



DEPARTMENT OF VETERANS AFFAIRS
Under Secretary for Health
Washington DC 20420

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WASHINGTON, D.C.

February 26, 2016

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 Nos. DI-14-2839 and DI-14-2975

Dear Ms. Lerner:

I am responding to your request for supplemental information related to report No. 14-02603-267 of the Office of the Inspector General, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (hereafter, the Medical Center), of August 26, 2014. In it, you ask for the Office of the Medical Inspector (OMI) to investigate these issues with reference to six specific questions. OMI conducted a site visit to the Medical Center on December 7, 2015, and submits the enclosed supplemental report.

This report replies to all six questions and makes no additional recommendations to the Medical Center.

If you have any other questions, I would be pleased to address them. Thank you for the opportunity to respond.

Sincerely,

A handwritten signature in black ink that reads "David J. Shulkin, M.D." with a stylized flourish at the end.

David J. Shulkin, M.D.

Enclosure

**Department of Veterans Affairs Supplemental Report
to the
Office of Special Counsel
OSC File Numbers DI-14-2839 and DI-14-2975**

**Phoenix Veterans Affairs Medical Center
Phoenix, Arizona**

February 19, 2016

TRIM 2016-D-290

In response to a request from the Office of Special Counsel (OSC), the Department of Veterans Affairs (VA) Office of the Inspector General (OIG) issued its report (hereafter, the OIG report) No. 14-02603-267, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (hereafter, the Medical Center), on August 26, 2014. On November 18, 2015, OSC emailed a request (Attachment A) detailing specific allegations noted in the spreadsheet that should be addressed in official correspondence responding to their original referral. The Secretary requested that the Office of the Medical Inspector lead the team to respond to the six specific questions (A through F below). VA reviewed the OIG report and the transcript testimonies of the two whistleblowers. VA conducted a site visit to the Medical Center on December 7-9, 2015, in conjunction with the investigation of OSC-DI-15-4594. The VA team interviewed Ms. DeWenter, one of the prior whistleblowers, as she was also listed in the letter of allegations related to OSC-DI-15-4594.

A. (4) Unassigned patients; the allegations in the referral letter describe a situation similar to the “ghost clinics” seen from the Jackson VAMC (see DI-12-3816 and DI-13-1713); this does not appear to have been addressed in the IG report.

In Primary Care (PC), Veterans are assigned to a Patient Aligned Care Team (PACT). In the PACT model of care, each Veteran works together with health care professionals to plan for whole-person care and life-long health and wellness. The care team considers all aspects of patient health, with an emphasis on prevention and health promotion. All members of the team have clearly defined roles with a focus on forging trusted personal relationships; the result is coordination of all aspects of health care. PACT uses a team-based approach. The patient is the center of the care team that includes family members, caregivers, and health care professionals—a primary care provider (PCP) such as a physician, nurse practitioner, or physician assistant; a nurse care manager (registered nurse, (RN)); a clinical associate (licensed practical nurse (LPN)), and an administrative clerk (medical support assistant (MSA)). When the PACT requires additional services to meet patient goals and needs, the PACT oversees and coordinates that care.

As described on page 5 of the OSC referral letter, “ghost panels” occur when a PCP leaves, and as a result, his or her patients are designated as “former patients” until they are assigned to a new PCP. Since September 8, 2014, the Medical Center has taken a

two-pronged approach to ensure that Veterans continue to receive care when their PCP leaves the PACT. Although the Medical Center may not immediately assign a new PCP to a vacancy, the Medical Center does make every effort to keep the remaining members of the PACT together. Veterans rely upon established relationships with all members of their PACT and continue to contact them for any care needs. If available, a float provider or locum takes over the clinic until the Medical Center can bring on a new provider. If there is no float provider or locum available, the remaining team members (Care Manager/RN, LPN and MSA) along with the Chief of Primary Care or designee will manage all clinical issues. This interim PCP allows the PACT to remain intact, ensures continuity of care for the Veterans, and decreases the need for multiple PACT reassignments in the same year. If a Veteran's needs exceed the ability of the team without a PCP to manage his/her care, he or she will be assigned to a new PACT. Therefore, even though a Veteran may not be immediately reassigned to a different PACT after his/her PCP leaves, he or she will continue to receive care as outlined above. Although, Ms. DeWenter no longer works in PC, she indicated that currently there are same day access appointments for PC and thus she no longer had concerns about "ghost clinics."

B. (5) Elimination of the weekend clinic service; does not appear to be addressed specifically in the OIG report. The report notes there were emails between Ms. Helman and Dr. Deering and Dr. Burke regarding these services, but does not explain the nature of the problems, or possible solutions.

The Medical Center has operated two Saturday PACT clinics without interruption since June 2013, and its Southeast Community-Based Outpatient Clinic (SECBOC) operates one. While the Medical Center does not currently conduct Saturday clinics on holiday weekends, it is reassessing the need for them. In reference to the above emails referred by OSC:

- a.) On page 41 of the OIG report, Ms. Helman requests an action plan to increase access ("...to start getting Veterans in."). She requested staffing, weekend/evening clinics, and blocked administrative time issues be addressed.
- b.) On page 51 of the OIG report, Dr. Burke's statement "I bring it up with HAS [Health Administration Service] and they tell me they are working on it, are offering overtime for clerks to work weekends scheduling pts off EWL, are enlisting the team MSA's, etc." is in reference to scheduling appointments for patients on the EWL, not staffing weekend clinics.

C. (6) Review of specific deceased veteran identified by Ms. DeWenter who was returned to the EWL; not specifically addressed in the OIG report.

The OIG addressed this concern on pages 42-43 in their report:

Deceased Veterans on the EWL

A PVAHCS [Phoenix VA Health Care System] employee told us that coworkers may have changed death dispositions of Veterans who died while on the EWL, causing the Veterans to reappear on the EWL. In

addition, four of the schedulers interviewed stated they were also aware of deceased Veterans that they had previously removed from the EWL (because they were told the Veterans were deceased) who later reappeared on the EWL.

Certain audit controls within VistA [Veterans Information Systems and Technology Architecture] were not enabled, which limited our ability to determine whether any malicious manipulation of the VistA data occurred. At our request, VA enabled this audit trail capability at PVAHCS and nationwide. We identified nine Veterans whose EWL record indicated a "Date of Death Error." We were able to review seven of nine Veterans' records that had been identified as altered after VA turned on the VistA audit trail function on April 24, 2014. For those seven Veterans, the VistA audit trail showed "Postmaster" as the user name. These actions were processed as an electronic action that removed the death disposition and added "Date of Death Error" to the records. This occurred because there was no date of death recorded in the Veteran's record by PVAHCS. The Postmaster automated routine deletes an electronic wait list EWL [electronic wait list] "Death" disposition if there is no date of death in the Veteran's record and enters the reopen reason as "Date of Death Error" as an electronic control to prevent errors in reporting deaths.

PVAHCS local policy, which refers to deaths inside the facility, states schedulers should notify Decedent Affairs or the Administrative Officer of the Day about a Veteran's death. According to a Decedent Affairs employee, upon verification of death, Decedent Affairs should record the Veteran's date of death in the electronic records. We found at least one example in which a scheduler noted a Veteran's death in VistA, but Decedent Affairs did not record the Veteran's date of death in the electronic records until about 3 months later. Because the Postmaster automated routine deletes an EWL "Death" disposition if there is no date of death entered in the Veteran's record, we believe it is imperative that staff timely notify Decedent Affairs, and Decedent Affairs staff timely verify and record Veteran deaths in VistA.

It appears that deceased Veterans were automatically placed back on the EWL when a date of death had not been appropriately entered into the record.

In December 2014, the Medical Center developed a "Decedent Affairs" Standard Operating Procedure (SOP). This SOP describes many scenarios including the specific steps to take when recording a death. The Decedent Affairs Clerk investigates all outside death notifications to verify and enter the date of death in accordance with the nationally established notification standards, and submits data regarding date of death entries every month for supervisory monitoring and verification that the clerk has closed out the date of death appropriately in VistA.

D. (9) Staff who were directed not to schedule new patient appointments; IG report notes that EWLs was not being used as of May 2014. Can we get an update on this and whether this practice is ongoing?

The past practice identified in the OIG report is no longer in effect. The Medical Center is using EWLs for PC and Specialty Care Clinics; however, it does not place Veterans waiting for Home Based Primary Care (HBPC), Respite, and Geriatrics and Extended Care (GEC) on an EWL. It adds these Veterans directly to the HBPC, Respite, or GEC clinic list. Currently, the Medical Center has no patients on the PC's EWL. At its daily morning report, staff members report the number of patients on each EWL, as well as those waiting for HBPC, Respite, and other GEC programs. Clinical and HAS leadership review the information for accuracy and any indicated follow up.

On November 30, 2015, there were 259 Veterans on the Mental Health/Psychotherapy EWL who needed appointments scheduled. On December 11, 2015, the Medical Center contacted all of them, found that 178 still needed appointments, and made them; it plans to make these outreach calls until all patients needing appointments receive them. The Medical Center also contacted Veterans on other EWLs and either made the appointments or offered them the option to use the Veterans Choice Program. On February 19, 2016, the Medical Center reported that the current Mental Health EWL was 136. While continuing to monitor its EWLs and offering appointments or the Veterans Choice Program option, the Medical Center has increased staffing in the Mental Health, Podiatry, Physical Medicine and Rehabilitation, and Physical Therapy clinics in order to improve access and decrease wait times.

The Medical Center has trained MSAs in Specialty Care areas on EWL, the Veterans Choice Program, and Scheduling Best Practice. In addition, it conducts ongoing audits to ensure that scheduling practices comply with the Scheduling Directive. A full-time Scheduling Trainer now educates new and existing staff on VA's policies and procedures related to scheduling practice compliance.

E. (10) Managers directing schedulers not to call patients; No references provided in the OIG report.

As explained in the OIG report on pages 43-44, under the section titled New Enrollee Scheduling Process.

Prior to February 2013, when new patients to PVAHCS requested an appointment, PVAHCS staff referred them to the eligibility and enrollment staff to verify eligibility. Once eligibility was verified, the eligibility and enrollment staff scheduled a primary care (appointment) for the Veteran, regardless of the available time frame for an appointment. A prolonged period between the appointment request and the available appointment date was not unusual.

As part of the restructuring and clinic clean-up process, the Chief of HAS issued a memo requesting the removal of scheduling responsibilities from a list of individuals. The list included eligibility and enrollment staff as well

as Helpline staff. As a result the process to obtain an appointment became more complicated for the Veteran. Instead of scheduling an appointment for a newly enrolled Veteran or adding them to the EWL, eligibility and enrollment staff gave the Veteran the Helpline phone number to the call to schedule an appointment. The Helpline, in turn, printed screen shots representing Veteran appointment requests directly to printers in HAS data management services instead of actually scheduling the appointment. HAS personnel from outpatient services collected the screen shot printouts from data management to place Veterans on EWL, and eventually contact the Veteran to schedule an appointment. Ultimately, new patient primary care appointment requests from enrollment, Helpline, ED, or inpatient providers were funneled to only about three staff responsible (sometimes more staff during overtime work) for adding Veterans to the EWL and contacting the Veterans to schedule an appointment. This change in process resulted in delays in Veteran receiving appointments."

A February 2013 Medical Center process change directed schedulers not to call patients in order to funnel new patient PC appointment requests to a limited number of staff in the HAS. This attempt to improve processing is no longer in effect.

F. (11) See above-Similar to no. 4; Large numbers of unassigned patients waiting to be assigned to a provider.

PCP assignment occurs when the provider's name and team are populated to the Veteran's electronic record. The Medical Center's past practice had been to assign a PCP after the initial PC appointment had occurred, but since this process can take up to a week to complete, it has been changed. The PCP assignment now occurs at the same time as the initial appointment. As of January 14, 2016, the Medical Center no longer maintains a separate wait list for assignment of patients to PCPs.

The Medical Center uses the Newly Enrolled Appointment Requested (NEAR) list to track new Veterans. On January 14, 2016, 24 Veterans were on this list. Of the 24, the Medical Center had already attempted to contact and assign PCPs and initial appointments to 21. Of these, 1 was assigned and appointed to a new PCP, 2 declined appointments, and letters had been sent to the address of record of another 18 Veterans after 1-3 unsuccessful attempts to contact them by telephone had been made. The remaining three Veterans had appeared on the NEAR list within the previous 24 hours, and staff members were in the process of contacting them. We did not find large numbers of unassigned patients, and the Medical Center provided evidence that it was actively managing its NEAR list.

Attachment A

From: McMullen, Catherine [<mailto:CMcMullen@osc.gov>]
Sent: Wednesday, November 18, 2015 6:49 PM
To: Miranda, Bonnie
Cc: Nguyen, Nhi; Cox, Gerard R. VHACO; Young, John
Subject: [EXTERNAL] OSC File Nos. DI-14-2939 and DI-14-2975/Phoenix

Bonnie-

As discussed in our telephone conference today, I am sending a follow up email detailing specific allegations noted in the spreadsheet that should be addressed in official correspondence responding to our original referral. As noted previously, the report is due on January 18, 2016, [extension granted to March 4, 2016]. If you have any questions regarding these matters, please to not hesitate to contact us. Thank you.

4. Unassigned patients; the allegations in the referral letter describe a situation similar to the "ghost clinics" seen the cases from the Jackson VAMC (see DI-12-3816 and DI-13-1713), this does not appear to have been addressed in the IG report.

5. Elimination of the weekend clinic service; Does not appear to have been addressed specifically in the IG report. The report notes there were emails between Ms. Helman and Dr. Deering and Dr. Burke regarding these services, but does not explain the nature of the problem, or possible solutions.

6. Review of specific deceased veteran identified by Ms. DeWenter who was returned to the EWL; Not specifically addressed in the IG report.

9. Staff who were directed not to schedule new patient appointments; IG report notes that EWL was not being used as of May 2014. Can we get an update on this and whether this practice is ongoing?

10. Managers directing schedulers not to call patients; No references provided in the report.

11. See above- Similar to no. 4; Large numbers of unassigned patients waiting to be assigned to a provider.

Catherine