DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 4 2014

The Honorable Mike Coffman
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
U. S. House of Representatives
Washington, DC 20515

Dear Chairman Coffman:

This is in further response to your letter dated August 19, 2014, wherein you suggest that a greater than 50 percent standard or "more likely than not standard" be used to determine whether a veteran's death was caused by delays in care related to placement on an appointment wait list. My earlier response was emailed to your staff on August 22, 2014.

In regard to your Questions 1, 3, and 4, the tenor of these questions assumes that, in making our determinations in case reviews of clinical care provided to 3,409 veterans by the Phoenix Health Care System, the OIG is bound by a VA standard for determining service-connected conditions. Let me correct that misunderstanding. The OIG did not undertake these reviews to make service-connection decisions or medical malpractice decisions because that is not the role of the OIG. We addressed this matter in our response to Question 1 in the OIG's "Questions and Answers" provided at the August 26th briefing to congressional staff:

> This report includes case reviews of 45 patients who experienced unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care. The patients discussed reflect both patients who were negatively impacted by care delays (28 patients including 6 deaths), as well as patients whose care deviated from the expected standard independent of delays (17 patients including 14 deaths).
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> Our determinations were based on the professional judgment of the OIG's board-certified physician staff. We are unable to conclusively assert that these 20 deaths were caused by delays or sub-standard care. We did not evaluate these cases to make a determination of medical negligence under Arizona State law because that is not the role of the OIG. Federal law applies State tort law to malpractice involving VA care.
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> The VA Secretary concurred with our very first recommendation to "review the cases identified in this report to determine the appropriate response to possible patient injury and allegations of poor quality of care. For patients with adverse outcomes, the Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families."

We believe that the standard posited in your questions is one for application in the legal system, and in fact is lower than the standard described in material provided by the Subcommittee on Oversight and Investigations (O&I) staff on April 9, 2014, when the OIG was first requested by the Committee to review potentially 40 veterans who died awaiting appointments. The O&I analysis asserts the need to review the medical records of the 17 deaths provided to the OIG "in order to unequivocally prove" that the deaths occurred due to delays in care—a higher and more difficult standard to meet than the 50 percent standard now suggested.

In conducting our case reviews, our physicians drew on their collective experience in practicing internal medicine, psychiatry, physical and rehabilitative medicine, rheumatology, and child neurology to make professional judgments about the quality of care provided to these patients. This is consistent with the establishment of the OIG's Office of Healthcare Inspections in 1991 to fully implement the provisions of Public Law 100-322, which calls for the OIG to oversee, monitor, and evaluate the operations of the Veterans Health Administration's quality assurance programs so as to provide the Secretary and Congress with clear and objective assessments of the effectiveness of those programs and operations.

The OIG has no authority or responsibility to make determinations as to whether acts or omissions by VA constitute medical negligence under the laws of any state or to compensate veterans or their families if the veteran suffered an injury as the result of the provision of health care. Making such determinations is a Department program function and the OIG is prohibited by statute from making program decisions to preserve its independence to conduct oversight of VA's programs and operations. Decisions regarding VA's liability in these matters lie with the Department and the judicial system under the Federal Tort Claims Act.

Although we often opine about the quality of care provided in VA facilities, these are professional judgments made based on our combined experience and expertise and are not intended to be, nor should they be used as, standard of care determinations needed to determine medical negligence in the location in which the care was provided. This has been the consistent past practice of the OIG, including prior OIG reporting where we severely criticized care provided at VA facilities such as Marion, Illinois, Columbia, South Carolina, and Atlanta, Georgia, to name just a few.

In regard to Question 2, no person at VA attempted to persuade the OIG not to use the greater than 50 percent standard or any other standard.

In regard to Question 5, we reviewed 3,409 medical records of veterans. For these 3,409 reviews of medical records, we did not record whether veterans were waiting for new appointments and/or follow-up appointments.

In regard to Question 6 and 8, our report explains that we reviewed 3,409 cases that were identified on the following lists:

- EWL—deceased patients between April 2013 and April 2014
- Former PVAHCS physician list
- HVAC list
- Hotline referrals up to June 1, 2014
- Media list
- Institutional Disclosure List for disclosures made in calendar years 2012 and 2013
- Deceased patients on the NEAR list after January 1, 2012
- Suicides after January 1, 2012

In regard to Question 7, as stated in our August 26th report on pages 36-37, we determined through interviews with Phoenix HCS Health Administration Service staff that they destroyed printouts that contained personally identifiable information. Staff stated they destroyed these printouts after they scheduled the veterans' appointments or placed them on the Electronic Wait List. Because staff destroyed the printouts during the approximate period February 2013 through March 2014, we could not identify those veterans affected by this process or confirm that they were eventually placed on the Electronic Wait List or provided an appointment. Through our interviews with staff in Phoenix, we found no evidence of removal of veterans' records and no staff stated they were aware that records were inappropriately deleted or removed from the VistA scheduling system.

In regard to Question 9, we updated the timeline of the Office of Healthcare Inspections' contacts with Dr. Foote that was provided to the Committee on August 29, 2014. The updated timeline includes details on other work activities related to our Phoenix review up to April 2014 when the Committee requested that the OIG open an investigation.

In regard to Question 10, we are providing the requested draft report under separate cover.

Sincerely,

RICHARD J. GRIFFIN
Acting Inspector General

Enclosure