Briefing
Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System
August 26, 2014

Agenda

- Were there clinically significant delays in care?
- Did PVAHCS omit the names of veterans waiting for care from its electronic wait list?
- Were PVAHCS personnel following established scheduling procedures?
- Did the PVAHCS culture emphasize goals at the expense of patient care?
- Are scheduling deficiencies systemic throughout VHA?

Who are the 40?

(Interview in progress)

Interviewer: And so, obviously I was hoping to get a list of names.

Foote: I do not have those names. Congress has those names. We have 23 of the, well, now 23 of the *suspected* 45 that are dead.

Interviewer: Congress does have them?

Foote: Oh, yes, they do….Jeff Miller's congressional oversight committee has them. I was going to get hit with a HIPAA violation holding on to that, so, I, you know, I'm sorry…

Delays and relationship to Death

(interview in process)

Foote: It could have been somebody on the heart. It could have been somebody hit by a bus.

Interviewer: Right.

Foote: We do not know.

Interviewer: So you don't know. Okay.

Foote: We never got a chance to see them. Okay. We don't know what their cause of death is. Now, one thing you can do is if you can get those names, look it up in the Maricopa County register and see what they died of, bus crash or heart attack, okay? And then you may get some idea of what happened if you can get that date,.....

Methodology (list)

- **Veterans' Health Administration (VHA) Electronic Wait List (EWL):** The EWL was used to list patients waiting to be scheduled. It is a VHA sanctioned list described in a June 9, 2010 Under Secretary for Health Directive. Patients on the system's EWL could be waiting for scheduling for either primary or specialty care.
- **Phoenix VAMC Physician List (Foote & Mitchell):** Two Phoenix VAMC physicians provided the names of patients for whom substandard care due to scheduling delays was alleged.
- **House Committee on Veterans Affairs (HVAC):** On April 10, 2014, the HVAC provided to OIG a list of 17 Phoenix VAMC patients, all deceased, who allegedly had both excessive and harmful waiting times. (Note: HVAC, as well as other Congressional sources, provided lists of other names. Those are noted in "Hotlines" below).
- **Hotline List:** OIG's Hotline received numerous contacts concerning Phoenix VAMC. Many allege poor quality of care or harm to individual patients.
- **Media:** Many print and electronic media report appeared alleging substandard care at Phoenix VAMC. Many reports named and described individual patients.

Methodology (list)

- **Schedule An Appointment Consult List:** Hospitalists at Phoenix VAMC wanted to ensure that inpatients who did not have a primary care physician (PCP) would have primary care follow-up post-discharge. They began using the system's "Schedule An Appointment" consult function to accomplish this (usually a clinical consult request is for an additional opinion, advice, or expertise). Emergency Room (ER) clinicians and some specialty services staff also adopted this practice.
- **Paper Wait List:** From March – May 2014, patients who called the system's Helpline requesting an appointment were placed on a paper screenshot list of appointment requests.
- **Institutional Disclosure List:** Phoenix VAMC patients for whom institutional disclosures had been made to patients or their families for any care related reason.
- **Newly Enrolled/Appointment Requested (NEAR) List:** During the enrollment application process, a veteran may indicate on their 10-10EZ that he/she would like to be contacted to schedule an initial appointment. The NEAR list is a tool used by enrollment staff to tell schedulers that a newly enrolled veteran has requested an appointment. The NEAR list is used for the initial appointments only.
- **Suicides:** Phoenix VAMC who committed suicide that was known by either the facility or the Maricopa County, Arizona Medical Examiner's Office are included.

Methodology (list)

- **Expired on AW Backlog:** Backlog patients - Not seen in Primary Care before death

New Patient Appoint list from 10/20/12 provided by [redacted] on 5/16/14. This list was referred to as the backlog patient list was a list of patients that had new patient primary care appointments more than 90 days in the future. According to [redacted] the facility divided this list evenly among all primary care providers and instructed them to add them to their panels and reschedule the patients sooner. We have obtained a listing of 1,812 veterans of the approximate 2,500 veterans that were on that list. Of those, we identified 452 patients that had not completed an appointment in primary care as of March 31, 2014. Of those, we found 16 had died.

A review of prior OIG lists found that one patient was already under review.

This list represents the 15 veterans who died waiting for primary care that were not previously identified through the EWL, Schedule an Appointment consult, or Pending Appointment Not Enrolled lists.

- **Backlog Never Completed:** List provided by Audit
- **Urology Service:** Partial list of patients from the Closed Consult & Paper Lists
- **Helpline Paper List:** List compiled and maintained by an employee

Source	# Patients On Source List	Uniques	MD Review	Deaths (using Uniques)
a) House Veterans Affairs Committee - Patient Deaths	17	17	17	17
EWL-Deaths	47	44	44	44
Helpine Paper Wait List (secret)	176	176	10	3
Paper Wait List	553	542	30	1
Schedule an Appointment Consult List	1873	1804	354	39
NEAR List-Deaths (from 01/01/12)	29	28	28	28
Suicides (from 01/01/12)	77	74	74	74
Urology Total a. Closed Consults(8) b. Paper List (4)	12	8	8	4
Phoenix VAMC Physicians	11	10	2	0
Expired on AW Backlog	14	12	12	12
Backlog never completed	561	533	45	41
Calls/Letters to VAOIG Hotline	132	118	76	21
Media (from 01/01/12)	47	32	32	8
Institutional disclosures	13	11	11	1
TOTALS	3562	3409	743	293

Were there clinically significant delays in care?

Review Process, Step 1
MD review of all cases from these sources

- **Electronic Wait List (EWL)**
- **House Committee on Veterans Affairs (HVAC)**
- **OIG Hotline**
- **Media**
- **Institutional Disclosure List**
- **Suicides**

Were there clinically significant delays in care?

Review Process, Step 2
MD review of *Mortality* cases from these sources

- **Newly Enrolled/Appointment Requested (NEAR) List:**
- **Expired on AW Backlog**
- **Backlog Never Completed**
- **Helpline Paper List**

Review Process, Step 3
OHI Healthcare Inspectors *Screened* the EHR of All Cases from These Sources

- **Schedule An Appointment Consult List**
- **Paper Wait List**

This accounted for 2,426 EHR Screens which resulted in 341 physician review referrals.

Methodology (limitations)

- Primary source of data is VA EMR.
- Supplementary source is private records, Medicare data, Death Certificates.
- Date range for cases

Results (case review)

OIG examined the electronic health records and other information for the **3,409** veteran patients, including the 40 patients reflected above in PVAHCS's records, and identified **28** instances of clinically significant delays in care associated with access or scheduling. Of these 28 patients, **6** were deceased. In addition, we identified **17** care deficiencies that were unrelated to access or scheduling. Of these 17 patients, **14** were deceased The **45** cases discussed in this report reflect unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care.

Results (mental health)

- Use of CSTAT clinics.
- Changes instituted since new chief of Psychiatry (October 2013).
- Individual and specialized psychotherapy.
  - 171 on list
  - 128 authorized and not treated
    - 96 authorization sent to patient, not TriWest
    - 9 not received or loaded by TriWest
    - 8 had appointment with a provider
    - 8 not scheduled by TriWest
    - 7 declined care

Results (mental health)

Suicides	Physician Reviewed	Delays in Care	Clinically Significant Delays	Other Quality of Care Issues
77	77	9	1	5

- The clinically significant delay related to primary care delays
- These cases are reflected in the case descriptions in the report

Results (additional cases)

We also found problems with access to care for patients requiring Urology Services. These cases will be reviewed and reported, when the work has been completed.

Conclusions

- Patients at PVAHCS experienced access barriers that adversely affected the quality of primary and specialty care provided for them.
- Although we found that a process to provide access to mental health assessment, triage, and stabilization was in place at PVAHCS, we identified problems with the continuity of mental health care and care transitions, delays in assignment to a dedicated provider, and limited access to psychotherapy.
- In addition, we found substantial problems with access to care for patients requiring Urology Services.

Recommendations

- We recommended 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.
- We recommended the VA Secretary require the Phoenix VA Health Care System to ensure the continuity of mental health care, improve delays in assignments to a dedicated provider, and expand access to psychotherapy services.

Recommendations

- We recommended the VA Secretary require the Phoenix VA Health Care System to reevaluate and make the appropriate changes to its method of providing veterans primary care to ensure they provide veterans timely and quality access to care.
- We recommended the VA Secretary direct the Veterans Health Administration to establish a process that requires facility directors to notify, through their chain of command, the Under Secretary of Health when their facility cannot meet access or quality of care standards.

End of this section of the brief