STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
HEARING ON
"THE STATE OF VA HEALTHCARE"
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Mr. Chairman, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to discuss the results of the Office of Inspector General's (OIG) extensive work at the Phoenix VA Health Care System (PVAHCS), as outlined in our report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (August 26, 2014). I am accompanied by John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections; Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations; Ms. Maureen T. Regan, Counselor to the Inspector General; and Mr. Larry Reinkemeyer, Director, OIG Kansas City Audit Operations Office.

BACKGROUND

The OIG reviewed allegations at the Phoenix VA Health Care System (PVAHCS) that included gross mismanagement of VA resources, systemic patient safety issues, possible wrongful deaths, and we are continuing to review possible criminal misconduct by VA senior hospital leadership. We initiated this review in response to allegations first reported through the OIG Hotline. We expanded our work at the request of the former VA Secretary and the Chairman of the House Committee on Veterans' Affairs (HVAC) following an HVAC hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths. We also received requests from this Committee, as well as individual Members of Congress.

On May 28, 2014, we published our report, *Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System – Interim Report,* substantiating serious conditions at the PVAHCS. We provided VA leadership with recommendations for immediate implementation to ensure all veterans receive appropriate care.

Our August 26, 2014, report provides more extensive information previously provided in the interim report to reflect the results of our review and includes information on the reviews by OIG clinical staff of patient medical records. We addressed the following questions in our August report:

- Were there clinically significant delays in care?
- Did PVAHCS omit the names of veterans waiting for care from its Electronic Wait List (EWL)?

- Were PVAHCS personnel following established scheduling procedures?
- Did the PVAHCS culture emphasize goals at the expense of patient care?
- Are scheduling deficiencies systemic throughout VHA?

SCOPE OF REVIEW

Due to the multitude and broad range of issues, a multidisciplinary team comprising board-certified physicians, nurses, health care inspectors along with special agents and auditors evaluated the many allegations to determine their validity and assign individual accountability if appropriate. The team interviewed numerous individuals to include the principal complainants: Dr. Samuel Foote, a retired PVAHCS physician, and Dr. Katherine Mitchell, the Medical Director of the PVAHCS Operation Enduring Freedom/Operation Iraqi Freedom/and Operation New Dawn (OEF/OIF/OND) clinic. In addition:

- We obtained and reviewed VA and non-VA medical records of patients who died while on a wait list or whose deaths were alleged to be related to delays in care.
- We reviewed two statistical samples of completed primary care appointments to determine the accuracy of patient wait times based on our assessment of the earliest indication a patient desired care.
- We reviewed over 1 million email messages, approximately 190,000 files from 11 encrypted computers and/or devices, and over 80,000 converted messages from Veterans Health Information Systems and Technology Architecture emails.

Patient Care Reviews

Board-certified physicians and nurses in the OIG Office of Healthcare Inspections conducted a review of VA medical records for 3,409 veterans to identify delays and/or lapses in providing quality care. We also requested death certificates for 166 veterans and subpoenaed medical records from non-VA facilities for three veterans. We reviewed Medicare and other records to determine whether these veterans received care by non-VA providers.

The delays described in the report show that access barriers resulted in delays in providing quality primary and specialty care at the PVAHCS. In the course of patient case reviews, we also identified other quality of care issues unrelated to delays. These delays and lapses in care may have had or could have had a negative impact on the health and welfare of the veteran. However, we did not conclusively assert that the absence of timely quality care caused the deaths of these veterans.

In conducting our reviews, we did not apply the medical negligence standard applicable to care provided in the State of Arizona. The OIG has no authority or responsibility to make determinations as to whether acts or omissions by VA constitute medical negligence under the laws of any state or to compensate veterans or their families if the veteran suffered an injury as the result of the provision of health care. Making such determinations is a Department program function and the OIG is prohibited by statute from making program decisions to preserve its independence to conduct oversight of

VA's programs and operations. Decisions regarding VA's liability in these matters lie with the Department and the judicial system under the Federal Tort Claims Act.

Dr. Foote first contacted the OIG in September 2013 and met with OIG representatives in December 2013. In February 2014, Dr. Foote alleged that potentially 40 veterans died waiting for an appointment, and these alleged deaths were widely reported in the media. We pursued this allegation and interviewed Dr. Foote, but he was unable to provide us a list identifying by name 40 specific patients. He provided HVAC the names of 17 deceased patients, which we received from the Committee and reviewed. Based on our own review of PVAHCS electronic records, we were able to identify 40 veterans who died while on the EWL during the period April 2013 through April 2014. These veterans were included in the review of records for 3,409 patients derived from multiple sources, which included 293 deaths.

During our review, we were provided with numerous lists of PVAHCS patients. These patient lists were obtained by OIG staff while onsite at PVAHCS; obtained from the PVAHCS Quality Management office and other similar offices; submitted to the OIG Hotline; and obtained from external sources such as the HVAC, other congressional sources, and media reports. In all, OIG Office of Healthcare Inspections physicians and clinical staff examined the electronic health records (EHR) and other information for 3,409 veteran patients on the following lists:

- Veterans Health Administration (VHA) EWL – The EWL was used to list patients waiting to be scheduled for an appointment. It is a VHA-sanctioned list described in a June 9, 2010, Under Secretary for Health Directive. Patients on PVAHCS's EWL could be waiting for scheduling for either primary or specialty care.
- PVAHCS Physician List – Two PVAHCS physicians provided the names of patients for whom substandard care due to scheduling delays was alleged.
- HVAC – On April 9, 2014, the HVAC provided to the OIG a list of 17 PVAHCS patients, all deceased, who allegedly had both excessive and harmful waiting times.
- Hotline List – OIG's Hotline received numerous contacts concerning PVAHCS. Many alleged poor quality of care or harm to individual patients.
- Media – Print and electronic media reported allegations of substandard care at PVAHCS. Many reports identified and described individual patients' issues.
- Schedule an Appointment Consult List – Clinical staff at PVAHCS wanted to ensure that inpatients who did not have a primary care physician (PCP) would have primary care follow-up post-discharge. They began using the system's "Schedule an Appointment" consult function to accomplish this. Usually a clinical consult request is for an additional opinion, advice, or expertise. Emergency Room clinicians and some specialty services staff also adopted this practice.
- Institutional Disclosure List – PVAHCS patients for whom institutional disclosures had been made to patients or their families for any care-related reason. Institutional disclosures include discussions of events not associated with substantial harm. For example, PVAHCS would disclose that a patient's temperature was taken using an oral probe without a protective cover, a minor

surgical procedure had to be interrupted because of a power failure, or an x-ray was performed on the wrong patient.

- Newly Enrolled/Appointment Requested (NEAR) List – During the enrollment application process, a veteran may indicate on the enrollment form that he/she would like to be contacted to schedule an initial appointment. The NEAR list is a tool used by enrollment staff to tell schedulers that a newly enrolled veteran has requested an appointment. The NEAR list is used for initial appointments only.
- Suicides – PVAHCS patients known by either the facility or the Maricopa County, Arizona, Medical Examiner's Office to have committed suicide.
- Backlog Never Completed – 544 patients who were to be scheduled through the new patient backlog redistribution process but who never received an appointment.
- Urology Service – Partial list of patients from the closed consult and paper lists.
- Helpline Paper Printouts – From March–April 2014, patients who called the PVAHCS's Helpline requesting an appointment were placed on a paper screenshot.
- Helpline Paper Printouts – Paper screenshots found by an employee in June 2014.

The OIG examined the EHRs and other information for the 3,409 veteran patients, including the 40 patients we found on the EWL who were deceased, and identified 28 instances of clinically significant delays in care associated with access or scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 cases of care deficiencies that were unrelated to access or scheduling. Of these 17 patients, 14 were deceased. During our review of EHRs, we considered the responsibilities and delivery of medical services by PCPs versus specialty care providers (such as urologists, endocrinologists, and cardiologists). Our analysis found that the majority of the patients were on official or unofficial wait lists and experienced delays accessing primary care, although in some cases, patients were receiving specialty care through VA or non-VA providers for pressing clinical issues. For example, a patient was being seen by a VA cardiologist, but was also on the wait list to see a PCP at the time of death. The 45 cases discussed in the report reflect unacceptable and troubling lapses in follow-up, coordination, quality, or continuity of care.

The review process included an evaluation of the medical records of 3,409 patients from the sources discussed above. The OIG staff who conducted the reviews are physicians and clinicians. Reviewers used clinical judgment to determine whether, in their professional opinion, an identified delay resulted in a harmful outcome or a potentially harmful outcome. OIG physicians reviewed 743 patients. If a physician's review of the records identified deficiencies in the quality of care provided to the patient, the case was reviewed by a second OIG physician. If the two physicians agreed, the case was included in the report. Information on the qualifications of the OIG physicians who conducted these reviews can be found in the attached curricula vitae.

Several patients in cases reviewed opted for non-VA care at critical junctures. As needed, but not in all cases, we obtained and reviewed the relevant private sector

medical records. For 166 deceased patients reviewed in a second-level physician review, we requested death certificates from Maricopa County and the State of Arizona, whom we would like to acknowledge for their cooperation and expedience in meeting our requests. Supplementing the data gathered from the EHR, we also analyzed information, when available, from sources that included Medicare, non-VA health records, death certificates, media reports, and interviews with VA staff. Approximately 23 percent of the patients we reviewed received private sector medical care funded by Medicare or Medicaid, and 35 percent had insurance coverage beyond VA.

OBSTACLES TO CARE

We identified several patterns of obstacles to care that resulted in a negative impact on the quality of care provided by PVAHCS. Patients recently hospitalized, treated in the emergency department, attempting to establish care, or seeking care while traveling or temporarily living in Phoenix often had difficulty obtaining appointments. Furthermore, although we found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization, we identified problems with continuity of mental health care and care transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services.

Panel Size

Primary care was one important medical service that was not able to keep up with demand. A primary care provider's target panel size is locally determined as it is dependent on such factors as disease complexity, number of support staff, number of clinic rooms available for a provider's use, whether a provider is a new hire, and time available for direct patient care versus other activities. When a provider's panel size exceeds a clinic's target panel size, the capacity to add new patients becomes limited. Constrained panel capacity can lead to increases in the length of time it takes new patients to get an appointment. While onsite, we obtained individual provider appointment grids and panel assignments and the targeted panel capacities for April 2014. The target panel size at the PVAHCS is 1,260 patients. For the PVAHCS as a whole, the aggregate primary care panel capacity used was 98 percent. When PCPs left VA employment and their unassigned patients were factored in, aggregate panel capacity used was greater than 100 percent.

The number of unassigned patients represents a demand for established clinic spaces and panel capacity that is masked when these patients remain unassigned for extended periods. If a new provider has been hired and is known to be coming on-board within a tenable time frame, this may be practical. However, in situations where recruiting is difficult and on-boarding fairly lengthy, or for other reasons (e.g., a series of provider medical illnesses) primary care clinics routinely have substantial numbers of unassigned patients, access and continuity of patient care suffer.

Actions that can be taken to increase primary care access include increasing the number of providers, increasing target panel size, optimizing the match between variations in appointment demand and supply, expanding clinic hours, and increasing the use of non-VA purchased care. Increases in staff or panel size may be contingent

on having necessary space, the ability for providers to simultaneously use multiple exam rooms, efficient scheduling processes, sufficient support staff, or other process changes such as support for streamlining medical record documentation. For example, in several primary care clinics, available space at the PVAHCS is only able to support 1 room per clinician while the VHA recommended target panel size (1,200) assumes the availability of 3 rooms per provider.

Urology Service

Urology Service was also unable to keep up with the demand for services. During our review, it became clear that the Urology Service at PVAHCs was in turmoil during the 2012 to 2014 timeframe. There were a number of urology physician staffing changes, delays in the procurement of non-VA purchased care consults for urology, and difficulties coordinating urologic care. The OIG is currently working from a list of 3,526 patients who may be at risk for having received poor quality urologic care. As a result, urology services at PVAHCS is the subject of an ongoing review. In addition, non-urology cases whose evaluation could not be completed within the time constraints of the August 2014 report will be included in the upcoming final review.

Mental Health Services

We found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization. However, we identified problems with continuity of mental health care and care transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services. When a facility becomes reliant on a walk-in clinic structure to increasingly provide daily routine or ongoing mental health services because of diminished access to the regular outpatient mental health clinic, issues with provider continuity, care transitions, and provider assignment arise. Since coming to PVAHCS in October 2013 from outside the VA system, the Chief of Psychiatry has taken several steps to address these issues. Thirteen additional mental health prescribing clinicians were recently hired to provide the ability to assign patients to a mental health provider and increase the availability of new and established patient appointments. The mental health clinic has recently been re-organized to help improve both access to and continuity of care.

We identified prolonged waits for access to types of individual psychotherapies. In April 2014, 105 patients were waiting to be seen by a non-VA provider; as of September 4, 2014, 24 patients are waiting to be seen.

Patients Waiting for Care

As of April 22, 2014, we identified about 1,400 veterans waiting to receive a scheduled primary care appointment who were appropriately included on the PVAHCS EWL. However, as our work progressed, we identified over 3,500 additional veterans, many of whom were on what we determined to be unofficial wait lists, waiting to be scheduled for appointments but not on PVAHCS's official EWL. These veterans were at risk of never obtaining their requested or necessary appointments. PVAHCS senior administrative and clinical leadership were aware of unofficial wait lists and that access delays existed but did not effectively address these issues. Throughout the course of our review, we

promptly provided PVAHCS leadership the names of all veterans we identified as being on an unofficial wait list to enable them to take the necessary actions to get veterans the care they needed.

Inappropriate Scheduling Practices in Use at PVAHCS

From interviews of 79 PVAHCS employees involved in the scheduling process, we identified the following types of scheduling practices not in compliance with VHA policy. Some schedulers identified multiple inappropriate scheduling practices.

- Thirty staff stated they used the wrong desired date of care, resulting in appointments showing a false 0-day wait time.
- Eleven staff stated they "fixed" or were instructed to "fix" appointments with wait times greater than 14 days. They did this by rescheduling the appointment for the same date and time but with a later desired date.
- Twenty-eight staff stated they either printed out or received printouts of patient information for scheduling purposes. Staff said they kept the printouts in their desks for days or sometimes weeks before the veterans were scheduled an appointment or placed on the EWL.

PVAHCS executives and senior clinical staff were aware that their subordinate staff were using inappropriate scheduling practices. In January 2012 and later in May 2013, the Veterans Integrated Service Network (VISN) 18 Director issued two reports that found PVAHCS did not comply with VHA's scheduling policy. Our review also determined PVAHCS still did not comply with VHA's scheduling policy. Specifically, according to VISN 18 staff, PVHCS had not completely trained their clerks or established EWLs in the clinics. As a result of using inappropriate scheduling practices, reported wait times were unreliable, and we could not obtain reasonable assurance that all veterans seeking care received the care they needed.

The emphasis by Ms. Sharon Helman, the Director of PVAHCS, on her "Wildly Important Goal" (WIG) effort to improve access to primary care resulted in a misleading portrayal of veterans' access to patient care. Despite her claimed improvements in access measures during fiscal year (FY) 2013, we found her accomplishments related to primary care wait times and the third-next available appointment were inaccurate or unsupported. After we published our interim report, the Acting VA Secretary removed the 14-day scheduling goal from employee performance contracts.

HISTORY OF VHA SCHEDULING AND DATA RELIABILITY PROBLEMS

Since July 2005, OIG published 20 oversight reports on VA patient wait times and access to care yet VHA did not effectively address its access to care issues or stop the use of inappropriate scheduling procedures.

When VHA concurred with our recommendations and submitted an action plan, VA medical facility directors did not take the necessary actions to comply with VHA's program directives and policy changes.

In April 2010, in a memorandum to all VISN Directors, the then-Deputy Under Secretary for Health for Operations and Management (DUSHOM) called for immediate action to review schedule practices and eliminate all inappropriate practices. The memorandum stated that in order to improve scores on assorted access measures, certain facilities have adopted the use of inappropriate scheduling practices that were not in line with patient-centered care.

In May 2013, the then-DUSHOM waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. This annual certification requirement was initiated in January 2011. Additionally, the breakdown of the ethics system within VHA contributed significantly to the questioning of the reliability of VHA's reported wait time data.

NATIONWIDE SYSTEMIC PROBLEM

Inappropriate scheduling practices were a nationwide systemic problem. We identified multiple types of scheduling practices in use that did not comply with VHA's scheduling policy. These practices became systemic because VHA did not hold senior headquarters and facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures.

Since the PVAHCS story first appeared in the national media, we received approximately 225 allegations regarding PVAHCS and approximately 445 allegations regarding manipulated wait times at other VA medical facilities through the OIG Hotline, from Members of Congress, VA employees, veterans and their families, and the media.

The OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. The investigations focused on whether management ordered schedulers to falsify wait times and EWL records or attempted to obstruct OIG or other investigative efforts. Investigations continue, in coordination with the Department of Justice and the Federal Bureau of Investigation. While most are still ongoing, these investigations are confirming that wait time manipulations were prevalent throughout VHA.

As of August 2014, among the variations of wait time manipulations, our ongoing investigations at the 93 sites have, thus far, found many medical facilities were:

- Using the next available date as the desired date to "0-out" appointment wait times.
- Canceling appointments and rescheduling appointments to make wait times appear to be less than they actually were. We substantiated that management at one facility directed schedulers to do this.
- Using paper wait lists rather than official EWLs.
- Canceling consultations (consults) without appropriate clinical review.
- Altering clinic utilization rates to make it appear the clinic was meeting utilization goals.

Wherever we confirm potential criminal violations, we will present our findings to the appropriate Federal prosecutor. If prosecution is declined, we will provide documented results of our investigation to VA for appropriate administrative action. We will do the same if our investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, we have also kept the U.S. Office of Special Counsel apprised of our active criminal investigations as they relate to their numerous referrals to VA of whistleblower disclosures of allegations relating to wait times and scheduling issues.

Prior to our work at PVAHCS, we initiated an audit of the Health Eligibility Center. Soon after, the OIG Hotline received complaints that the Health Eligibility Center purged over 10,000 veterans' health care applications to improve performance metrics. The same complaint also identified that VHA had a backlog of over 600,000 unprocessed enrollment applications. We have expanded our work to assess the merits of these allegations, as processing veterans' applications for enrollment in VA health care is a first and important step to ensuring access to care is available and meeting veterans' needs.

CONCLUSION

The VA Secretary has acknowledged the Department is in the midst of a serious crisis and has stated VA must work to get veterans off wait lists, address cultural and accountability issues, and use their resources to consistently deliver timely health care. The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans.

Our findings and conclusions provide VA a major impetus to re-examine the entire process of setting performance expectations for its leaders and managers. Along with a rigorous follow up to ensure full implementation of all corrective actions, we plan on initiating a series of reviews based upon allegations received of appointment scheduling irregularities, barriers to access to care, and other issues that affect medical care, quality, and productivity. These reviews will provide us the opportunity to determine whether senior VA medical facility officials have implemented the Secretary's action plan.

If headquarters and facility leadership are held accountable for fully implementing VA's action plans, VA can begin to regain the trust of veterans and the American public. Employee commitment and morale can be rebuilt, and most importantly, VA can move forward to provide timely access to the high-quality health care veterans have earned—when and where they need it.

Mr. Chairman, this concludes our statement and we would happy to answer any questions you or other Members of the Committee may have.