DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

JUN 17 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-2754

Dear Ms. Lerner:

I am responding to your inquiry regarding outstanding issues in the Department of Veterans Affairs' (VA) report on its whistleblower investigation at the Phoenix VA Medical Center (hereafter, the Medical Center), which was transmitted to your office on December 12, 2014. We conducted a second site visit to the Medical Center on January 27–29, 2015, to answer the seven specific questions you raised in your inquiry. In the original report, we substantiated three of the whistleblower's four allegations and made nine recommendations to the Medical Center, all endorsed by the Secretary of VA and the Interim Under Secretary for Health. We have reviewed and concurred with the Medical Center's action plan in response to the report recommendations; all actions are ongoing. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

Findings from the current investigation, along with responses to each of the seven questions, are contained in the enclosed report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

Carolyn M. Clancy, M.
Interim Under Secretary for Health

Enclosure

Department of Veterans Affairs
Supplemental Report
to the
Office of Special Counsel
Carl T. Hayden Veterans Affairs Medical Center, Phoenix, Arizona
OSC File Number DI-14-2754
May 5, 2015

TRIM 2015-D-136

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Phoenix VA Health Care System, (hereafter, the Medical Center, but commonly referred to as the Hayden VA), located in Phoenix, Arizona. (b) (6) (hereafter, the whistleblower), a physician who is board certified in internal medicine and (at the time of the investigation) was Director of the Post-Deployment Center, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. VA conducted a site visit to the Medical Center on September 8–11, 2014, and transmitted its report to OSC on December 15, 2014.

Based on its findings, VA made nine recommendations for the Medical Center, all endorsed by the Secretary of VA and the I/USH. The VA team and the Veterans Health Administration (VHA) Office of the Deputy Under Secretary for Health for Operations and Management reviewed and concurred with the Medical Center's action plan in response to report recommendations. All actions are ongoing.

VA conducted a second site visit to the Medical Center on January 27–29, 2015, to address outstanding issues OSC had raised in their review of the original report.

Question 1: The whistleblower stated that the investigative team failed to investigate 22 of 33 additional cases that the whistleblower provided, and neglected to document its conclusions regarding the 11 cases it did investigate.

Answer: During both interviews with the whistleblower, we attempted to ascertain the identities of the Veterans cited in the 13 clinical scenarios referenced in OSC's letter. The whistleblower was able to identify the Veterans involved in 8 of them (scenarios 2, 3, 4, 7, 9, 10, 11, and 12). In some scenarios, the same patients were involved, e.g., scenarios 3 and 4 related to the same Veteran. The whistleblower was unable to identify the patients involved in scenarios 1, 5, 6, 8, and 13; therefore, VA was unable to provide any further information on these cases. The scenarios were addressed in the original report under the allegation that they were identified to support. The conclusions were listed in the conclusions section under each allegation as a collective assessment.

For clinical scenarios 2, 3, 4, and 7, which were provided as examples to support Allegation 1 that nurses failed to conduct appropriate triage in Outpatient Ambulatory Care Clinics and in the Psychiatry Clinic, "VA substantiates that nurses failed to conduct

appropriate triage in the ED. We have reviewed all cases identified by the whistleblower and have concerns regarding the care provided. These practices constitute a significant risk to public health and safety." Additionally, as provided in the original report, "VA substantiates that a nurse failed to conduct appropriate triage in MH."

Clinical scenarios 9 through 12 were provided as examples to support Allegation 3 that ED employees had engaged in numerous instances of patient neglect, and that ED nurses were drawing blood at the bedside, but labeling the specimens in a common area. On this matter, VA found the following: at the time of the investigation, there was no documentary evidence of verbal reports in the electronic health record (EHR), so "VA was not able to substantiate the allegation that nurses have engaged in numerous instances of patient neglect." There was also no evidence to support the allegations included in clinical scenarios 9, 10, and 12. VA reviewed the original interview statements of ED staff and completed additional interviews to determine whether there had been a general failure of the nursing staff to provide verbal reports to the whistleblower and other ED physicians. All ED staff interviewed during both site visits said that verbal reports had been and are currently provided.

In the original report, regarding clinical scenario 11, "VA substantiates that nurses failed to perform EKGs when ordered, and that they failed to act upon orders for serious patient complaints such as chest pain."

At the time of the site visit, as documented on page 14 of the original report, "VA substantiate[d] that labelling errors continue[d] to occur in the ED due to poor adherence to [Medical Center] policy;" *Collecting the Blood Sample*, which requires staff members to label laboratory specimens at the bedside where they can compare the label directly with the armband of the Veteran.

VA received and reviewed an additional 110 clinical scenarios provided by the whistleblower. VA finds that these clinical scenarios demonstrate evidence in support of the allegations of improper triage and delays in care, but is unable to find evidence of any adverse outcomes. In each case, Veterans received appropriate and thorough medical care by the whistleblower following her initial evaluation. None of the Veterans suffered morbidity or mortality as a result of the nursing triage. The review of these additional clinical scenarios confirms the findings included in the original report; therefore, VA makes no additional conclusions or recommendations.

Question 2: The whistleblower asserted that the OMI investigative team failed to interview key witnesses. She noted that no ambulatory care physicians, police officers, or administrative officers of the day (AOD) were interviewed. This conclusion was based upon the whistleblower's review of the witness list attached to the report.

Answer: During our return site visit on January 27–29, 2015, VA conducted interviews with ambulatory care physicians, police officers, and AODs; the list of interviewees is included in a list on the final page of this document. According to the original report (p.8 paragraph B) the whistleblower said she observed deficiencies in the ambulatory care

center (ACC) and in mental health (MH) because the nurses in these areas received emergency severity index (ESI) triage training. The ESI tool is designed exclusively for the ED, and is not appropriate or relevant to the type of care that these clinics provide.

The ambulatory care physicians reported that there are no issues with ESI triage of patients referred from primary care because the patients from this area are triaged differently than ED patients. ACC utilizes both the Briggs telephone triage manual and the Patient Aligned Care Teams (PACT) roles and responsibilities protocols for triage guidance; these are different from the ESI tool. For triaging its patients, the MH uses the Patient Assessment policy (Medical Center Memorandum No. COS/11-70, December 27, 2011), as well as a risk assessment.

The AODs and police officers reported significant improvement in the ESI triage process within the past 2 years; however, they did indicate that there appeared to be improper triage during the whistleblower's tenure as Co-Director or Director of the ED.

The completion of the requested interviews confirms the findings included in the original report.

Question 3: While noting that the training qualifications of many Phoenix VA ED triage nurses are grossly inadequate and not in keeping with the Emergency Nurses Association guidelines, there was no recommendation to expedite the immediate training of Phoenix VA ED nurses or the removal from triage of any unqualified ED nurses.

Answer: During the VA site visit in September 2014, the ED Nurse Manager immediately removed unqualified nurses from triage, and has restricted nurses from performing triage duties until their competency is assessed and training completed. Since the time the whistleblower worked in this ED, 14 of the original nurses no longer work there and have been replaced with qualified, experienced ED nurses.

The ED Nurse Manager immediately received approval for ESI triage training for all current and future ED nurses through the only course developed and taught by the creators of ESI, the Agency for Healthcare Research and Quality (AHRQ) - ESI Research Team, LLC. The ED Nurse Manager initiated expedited training of all ED nurses to ensure that they were able to perform accurate ESI triage. Training is ongoing. The Medical Center set a target date for completion of all training by May 29, 2015. Only nurses with demonstrated competency in ESI triage, which is demonstrated by the completion of the course and a score of 85 percent or better on the post-test, are assigned triage duties.

There are currently 33 nurses assigned to the ED. Thirty-two of them have now completed the ESI training and passed the post-test.

Question 4: The report referenced specific violations of VA and VHA policy in the executive summary of the report, but neglected to enumerate the nature of the specific violations, and whether any disciplinary action was taken.

Answer: Pertaining to Allegation 4, the Medical Center was found to be in violation of VHA Handbook 1101.05, *Emergency Medicine Handbook*, as documented on page 19 of the original report. The failure to make sure that vascular technicians provide 24-hour services, as required in Appendix E, page E-1 of this Handbook, poses a risk to public health and safety. Disciplinary actions were not taken.

Also pertaining to Allegation 4, VA substantiated that there were staffing shortages in the Suicide Prevention Team; however, these issues have been resolved. As additional clarifying information, the Suicide Prevention Team is providing services in accordance with Medical Center Memorandum 122-19, *Suicide and Suicide-Related Behavior*, September 15, 2014.

Question 5: The whistleblower further asserted that the report did not thoroughly investigate if verbal nursing reports and/or EKGs were withheld from the whistleblower. The report stated, "Because there are no written records in the EHR of verbal reports, there is no evidence available to either prove or disprove the whistleblower's statement that nurses did not provide verbal reports." (VA Report, p. 7) The whistleblower noted that if the agency had interviewed ED nursing staff or physicians they could have obtained answers to these allegations.

Answer: During VA's original site visit, we interviewed ED nurses and physicians who did not substantiate that verbal nursing reports and/or EKGs were withheld from the whistleblower. The list of ED staff members interviewed is listed in the original agency report. During VA's second site visit, additional staff members were interviewed who did not substantiate these allegations either.

Question 6: The report failed to address the unsafe policy of sending ill, unenrolled Veterans to the Eligibility Clinic to enroll prior to having triage in the ED. The whistleblower explained that since 2013 Veterans new to VA have been sent to the Eligibility Clinic to enroll prior to receiving an ED nurse triage evaluation, unless the patient appeared to be in dire distress. The report recommended training enrollment staff to recognize serious conditions, but did not suggest ending this practice. The whistleblower noted enrollment sometimes takes hours, and this practice is against both community standards and JCAHO regulations.

Answer: None of the employees interviewed stated that patients were sent to the Eligibility Center if they presented to the ED for medical care. The Federal Emergency Medical Treatment and Labor Act (EMTALA), also known as the Patient Anti-Dumping Law, requires most hospitals to provide an examination and needed stabilizing treatment, without consideration of insurance coverage or ability to pay, when a patient presents to an emergency room for an emergency medical condition. VHA Handbook 1101.05 requires that VHA EDs comply with EMTALA. The ED follows EMTALA regulations with all patients that present for care. The ED also treats non-Veterans for emergency reasons, and any insurance information is obtained at the bedside after an evaluation by a provider.

Question 7: The report overlooked making any recommendation for addressing the potentially life-threatening lack of sufficient cardiac monitoring in the Phoenix VA

Emergency Department. Page 6 of the report states that "At times, the need for a monitored [cardiac telemetry] bed exceeds the ED's capacity to provide it." The whistleblower questioned why the report did not recommend increasing cardiac telemetry monitoring capacity in the ED.

Answer: During the whistleblower's tenure in the ED, there were a total of 8 monitored beds. In 2014, the Medical Center increased the number of available beds in the ED from 8 to 22 by expanding into adjacent available examination rooms. This allows ED staff to move patients who no longer require cardiac telemetry monitoring to unmonitored beds. Currently, construction is underway to build a new ED that will have 22 beds, all of which would be capable of cardiac telemetry monitoring. The new ED is scheduled to open in fiscal year 2016.

Interviewee List

(b) (6), Police Officer

(b) (6), Police Officer

(b) (6) Administrative Officer of the Day (AOD)

(b) (6), Administrative Officer of the Day (AOD)

(b) (6), MD, Ambulatory Care Service

(b) (6), MD, Ambulatory Care Service