Department of Veterans Affairs
Office of Inspector General
August 26, 2014

Questions and Answers
Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System

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1. What are the most significant findings from your report?

- The OIG found that patients at the Phoenix VA Health Care System experienced access barriers that adversely affected the quality of primary and specialty care provided for them.

- Patients frequently encountered obstacles when patients or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or emergency department visits, and when seeking care while traveling or temporarily living in Phoenix.

- 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).

- 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.

- 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."

2. Did you substantiate the allegations widely reported in the media about 40 patient deaths at the Phoenix facility?

- In February 2014, a whistleblower alleged that 40 veterans died waiting for an appointment but the whistleblower did not provide us with a list of 40 patient names.

3. How many individual clinical patient reviews did you complete as part of this report?

OIG conducted a clinical review of 3,409 veteran patients identified from multiple sources, including:

- The electronic wait list
- Various paper wait lists
- The OIG Hotline
- The U.S. House Veterans' Affairs Committee and other congressional sources
- Media reports

4. Did you make any recommendations for improvement?

OIG made 24 recommendations for improvement.

5. Did the VA Secretary agree with your recommendations?

- The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans.

- OIG will use its rigorous follow up procedures to ensure full implementation of all corrective actions. The VA Secretary acknowledged that VA is in the midst of a very serious crisis and will use the OIG's recommendations to hone the focus of VA's actions moving forward.

6. Did you receive additional allegations about VA facilities after the February 2014 whistleblower complaint?

Since the Phoenix VA Health Care System story first appeared in the national media, the OIG received approximately 225 allegations regarding health care at Phoenix and approximately 445 allegations regarding manipulated wait times at other VA medical facilities.

7. What is the status of wait times investigations outside of the Phoenix review?

- The VA OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations.

- We are coordinating our investigations with the Department of Justice and the Federal Bureau of Investigation. These investigations, while most are still ongoing, have confirmed that wait time manipulations were prevalent throughout VHA.

8. Who should a veteran contact if they have additional questions about individual patients discussed in this report?

OIG policies and procedures require that all requests for information contained in OIG records be submitted to the Release of Information Office. You may mail your written request to the VA OIG Release of Information Office (50CI), 810 Vermont Avenue, N.W., Washington, DC 20420. Additional information is located on our webpage at www.va.gov/oig/foia.

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