clinic to handle all of the patients and the GI Clinic also used Non-VA Medical Care to increase capacity when needed. She added that there were so many open appointments in the GI Clinic that she sometimes worried she would not be able to fill up the schedule for the doctors.

- Two union officials stated that they had no direct knowledge of any hidden wait lists at the PAD GI Clinic. After the VAMC Phoenix[*] issue became known, one of the local officials asked several schedulers from the VAPAHCS if they were instructed to do anything they were not supposed to do, such as hiding lists of patients. All the schedulers she talked with denied receiving instructions to do anything they were not supposed to do.

- A former GI medical provider made available to us an email and short letter that outlined his complaints with VA. The document contained only a single sentence related to a second "illegal" list of patients at the PAD. The sentence read, "The second list is the illegal list that was created in order to make the waiting time within the required performance measures." He did not provide more specific information and did not respond to follow-up emails requesting a telephonic interview.

- A service chief for the VAPAHCS was not aware of any other lists besides the consults in CPRS and the patients who were scheduled for appointments. He stated that he had not

[*] Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

directed any of his staff to use a secondary list of patients. He was not aware of any extra lists of patients for any departments at the PAD for as long as he had been employed with VA.

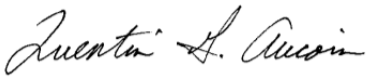
Records Reviewed

A review of appointment data for endoscopy procedures and liver studies by the PAD GI Clinic identified appointments for which the desired date and the appointment date matched. The review also identified two individuals who scheduled many of the appointments for the PAD GI Clinic.

4. Conclusion

The allegations were not substantiated. The investigation found no evidence that there were hidden patient wait lists in the PAD GI Clinic. All employees interviewed during the investigation stated they were not aware of any secondary or hidden patient wait lists. No VA employees stated that they were instructed to keep any secondary patient wait lists. The PAD GI Clinic appeared to have the capacity to handle the number of patients requiring appointments. The employee responsible for scheduling most of the patient appointments for GI Clinic stated that the majority of the time she was able to schedule a patient on the actual day requested by the patient or very close to the actual day requested.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 9, 2015.



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