DEPARTMENT OF VETERANS AFFAIRS
INSPECTOR GENERAL
WASHINGTON DC 20420

SEP 4 2014

The Honorable Jeff Miller
Chairman
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Chairman Miller:

This is in response to an email message from your staff on September 2, 2014, inquiring whether the Office of Inspector General (OIG) is going to provide the Committee on Veterans' Affairs a written copy of the original (unaltered) draft copy of the report, *Veterans Health Administration – Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*. This follows a prior request from Chairman Mike Coffman, Chairman, Subcommittee on Oversight and Investigations, requesting the draft report.

As I explained in my letter dated August 22, 2014, to Chairman Coffman, the deliberative nature of the draft report review and comment process is consistent with the principle of Inspectors General as independent and objective units of Government and long-standing practice across the Inspector General community. This process provides VA with the opportunity to provide comments to ensure that the facts and findings are accurate, to obtain concurrence with recommendations, and have VA submit a plan to implement the recommendations. During this process, VA has the opportunity to raise factual issues and other concerns. To ensure each report is accurate and complete, the OIG has an obligation to review the issues raised by VA and determine whether to make changes to the report or not. However, VA has no authority to demand that changes be made or impede the issuance of a report unless changes are made. VA's response to our reports is included in the final report. When deemed necessary, we provide a rebuttal to comments and non-concurrences with recommendations. This process ensures that VA is aware of the findings and held accountable to correct any deficiencies identified in the reports through the OIG's follow-up program.

In the last 6 years, the OIG has issued between 235 to 350 reports annually, and this same draft review and comment process has been utilized effectively to provide the VA Secretary and Members of Congress with factual objective findings and recommendations for improvements in VA programs and services for veterans. These reports have served as the basis for congressional oversight hearings, including many before the Committee on Veterans' Affairs. With a proven track record as an independent oversight organization, the OIG has never in its history received a request for a draft report for the purpose of comparing the draft and final versions until your and Chairman Coffman's requests for the OIG's original Phoenix draft report. In consideration of the extraordinary importance of the OIG's Phoenix report to bring about significant improvements to veterans access to quality health care, I have decided to

provide the original draft report to the Committee so that it can carry out its vital oversight responsibilities with the full assurance of the integrity of the OIG's reporting.

I can assure you that minimal changes were made to the draft report following receipt of VA's comments and that changes were made solely for purposes of clarity, and in no way altered the substance of the report. Many of the changes were made at the suggestion of OIG reviewers and editorial staff, who continued to review the facts and refine the language in the draft report after it was released to VA for comment up until the time the final report was published. In all instances, the OIG, and not VA, dictated the final findings and recommendations.

As you will read, the principal changes occurred in the executive summary with very few revisions to the body of the report. After much internal deliberation, we decided to directly address the potential of 40 deaths of veterans on Electronic Wait Lists in the executive summary and under Question 1, "Were There Clinically Significant Delays in Care?" The rationale was that, while whistleblowers were unable to produce a list with 40 names of veterans who died awaiting care, the allegation of 40 deaths was so pervasive that it could not go unaddressed. This revision added clarity for readers who were exposed to repeated reporting of 40 patient deaths.

We also decided to highlight in the executive summary the 20 patient deaths described later in the 45 case reviews under Question 1 (6 deceased patients who encountered significant clinical delays plus 14 deceased patients who experienced care deficiencies unrelated to access or scheduling). We note that in the material provided by the Subcommittee on Oversight and Investigations (O&I) staff on April 9, 2014, 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. While we could not conclusively establish a causal connection between these patients' deaths and their care or delays in care, nevertheless, because of the serious nature of our findings, we believed the 20 deaths warranted greater prominence in our reporting by including them in the executive summary. All 45 of the veterans in the case reviews were the subject of our first recommendation, "We recommend the VA Secretary direct the Veterans Health Administration 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 who suffered adverse outcomes, the Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families."

The 45 case reviews—truly the core of the health care findings in the report— contained minimal minor revisions; for example the blood pressure reading in Case 9 was erroneously inverted and corrected, and "late winter" was changed to "early 2014" in Case 29.

In order to both streamline and strengthen the recommendations related to lapses in organizational ethics, we changed a few recommendations in the draft report. We consolidated Recommendations 22 through 26 in the draft into Recommendation 22 in the published report. The draft recommendations focused more narrowly on the Veterans Health Administration Chief Ethics Officer for Health Care's reporting authority and training, reporting, and coordination responsibilities. The final recommendation broadened the single recommendation to conduct an overall review of the operational effectiveness, and integrity of the VHA Ethics Program. This change not only reduced the number of recommendations from five to one, but also expanded the scope beyond the few delineated areas of the draft recommendations.

The VA Secretary and Acting Under Secretary for Health agreed with our findings and recommendations, and submitted an acceptable implementation plan. We intend to rigorously follow up with VA to ensure that these plans achieve their intended results.

This draft report is provided solely for the Committee's oversight purposes and is not intended for public distribution. It contains protected health information that if released could lead to the identification of the veterans described in the 45 case reviews.

Sincerely,

RICHARD J. GRIFFIN
Acting Inspector General

Enclosure

Copy to:

Ranking Member Mike Michaud, Committee on Veterans' Affairs
Chairman Mike Coffman, Subcommittee on Oversight and Investigations