

Ms. Paula Pedene

Ms. Pauline DeWenter

March 26, 2016

Mr. John Young
Attorney, Disclosure Unit
Office of Special Counsel
1730 M. Street NW, Suite 218
Washington, DC 20036-4505

Re: OSC File No. DI-14-2839 and DI-14-2975

Dear Mr. Young:

We are providing the following responses to the February 19, 2016, VA response TRIM 2016-D-290:

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.

We counter the VA response. At the time of the allegation, evidence was provided to OIG to show that in fact Phoenix VA would drop the PACT team and the Provider assignment from the Primary Care Management Module (PCMM). Ms. DeWenter testified that Ambulatory Care would leave the patient unassigned, allowing the medical center to still collect the funds from the patient even though they were not assigned a provider. It was also standard practice to NOT send a letter to the patient if their provider had left, thus leaving them in “limbo” until the Veteran contacted the medical center. Thus, if a provider would leave or if a new patient was seen and vested, the Provider assignment would take place only when the Veteran called in to make an appointment, which in some cases could be six months, or one year. If it was greater than two years, a new patient exam would need to be scheduled. This “false vesting” was referred to the OIG and it is whistleblower beliefs that such practices allowed the medical center to collect millions of dollars for patients that were not being provided care.

Had the OIG asked, this information could have been verified by any of the staff who work within MyHealthEVet office or in the library. In fact, library staff, as part of their recurring duties, would assist patient who would come into the library and say their “MyHealthEVet” account wasn’t working. Staff would sit down at the computer with the patients, watch them log in, go to their Provider tab and see it was blank. As the system needs a primary care provider assignment to send secure messages, patients would receive no reply. When this discovered, staff would then refer the Veteran back to their clinic to find out who/when a provider would be assigned.

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.

We counter the VA response. The response from VA confuses a Saturday New Patient Clinic with a Saturday Patient Aligned Care Team (PACT) Clinic with already established patients. Due to the nature of PACT, a new patient may or may not be scheduled in a Saturday clinic. If the VA would refer back to the anonymous letter "Hurting Patient Care" (Attachment 1) sent on April 11, 2013 to--

- Office of the Medical Inspector, OMI (10MI), 810 Vermont Avenue NW, Washington, DC 20420
- Office of Quality Monitoring, Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181
- Department of Veterans Affairs, Office of Inspector General (50), 810 Vermont Avenue, NW, Washington, DC 20420
- Secretary of Veterans Affairs Eric Shinseki, 810 Vermont Ave. NW, Washington, DC 20010

...the letter clearly states the following:

To understand the concerns that have developed I hope to put into context the background of this VA. For 7 years prior to this administration, the overflow of patients seeking care was handled through a Saturday clinic. This involved staff who volunteered to work for overtime pay, and to provide intake for the patients waiting to be seen by a primary care provider. Labs and other tests were obtained, and the patients were assessed by a provider who determined how stable the patients were, and recommended appointments as quickly as warranted. Some patients were found to be critically ill, and received immediate appointments and consults to specialty clinics, such as GI, Oncology, Pulmonology. The providers would typically provide interim care in the days and weeks after the Intake appointment as warranted until they could be seen. It was a short term solution to the burgeoning influx of patients. However, shortly after the new Director Sharon Helman took over, this clinic was shut down, without any viable options to manage the workload. Staff who thought it best to schedule patients earlier or later in the day were prohibited because the director threatened that the use of overtime would negatively impact their performance evaluations.

After the closing of the Saturday Clinic, patient access rapidly declined. There was a point when the first appointment available was 9 months out, and now some appointments may take as long as a year. The new way patients are now dispersed to providers is not organized. Then it was discovered HAS had begun compiling several lists, and that some providers were getting an unfair share of new patients. Chaos was the word of day. After some dialogue it was decided there would be one list, but only one person had access to it, which was likely an improbable task based on the volume.

Because the changes were never communicated or shared, there was so much confusion, nobody was confident of the correct process. In addition to new patients, as more and more providers left, the providers that stayed would find themselves cross covering as many as two separate

panels. The patients of the providers who left had to be assigned to new providers as if they were new patients. Then the rules on this changed too, in that some provider's patients could be dispersed to any clinic, while others had to stay in their own clinic. Then the rules would change again.

To date, no New Patient Saturday Clinics are running and the recent Feb. 27, 2016 "Access Standown" as called for by the Under Secretary for Health, saw zero appointments at the Phoenix VA.

We know that the OIG received a copy of this "Anonymous Letter" as it was verified as created by Ms. Pedene and others during Ms. Pedene's testimony with the OIG.

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

We counter the VA response. Ms. DeWenter reiterates that she provided evidence to the Criminal OIG Officer McDonald of "manual data manipulation" being conducted to cover up the fact that *Veterans on the wait list did indeed die while awaiting care (emphasis added)*. Ms. DeWenter discovered this after families were called multiple times. The highly publicized case of Veteran Thomas Breen, is an example of an entry that was manually manipulated by Elmer Moore on Dec. 6, 2013. As the clerk's name was attached to this change in the list, whoever was conducting this "cover up" realized they needed more anonymity. Thus between Dec. 6, 2013 into January 2014 is when they began running an automated "Fileman" program at midnight on the Electronic Wait List. The "Fileman" was designed to mark whoever was deceased on the EWL and place them back on the list. Since this was now an automatic program being run it would now code it as date of death error and list the correction under the title "Postmaster". Therefore, the account provided in the OIG report is not accurate when compared to the evidence provided.

It is correct that after the OIG was brought into investigate on Dec. 14, 2013, the audit trail was initiated so the OIG could track the status, *but this was after multiple deaths had occurred (emphasis added)*.

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?

We concur with the findings that this has been corrected.

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

We concur with the statement and process provided in the VA response which demonstrates that primary care staff in the call center and eligibility were all instructed by the HAS Chief not to schedule new patients and scheduling keys were removed and that this process is no longer in place.

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

We counter the VA response in the first paragraph. The evidence provided on this refers to the "Gold Holding Clinic". When the Office of the Medical Inspector visit came in Dec. 2016, the practice of not assigning patients until the PCP appointments were scheduled was still occurring. PVAHCS still does not assign patients when the new patient appointment is scheduled, instead they assign once the initial appointment is completed. This practice is in place to this day. Thus we disagree with the response which state that patients are assigned once they are scheduled.

We concur with the second paragraph that is actively managing the NEAR list.

We appreciate your support in this matter.

Sincerely,



PAULA L. PEDENE



PAULINE DEWENTER

Attachment: "Hurting Patient Care" Anonymous Letter
Consent to Public Release-Pedene
Consent to Public Release-DeWenter