Moffett, Joanne (OIG)

From:	Moffett, Joanne (OIG)
Sent:	Monday, July 28, 2014 2:51 PM
To:	Gibson, Sloan
Cc:	Riojas, Jose (Jose.Riojas@va.gov); Bradley, Leigh A.; Rasmussen, Karen M.; Williams, Alyce
Subject:	Draft OIG Report on Phoenix HCS
Attachments:	Draft Phoenix Report Transmittal_7_28_2014_8_14_22.pdf; 07-28-14 DRAFT Phoenix Wait List.docx

Mr. Gibson – Mr. Griffin asked me to send the draft report on the Phoenix HCS to you. We are asking for comments by close of business Monday, August 11th. Linda Halliday, our AIG for Audits and Evaluations, and Dr. David Daigh, our AIG for Healthcare Inspections, are available if you have any questions about the report. Their contact information is in the transmittal letter along with guidance on responding to the report.

Joanne Moffett
Special Assistant to the Inspector General

https://twitter.com/VetAffairsOIG

Department of Veterans Affairs

Memorandum

Date: JUL 28 2014

From: Acting Inspector General (50)

Subj: Draft Report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*

To: Acting Secretary of Veteran Affairs (00)

Enclosed is the draft report for the *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*. The objectives of the review were to investigate allegations at the Phoenix VA Health Care System that included gross mismanagement of VA resources, criminal misconduct by VA senior hospital leadership, systemic patient safety issues, and possible wrongful deaths.

1. Please provide your written comments to this report. In particular, state whether you concur or nonconcur with each finding and recommendation. If you nonconcur with a finding, please provide a specific explanation including supporting documentation for your decision. If you concur with a finding but do not concur with a recommendation, please provide alternative corrective action to permanently resolve the issue. If you concur with the recommendation, please provide an implementation plan with a target completion date. Comments to recommendations that do not clearly concur or nonconcur, such as "concur in principle" or "concur with comment," will not be accepted.

2. The enclosed OIG draft report is for official use only. Recipients must not show or release its contents other than for purposes of official review and comment. Since it is a draft document, the contents are subject to revision by the OIG prior to issuance of a final report. The contents must be safeguarded to preclude any improper disclosure of the information in the report. This draft and all copies of it remain the property of the OIG and must be returned to the OIG on demand. In addition, please do not transmit this draft report to stakeholders using VA's document management system.

3. We would appreciate receiving your written comments by close of business, Monday, August 11, 2014. Please submit your comments to us in memo form and transmit the memorandum electronically with a scanned copy of the signed letter and all the attachments. To adhere to 508 Compliance requirements, please also send an unsigned copy in Microsoft Word. If you or your staff wish to discuss the report, please contact Linda Halliday, Assistant Inspector General for Audits and Evaluations, at (202) 461-4542, or Dr. David Daigh, Assistant Inspector General for Healthcare Inspections at (202) 461-4662.

RICHARD J. GRIFFIN

Attachment

Halliday, Linda (OIG)

From: Rasmussen, Karen M.
Sent: Wednesday, July 30, 2014 1:02 PM
To: Abe, Gary (SES) (OIG)
Cc: Halliday, Linda (SES) (OIG); Reinkemeyer, Larry (OIG); Morris, Daniel (OIG)
Subject: RE: Discussion of PVAHCS Draft Report Recommendations (7-30-14)

Gary,

I thought we also agreed on:

22. We recommend the Acting VA Secretary ensure the Veterans Health Administration's Chief Ethics Officer for Health Care or alternate comparable position in VHA with appropriate authority has direct reporting authority to the Under Secretary for Health.

Additionally I have two questions from senior leadership regarding the report:

1. Mr. Rob Nabors and Acting Secretary Gibson anticipate questions about the list of 40 patients who died waiting for care at Phoenix that was initially provided by Dr. Foote, and announced by Chairman Miller during the HVAC Hearing in April. We've noticed the report doesn't mention that particular list or how it was investigated by OIG. We've been asked to develop a response to this anticipated question and need your input on the matter. Perhaps you've already worked out a message you can share with us?
2. Can you provide us with the list of 3500 patients who were waiting for an appointment but were not on the EWL (cited on page 34 of the report) – so we can validate that VHA has contacted all of the patients you identified.

Can you get back to me as soon as possible today – we are accountable for a response to the Acting Secretary later today.

Karen M. Rasmussen, M.D.
Director, Management Review Service (10AR)
Phone: (202) 461-6643
e-mail: VHA10ARMRS2@va.gov

From: Abe, Gary (SES) (OIG)
Sent: Wednesday, July 30, 2014 11:11 AM
To: Rasmussen, Karen M.
Cc: Halliday, Linda (SES) (OIG); Reinkemeyer, Larry (OIG); Morris, Daniel (OIG); Abe, Gary (SES) (OIG)
Subject: Discussion of PVAHCS Draft Report Recommendations (7-30-14)

Karen,

Please reply back to us that these are the changes you understand we discussed this morning.

17. We recommended the Acting VA Secretary establish veteran-centric goals and eliminate current goals that divert focus away from providing timely quality care to all eligible veterans.

19. We recommended the Acting VA Secretary provide veterans needed care in a timely manner that minimizes the use of the electronic wait list.

23. We recommended the Acting VA Secretary conduct a nationwide review of the Veterans Health Administration to assess its ethical culture and make recommendations that ensure its workplace culture is based on integrity, fairness, and respect.

Also, let us know if Secretary McDonald is going to sign. If so, we and VHA will need to change all references to Acting Secretary to Secretary in the recommendations in the final report.

Gary K. Abe
Deputy Assistant Inspector General
Office of Audits and Evaluations (52A)
Office of Inspector General
Department of Veterans Affairs

Telephone: (202) 461-4543
Cell: (206) 953-7227

Daigh, John (OIG)

From: Daigh, John (SES) (OIG)
Sent: Wednesday, July 30, 2014 3:38 PM
To: Rasmussen, Karen M.
Subject: The "40" deaths

Karen, My response to this question. My cell is ...david

1. Mr. Rob Nabors and Acting Secretary Gibson anticipate questions about the list of 40 patients who died waiting for care at Phoenix that was initially provided by Dr. Foote, and announced by Chairman Miller during the HVAC Hearing in April. We've noticed the report doesn't mention that particular list or how it was investigated by OIG. We've been asked to develop a response to this anticipated question and need your input on the matter. Perhaps you've already worked out a message you can share with us?

During the course of the Phoenix review many list of patients who were potentially harmed by delays in care were presented to OIG. In total, we looked at 3409 patient records which included the "40" deaths referred to in the media. Some of these patients were on list provided by Congress, some on list that were identified in the course of OIG field work at Phoenix, some through hotlines to VA OIG, and some from press reports. There are significant legal restrictions placed upon the OIG with respect to the public presentation of medical information about specific veterans.

The OIG report addresses the issue of possible veteran harm to veterans at Phoenix as the result of delays in medical care. The presentation of data in the report is designed to make clear the impact of these delays upon the Veteran population by presenting examples of patient harm without publically identifying any specific veteran.

Please note that Dr. Foote did not know the specifics of the "deaths" on the waiting list.

Daigh, John (OIG)

From: Daigh, John (SES) (OIG)
Sent: Thursday, July 31, 2014 8:54 AM
To: Rasmussen, Karen M.
Subject: message

Was the message on the deaths well received by leadership. Davi d

Griffin, Richard J. (SES) (OIG)

From: Gibson, Sloan
Sent: Monday, August 04, 2014 6:46 PM
To: Griffin, Richard J. (SES) (OIG)
Subject: Re: Meeting Today and Phoenix

Griff,

Thanks on all counts! I appreciate the focus on the 40 deaths, the follow up on the 3500, the offer to consolidate the ethics item, and also for the additional week to wrap up the response. We can follow up orally later on the interview as you suggested.

Appreciate you and your team meeting with us today. We won't get where we need to be with just one visit. Will need to keep working at this.

Welcome back.

Sloan

Sloan Gibson
Deputy Secretary
U.S. Department of Veterans Affairs

From: <Griffin>, Richard Griffin <Richard.Griffin@va.gov>
Date: Monday, August 4, 2014 5:36 PM
To: "U.S. Department of Veterans Affairs" <sloan.gibson@va.gov>
Subject: RE: Meeting Today and Phoenix

Sloan,

We can discuss the issues we didn't cover in our brief conversation in your office.
#1. As I mentioned, the mysterious "40 deaths is being added to the draft. We will forward updated language soon.
#2. The 20 investigations weren't ready for prime time. We are still working them diligently along with all the others.
#3. The 3500 were promptly provided per the spread sheet I gave you.
#4. Helman has not been interviewed for a number of reason. Best to describe orally.
#5. I am agreeable to consolidating the ethics recommendations if that is your desire.

Lastly, if it would help, we could give you another week to respond to the recommendations without jeopardizing our commitment to publish in August. Please advise.

From: Gibson, Sloan
Sent: Monday, August 04, 2014 5:42 AM
To: Griffin, Richard J. (SES) (OIG)
Subject: Meeting Today and Phoenix

Griff,

Welcome back from your well deserved time off! Hope you had a good time and a good break.

We are getting together later today I believe. This is a meeting that I suggested and I wanted to be sure you knew what I had in mind.

Every week I get the summaries of IG reviews of regional offices where I see the same findings over and over. Every time I follow up with Allison, I get the same sense of fundamental disconnect between what they consider important and what your teams audit. I would like to have an unemotional, open, and candid discussion about these issues to see if we can't reconcile these different views. I do not believe that Veterans are best served by the continued disconnect between VBA and our IG.

Separately, I wanted to share a couple of thoughts/questions from the Phoenix report now that you are back in the office.

1. I was surprised to see no reference to the allegation of 40 deaths. Normally, your reports clearly address whether an allegation was substantiated or not. What was the conclusion and is there a reason this very serious allegation doesn't get directly addressed?

2. We had expected to get information on 20 additional sites along with this report. Is that information being conveyed separately and when can we expect to receive it?

3. When you released your interim report, it referred to the 1700 names which we have worked vigorously since. The new report refers to 3500. Is there a reason we didn't get these sooner? I'm not sure we have the list of names. The last I heard we were trying to piece together a list that totaled about 3500 from our own sources. Do we have the list now?

4. I believe I understood from the ICRT that Sharon Helman has never been interviewed. Can this be correct? Is there any conceivable way that a review could be considered complete without interviewing the MC director?

5. There are five recommendations that have to do with reinforcing the existing ethics program. I think we need a "from the ground up" review and potential overhaul of our entire activity. Rather than non-concurring with your recommendations, perhaps we could agree on an approach that gets to the essence of the concern.

Thanks for giving all this your consideration and look forward to seeing you later today.

Very best,

Sloan

Sloan Gibson
Deputy Secretary
U.S. Department of Veterans Affairs

Abe, Gary (OIG)

From: Abe, Gary (SES) (OIG)
Sent: Wednesday, August 06, 2014 1:39 PM
To: Rasmussen, Karen M. (Karen.Rasmussen@va.gov)
Cc: Halliday, Linda (SES) (OIG) (Linda.Halliday@va.gov); Reinkemeyer, Larry (OIG) (Larry.Reinkemeyer@va.gov); Morris, Daniel (OIG); Moffett, Joanne (OIG); Griffin, Richard J. (SES) (OIG)
Subject: Updated Draft
Attachments: 8-6-14 DRAFT Phoenix Wait List (Updated 1).docx

Karen,

This is the updated draft. Changes occur on page ii and page 1, which discusses 40 patient deaths. Page 72 reflects changes in recommendation on Ethics Program. If you have any questions please give me a call.

Gary K. Abe
Deputy Assistant Inspector General
Office of Audits and Evaluations (52A)
Office of Inspector General
Department of Veterans Affairs

Telephone: (202) 461-4543
Cell: (206) 953-7227

Moffett, Joanne (OIG)

From: Miranda, Bonnie (SES)
Sent: Tuesday, August 19, 2014 5:43 PM
To: Moffett, Joanne (OIG)
Subject: Memo from SecVA to Acting IG
Attachments: 4450_001.pdf; FINAL SECVA USH Memo - OIG Draft Report - Patient Wait Times_8 17 14.docx

Attached is the scanned signed version of the transmittal memo and also the word document.

From: co1027ir40@va.gov [mailto:co1027ir40@va.gov]
Sent: Tuesday, August 19, 2014 4:22 PM
To: Miranda, Bonnie (SES)
Subject: Attached Image

Department of Veterans Affairs

Memorandum

Date: AUG 1 8 2014

From: Secretary of Veterans Affairs (00)

Subj: OIG Draft Report, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System

To: Acting Inspector General (50)

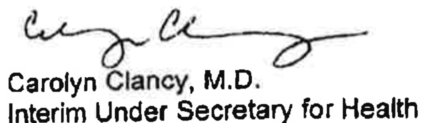
1. VA is in the midst of a very serious crisis. As we now tackle nationwide challenges to timely Veteran access to health care while also fixing our scheduling system, our priorities are clear: 1) to get Veterans off wait lists and into clinics; 2) to address VA's cultural issues, which includes holding people accountable for willful misconduct or management negligence, and creating an environment of openness and transparency; and 3) to use our resources to consistently deliver timely, high-quality health care to our Nation's Veterans.

2. We sincerely apologize to all Veterans and we will continue to listen to Veterans, their families, Veterans Service Organizations and our VA employees to improve access to the care and benefits Veterans earned and deserve.

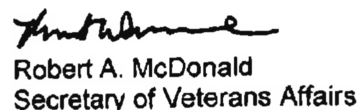
3. We concur with all the recommendations in the draft final report and will use them to hone the focus of VA's actions moving forward.

4. We appreciate OIG's in-depth investigation into a whistleblower's allegation that 40 Veterans died while waiting for an appointment. OIG pursued this allegation, but the whistleblower was unable to provide OIG with a list of 40 patient names. It is important to note that while OIG's case reviews in the report document substantial delays in care, and quality of care concerns, OIG was unable to conclusively assert that the absence of timely quality care caused the death of these Veterans.

5. VA took immediate and ongoing actions to address the deficiencies identified in the Interim Report. Attached are our specific responses to address the 24 recommendations contained in the OIG report. If you have any concerns regarding this memorandum, please email Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.



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



Robert A. McDonald
Secretary of Veterans Affairs

Attachment