

**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
OVERSIGHT HEARING ON
"DATA MANIPULATION AND ACCESS TO VA HEALTHCARE:
TESTIMONY FROM GAO, IG, AND VA"
JUNE 9, 2014**

Chairman Miller, Ranking Member Michaud, and Members of the Committee, thank you for the opportunity to testify today to discuss the interim results of the Office of Inspector General's (OIG) work related to the delays in care at the Phoenix Health Care System (HCS).¹ I am accompanied by Ms. Linda A. Halliday, Assistant Inspector General for Audits and Evaluations.

BACKGROUND

We initiated this review in response to allegations first reported to the OIG Hotline and expanded at the request of the VA Secretary and the Chairman of the House Veterans' Affairs Committee (HVAC) following an HVAC hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths. I want to stress that while our work is not complete, we have substantiated that significant delays in access to care negatively impacted the quality of care at this medical facility.

The issues of manipulation of wait lists is not new to VA and since 2005, the OIG has issued 18 reports that identified, at both the national and local levels, deficiencies in scheduling resulting in lengthy waiting times and the negative impact on patient care. As required by the Inspector General Act of 1978, each of the reports listed was issued to the VA Secretary and Congress and is publicly available on the OIG website. These reports are identified as an appendix to this statement.

Due to the multitude and broad range of issues, we are conducting a comprehensive review requiring an in-depth examination of many sources of information necessitating access to records and personnel, both within and external to VA. We are using our combined expertise in audit, healthcare inspections, and criminal investigations, along with our institutional knowledge of VA programs and operations and legal authority to conduct a review of this nature and scope.

A detailed assessment of the information obtained from Phoenix HCS' medical records and its business practices requires a full understanding of VA's current and historical policies and procedures as well as the current practices, facts, and circumstances

¹ *Interim Report: Review of VHA's Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System* (May 28, 2014).

relating to these serious allegations. We have and will continue to conduct comprehensive interviews of numerous individuals to evaluate the many allegations, determine their validity, and if appropriate, assign individual accountability. Despite the number of allegations, each individual allegation is nothing more than an allegation. We are charged with reviewing the merits of these allegations and determining whether sufficient, credible factual evidence exists to meet the standards required by applicable laws and regulations to hold VA or specific individuals accountable on the basis of criminal, civil, or administrative law and regulations.

In late April, the OIG assembled a multidisciplinary team comprised of board-certified physicians, special agents, auditors, and healthcare inspectors from across the country to address numerous allegations at Phoenix and other VA medical facilities. Since the Phoenix HCS story broke in the national media, we have received allegations of similar issues regarding manipulated waiting times at other Veteran Health Administration (VHA) medical facilities through the OIG Hotline, from members of Congress, VA employees, veterans and their families, and the media.

In response, we have opened reviews at other VHA medical facilities to determine whether scheduling practices were in use that did not comply with VHA's scheduling policies and procedures. Clearly, there are national implications associated with inappropriate and non-compliant scheduling practices, including the impact on patient care and a lack of data integrity. Veterans who utilize the VA health care system deserve quality care in a timely manner. Therefore, it is necessary that information relied upon to make mission-critical management decisions regarding the demand for vital health care services must be based on reliable and complete data throughout VA's health care networks.

Our review in Phoenix has focused on two fundamental questions:

- (1) Did the facility's electronic wait list (EWL) purposely omit the names of veterans waiting for care and, if so, at whose direction?
- (2) Were the deaths of any of these veterans related to delays in care?

To address the allegations received thus far and remain prepared to address new allegations at medical facilities throughout VA, we are deploying Rapid Response Teams. We are not providing VA medical facilities advance notice of our visits to reduce the risk of destruction of evidence, manipulation of data, and coaching staff on how to respond to our interview questions. To date, we have ongoing or scheduled work at 56 VA medical facilities and have identified instances of manipulation of VA data that distort the legitimacy of reported waiting times. When sufficient credible evidence is identified supporting a potential violation of criminal and/or civil law, we have contacted and are coordinating our efforts with the Department of Justice.

Our review at the Phoenix HCS includes the following actions:

- Interviewing staff with direct knowledge of patient scheduling practices and policies, including scheduling clerks, supervisors, patient care providers,

management staff, and whistleblowers who have stepped forward to report allegations of wrongdoing.

- Collecting and analyzing voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.
- Obtaining and reviewing VA and non-VA medical records of patients whose death occurred while on a waiting list, or is alleged to be related to a delay in care.
- Reviewing performance standards, ratings, and awards of senior facility staff.
- Reviewing past and new complaints to the OIG Hotline on delays in care, as well as those complaints shared with us by members of Congress or reported by the media.
- Reviewing other documents and reports relevant to these allegations, including administrative boards of investigations or reports of reviews conducted by VHA's Office of the Medical Inspector.
- Reviewing over 550,000 email messages and documents, extracted from over 50 gigabytes of collected email, and imaging and reviewing 10 encrypted computers and/or devices, and over 140,000 network files.

RESULTS TO DATE REGARDING PHOENIX HCS ALLEGATIONS

Our work to date has substantiated serious conditions at the Phoenix HCS. We identified about 1,400 veterans who did not have a primary care appointment but were appropriately included on the Phoenix HCS' EWL. However, we identified an additional 1,700 veterans who were waiting for a primary care appointment but were not on the EWL. Until that happens, the reported wait time for these veterans has not started. Most importantly, these veterans were and continue to be at risk of being forgotten or lost in Phoenix HCS's convoluted scheduling process. As a result, these veterans may never obtain a requested or required clinical appointment. A direct consequence of not appropriately placing veterans on the EWL is that the Phoenix HCS leadership significantly understated the time new patients waited for their primary care appointment in their FY 2013 performance appraisal accomplishments, which is one of the factors considered for awards and salary increases.

We reviewed a statistical sample of 226 Phoenix HCS appointments for primary care in FY 2013. VA national data, which was reported by Phoenix HCS, showed these 226 veterans waited on average 24 days for their first primary care appointment and only 43 percent waited more than 14 days. However, our review showed that those 226 veterans in our sample waited on average 115 days for their first primary care appointment with approximately 84 percent waiting more than 14 days. At this time, we believe that most of the waiting time discrepancies occurred because of delays between the veteran's requested appointment date and the date the appointment was created. However, we found that in at least 25 percent of the 226 appointments reviewed evidence in veterans' medical records indicates that these veterans received some level of care in the Phoenix HCS, such as treatment in the emergency room, walk in clinics, or mental health clinics.

Our reviews have identified multiple types of scheduling practices that are not in compliance with VHA policy. Since the multiple lists we found were something other than the official EWL, these additional lists may be the basis for allegations of creating “secret” wait lists. We did not report the results of our clinical reviews in our interim report on whether any delay in scheduling a primary care appointment resulted in a delay in diagnosis or treatment, particularly for those veterans who died while on a waiting list. The assessments needed to draw any conclusions require analysis of VA and non-VA medical records, death certificates, and autopsy results. We have made requests to appropriate state agencies and have issued subpoenas to obtain non-VA medical records. All of these records will require a detailed review by our clinical teams.

Lastly, while conducting our work at the Phoenix HCS our onsite OIG staff and OIG Hotline received numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility. We are assessing the validity of these complaints and if true, the impact to the facility senior leadership’s ability to make effective improvements to patients’ access to care.

RECOMMENDATIONS

While we will make recommendations to the VA Secretary in our final report, we made four recommendations to the VA Secretary for his immediate implementation to ensure that veterans receive appropriate care. We will address the sufficiency of the VA Secretary’s implementation of these recommendations in our final report. We recommended that:

- (1) The VA Secretary take immediate action to review and provide appropriate health care to the 1,700 veterans we identified as not being on any existing wait list.
- (2) The VA Secretary review all existing wait lists at the Phoenix Health Care System to identify veterans who may be at greatest risk because of a delay in the delivery of health care (for example, those veterans who would be new patients to a specialty clinic) and provide the appropriate medical care.
- (3) The VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition.
- (4) The VA Secretary direct the Health Eligibility Center to run a nationwide New Enrollee Appointment Request report by facility of all newly enrolled veterans and direct facility leadership to ensure all veterans have received appropriate care or are shown on the facility’s electronic waiting list.

We have provided VA with the list of the 1,700 veterans we identified as not being on any wait list so that VA can mitigate any further access delays to health care services, and deliver higher quality of health care.

CONCLUSION

Our work continues in Phoenix on the many allegations related to that facility. Our work also is ongoing in many other locations. Our reviews at this growing number of VA

medical facilities have thus far provided insight into the current extent of these inappropriate scheduling issues throughout the VA health care system and have confirmed that inappropriate scheduling practices are systemic throughout VHA. One challenge in these reviews is to determine whether these practices exist currently or were used in the past and subsequently corrected by VA managers. We will work diligently to complete our work and publish the results in August.

Mr. Chairman, that concludes my statement, and Ms. Halliday and I would be pleased to answer any questions that you or the Committee may have.

OIG Oversight Reports on VA Patient Wait Times

1. [Audit of the Veterans Health Administration's Outpatient Scheduling Procedures](#) (7/8/2005)
2. [Audit of the Veterans Health Administration's Outpatient Waiting Times](#) (9/10/2007)
3. [Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3](#) (5/19/2008)
4. [Audit of Veterans Health Administration's Efforts to Reduce Unused Outpatient Appointments](#) (12/4/2008)
5. [Healthcare Inspection – Mammography, Cardiology, and Colonoscopy Management Jack C. Montgomery VA Medical Center Muskogee, Oklahoma](#) (2/2/2009)
6. [Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program](#) (8/3/2009)
7. [Veterans Health Administration Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center](#) (8/17/2010)
8. [Healthcare Inspection – Delays in Cancer Care West Palm Beach VA Medical Center West Palm Beach, Florida](#) (6/29/2011)
9. [Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia](#) (7/12/2011)
10. [Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System](#) (11/8/2011)
11. [Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas](#) (1/6/2012)
12. [Review of Veterans' Access to Mental Health Care](#) (4/23/2012)
13. [Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas](#) (8/22/2012)
14. [Healthcare Inspection – Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, Washington](#) (9/25/2012)

15. [Healthcare Inspection – Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas \(10/23/2012\)](#)
16. [Audit of VHA's Physician Staffing Levels for Specialty Care Services \(12/27/2012\)](#)
17. [Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia \(4/17/2013\)](#)
18. [Healthcare Inspection – Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina \(9/6/2013\)](#)