

WRITTEN TESTIMONY OF DR. KATHERINE L. MITCHELL

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CONTENT SUMMARY

I. Introduction & Background

II. Executive Summary

III. Case Reviews: Omissions Potentially Influencing the Final Context & Conclusions of the 8/26/14 Phoenix VA OIG Report

Section 1: Brief Overview Summary

- A. Clinically Relevant Information Gaps/Omissions & Implications: Examples
- B. Causal Relationship Evident Between Delayed and/or Improper Care & Veteran Death (excluding Veterans for which cause of death was not listed): Cases 29d, 36ds, 39ds, 40ds
- C. Causal Link Suspected between Delayed and/or Improper Care & Veteran Death (excluding Veterans for which cause of death was not listed): Cases 30d, 42d
- D. Care Delays Contributing to Decreased Quality of Life and/or Significantly Shortened Lifespan in Terminally Ill Veterans: Cases 3d, 31d, 32d, 34d, 37d
- E. Special circumstance: Case 35ds

Section 2: Specific Case Reviews

IV. Persistent PVAHCS Issues Having Implications for Other VHA Facilities

V. Additional Comments on the OIG Report

Executive Summary

The VA OIG issued the 8/26/2014 report entitled “Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System”.

As per the report’s executive summary, “the patient experiences described in this report revealed that access barriers adversely affected the quality of primary and specialty care at the PVAHCS”. Although investigators did document local systemic barriers to quality patient care, the OIG was “unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans.”

After reading the case studies in the OIG report, as a clinician I was unable to reach the same conclusions as the OIG investigation team. Although I agreed with OIG’s observations in many patient cases, I believe the OIG case review overlooked actual and potential causal relationships between health care delays and Veteran deaths. When evaluating cause and effect between delays and negative outcomes, I did not make any distinction between health care delays related to long appointment wait times and health care delays related to slowed diagnosis/treatment of medical conditions.

As I reviewed the OIG report, I also noted inadvertent deficits in key information that could have identified a greater number of poor quality practices. In addition, although some deaths were not preventable because of the underlying diagnosis, the missing details would have determined if those Veterans potentially suffered untimely loss of high quality days from their diminished life spans because of delays in appropriate health care.

I have no reason to believe that any information gaps or omissions in the 8/26/14 report were intentional. As I read the cases, I simply felt that there was more data needed to understand the implications and conclusions of the cases.

When reading the OIG report & conclusions, I drew upon my Phoenix VA experiences working as a former nurse, former internal medicine resident, and current physician. I considered the potential for Phoenix VA system issues that could have affected case outcome and whether or not appropriate VA services/care was offered in a timely fashion. I also deliberated whether the standards of care and treatment within the community were followed. I remained aware that there are diseases which naturally evolve into terminal illness and unavoidable death.

The omissions or gaps in information I observed are detailed in Part III section 2 of this written testimony. Part III was written to be read in conjunction with the corresponding case in the OIG report although the omissions/conclusions entries are self-explanatory. In some instances, in order to convey the implications of the omissions to those outside the health care field, I have given very simplified descriptions of disease states, treatment, or other medical processes applicable to the case.

Part III Section 1 of this written testimony summarizes significant details & omissions I believe would have changed the context and outcome of the final in the OIG report:

1. In 4 cases the OIG did not list a cause of death for the Veteran on the Electronic Wait List (EWL). Without a cause of death it does not seem possible to determine the clinical relevance of the excessive waits for initial primary care.
2. In 19 cases the OIG report did not contain information to determine if Veterans with potentially significant medical issues were informed of the walk-in process to expedite outpatient entry into and/or continued medical management within the primary care provider (PCP) clinics. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without this information being contained in the report, it is unclear of the degree to which VA PCP appointment delays significantly contributed to a worsening of physical symptoms/quality of life. In at least two cases, those details may have revealed if the delays enabled the acute worsening of chronic illness to the point the Veterans died from the disease complications.
3. In 8 cases no information was provided to determine if the Veterans presenting with significant mental health issues and/or substance abuse issues were informed of the self-referral process to acute/chronic mental health services within the Phoenix VA. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without such data, it is unclear of the degree to which VA mental health appointment delays significantly contributed to worsening psychological symptoms and, in at least two cases, may have been a barrier to suicide prevention.
4. In 8 cases no information was given to determine if Veterans with significant mental health, polysubstance abuse, and/or social support issues were referred by a VA provider to appropriate VA social work services and/or Adult Protective Services. Social work services can provide assistance with accessing resources to address mental health problems, homelessness, poor finances, and other psychosocial stressors. Evidence for lack of timely social work referrals would have indicated another significant opportunity missed by the VA to ensure quality care.
5. In 3 cases there was insufficient information to determine if Veterans who received delayed diagnosis/treatment of cancer or tumor had any significant residual symptoms related to health care delays in treatment. Evidence of significant residual symptoms would have indicated that delays in care were clinically relevant and would have shown the lasting impact of poor quality care.
6. Excluding cases for which there was no cause of death listed, in 3 cases there

appeared to be a causal link evident between delayed and/or improper care and Veteran death

7. Excluding cases for which there was no cause of death listed, in 2 cases there appeared to be a potential causal link suspected between delayed and/or improper care and Veteran death.
8. In 5 cases health care delays contributed to decreased quality of life and/or a potentially significantly shortened lifespan in terminally ill Veterans.

Part IV of this testimony outlines persistent PVAHCS issues that have implications for other facilities within the Department of the VA. Just as the scheduling irregularities and Electronic Wait List (EWL) issues were not unique to the Phoenix VA, other problems within PVAHCS have the potential to be mirrored in sister facilities throughout the nation.

Part V deals with brief observations on the OIG investigation.

Once considered an institution almost immune to change, the Department of Veteran Affairs is in the process of re-examining its priorities and practices in all facilities so that it can serve our Veterans well. The information included in this written testimony is intended to serve as a potential springboard for further discussion and positive change in not only the Phoenix VA Health Care System but also throughout the VHA.

III. CASE REVIEWS: : Omissions Potentially Influencing the Final Context & Conclusions of the 8/26/14 Phoenix VA OIG Report

NOTE: I must clearly state that I did not participate in the OIG's collection/review of the cases or in the construction of the official report. My involvement in the official OIG investigation was very limited. I only helped hide the NEAR list (New Enrollee Appointment Request list), participated willingly in the one interview that the OIG requested of me, and immediately turned over unprocessed enrollment forms that inadvertently were discovered.

Section 1: Brief Overview Summary*

**The information listed in Section 1 is not a comprehensive list of omissions or case implications. It provides some details not emphasized in the 8/26/14 OIG report. It highlights conclusions differing from those made by that OIG investigation. There is no distinction made between health care delays related to long appointment wait times and health care delays related to slowed diagnosis/treatment of medical conditions.*

Abbreviations used after case numbers:

“d” = deceased

“ds” = deceased because of suicide

“dus” = deceased but uncertain if from suicide attempt

blank = still living

A. Clinically Relevant Information Gaps/Omissions & Implications: Examples

1. Cause of death is not listed for the Veteran. Without a cause of death, it is not possible to determine if delay in accessing VA primary care was clinically relevant.

Cases involved: 1d, 2d, 4d, 33d

2. No information provided to determine if Veterans with potentially significant medical problem(s) were informed of the walk-in process to expedite outpatient entry into and/or continued medical management within the primary care provider (PCP) clinics. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without this information being contained in the report, it is unclear of the degree to which VA PCP appointment delays significantly contributed to a worsening of physical symptoms/quality of life and, in at least two cases, may have caused acute worsening of medical problems to the point the Veteran died from the disease.

Cases involved: 1d, 2d, 4d, 5dus, 6, 7, 8, 9, 10, 11, 15, 17, 19, 20, 22, 23, 24, 25, 26

3. No information provided to determine if the Veterans presenting with significant mental health issues and/or substance abuse issues were informed of the self-referral process to acute/chronic mental health services within the Phoenix VA. Therefore it is unknown if the Veterans believed they had no other care options but to wait on the EWL for the first VA scheduled appointment. Without such data, it is unclear of the degree to which VA mental health appointment delays significantly contributed to a worsening of psychological symptoms and, in at least two cases, may have been a barrier to suicide prevention.

Cases involved: Cases 16, 19, 20, 24, 26, 27ds, 28, 42ds

4. No information given to determine if Veterans with significant mental health, polysubstance abuse, and/or social support issues were referred by a VA provider to appropriate VA social work services and/or Adult Protective Services. Social work services can provide assistance with accessing resources to address mental health problems, homelessness, poor finances, and other psychosocial stressors. Evidence for lack of timely social work referrals would have indicated another significant opportunity missed by the VA to ensure quality care.

Cases involved: 1d, 2d, 9, 19, 20, 26, 38d, 41d

5. Insufficient information to determine if Veterans who received delayed diagnosis/treatment of cancer or tumor had any significant residual symptoms related to health care delays in treatment. Evidence of significant residual symptoms would have indicated that delays in care were clinically relevant and would have shown the lasting impact of poor quality care.

Cases involved: 10, 12, 14

B. Causal Relationship Evident Between Delayed and/or Improper Care & Veteran Death (excluding Veterans for which cause of death was not listed): Cases 29d, 36ds, 39ds, 40ds

1. Case 29d

This patient had a severe cardiomyopathy which is a disease of the heart muscle that progressively impairs the heart's ability to pump blood and to maintain a normal heart rhythm.

A patient with severe cardiomyopathy is at high risk for having his heart suddenly stop beating without any warning as the result of a life-threatening heart rhythm known as ventricular fibrillation ("v-fib").

The treatment to avoid sudden death from v-fib/cardiomyopathy is permanently inserting a medical device known as an ICD "implantable cardiac defibrillator". Immediate defibrillation (giving the heart an electrical shock) has the best chance to restart the heart and prevent death or complications from prolonged v-fib such as brain damage or permanent heart muscle damage.

Per community medical standards, an ICD should be implanted quickly in patients diagnosed with severe cardiomyopathy. Unfortunately, this Veteran waited at least 4+ months after the

original cardiac consultation without having ICD placement scheduled. (Exact wait time could not be determined because OIG did not give dates in its report.)

Delayed scheduling of an ICD implant allowed the Veteran to have an episode of prolonged v-fib which resulted in severe damage to the brain/body from which the Veteran could not recover. Life support was withdrawn 3 days after he collapsed and was found to be in v-fib.

Although OIG concluded “ICD placement might have forestalled that death”, the investigators didn’t draw any direct connection between delayed access to specialty care procedure and the Veteran’s death.

Conclusion: The Veteran died from complications of prolonged v-fib because he didn’t have access to appropriate/timely specialty care for ICD placement that would have immediately treated v-fib.

2. Case 36ds

This Veteran with multiple medical problems had both depression and a history of chronic pain that was not well controlled. When his pain significantly worsened, he made statements to various VA health care providers indicating his pain was severe that he was feeling like “it might make him suicidal” and that he “could cry [because of pain]”. However, the Veteran denied having any overt suicidal thoughts. The OIG did not give any indication that the PCP provider responded to this Veteran’s message(s) regarding the worsening pain control.

When the Veteran did present in person to the walk-in PCP clinic to get treatment for the pain, the Veteran apparently was only referred to mental health to address the side effect of pain (depression) and did not get medical interventions to relieve the pain. The same day, the patient called the National Suicide Prevention Hotline to complain of “severe and chronic pain unresponsive to treatment” and complained that his PCP was not responding to his requests for contact. A consult was placed to the suicide prevention coordinator but the consult was closed, presumably because the Veteran indicated the issue was related only to severe/unrelenting pain and denied having suicidal thoughts. Within one week the Veteran committed suicide without ever having any medical intervention to control his unrelenting, severe pain.

As per the OIG, this patient should have been identified as having a high risk for suicide because of underlying depression. However, even if this had been done, it is clear that the impetus for the suicidal thoughts was unremitting, severe pain which was never addressed by the PCP.

The OIG did not draw a connection between the lack of PCP response/treatment of acutely worsening unrelenting pain and the Veteran’s subsequent suicide.

Conclusion: The Veteran did not receive appropriate/timely care for his unrelenting, severe pain that served as the impetus for his suicidal thoughts and ultimate suicide.

3. Case 39ds

This homeless Veteran had a history of PTSD, 3 suicide attempts requiring hospitalization in the prior 2 years, and schizoaffective disorder which is a serious psychiatric diagnosis predisposing him to irrational thoughts, paranoia, and hallucinations.

At the time of presentation to the ER, this patient was having intense emotional stressors as evidenced by the comment that he “ hates life and it is so stressful that he doesn’t want to be in it”. He also reportedly felt suicidal because he could not afford to stay at his motel. While inability to pay for a motel is normally not a reason for suicidal thoughts, this Veteran was predisposed to irrational thoughts based on his psychiatric diagnosis and could have easily felt overwhelmed at the thought of living on the streets again.

Despite his psychiatric history and intense current social stressors, the Veteran inexplicably was rated as having a low risk for suicide. Since the Veteran was not appropriately admitted to an inpatient unit where he his risk of completing suicide would have been almost zero, the Veteran found himself again in an unstable environment. He committed suicide the next day

Recognizing the Veteran’s risk factors for suicide and acute psychiatric instability, the OIG wrote psychiatric admission “...would have been a more appropriate management plan” for this patient with a history of “multiple suicide attempts, psychosis, homelessness”. However the OIG failed to draw a connection between inappropriate discharge from the ER and this unstable Veteran’s suicide the next day.

Conclusion: Lack of appropriate psychiatric admission for a patient with multiple risk factors for suicide enabled a death from suicide within 24 hours from point of last VA mental health/ER contact.

4. Case 40ds (almost certainly a suicide based on context)

This Veteran had a history of suicidal thoughts, 7 former psychiatric hospitalizations for mental health instability, and a history of hurting himself. He had been admitted to the Phoenix VA inpatient psychiatry unit because of suicidal thoughts, thoughts of harming his brother, and self-reported difficulty controlling his rage.

Although the Veteran denied suicidal/homicidal thoughts on the day of discharge, his behavior/demeanor on the inpatient ward and at the family conference indicated the Veteran was not yet stabilized psychiatrically on medication.

The Veteran was discharged home presumably by his insistence. Neither the family nor the VA inpatient psychiatry staff tried to block this discharge by requesting the Court grant permission to keep this patient involuntarily until his meds could be stabilized.

Two days later, the Veteran was found dead from a “possible overdose on medication” which, in this context, is consistent with suicide. Even if this was an accidental overdose, the Veteran’s psychiatric presentation indicated very poor impulse control that often predisposes an individual to make irrational decisions such as overuse of medication.

The OIG wrote it “would have been prudent” to continue the inpatient hospitalization (either voluntary or involuntary) for this Veteran. Failure to prudently continue inpatient psychiatric care resulted in discharge of a Veteran to an unmonitored outpatient setting wherein the Veteran died from a suspected overdose 2 days later. If the Veteran would have remained on the inpatient psychiatric unit, his risk of accidental/intentional death would have been almost nonexistent.

The OIG did not draw a connection between lack of “prudent” continued psychiatric inpatient care and the death of this unstable Veteran from suicide two days later.

Conclusion: Premature discharge from a psychiatric ward for a patient with multiple risk factors for suicide enabled a death from suicide within 48 hours from point of last VA mental health contact.

C. Causal Link Suspected between Delayed and/or Improper Care & Veteran Death (excluding Veterans for which cause of death was not listed): Cases 30d, 42d

1. Case 30d

Four days after starting a strong pain medication to control new “torso pain”, this Veteran died from complications related to having a perforation (hole) in his bowels that leaked bacteria into his blood stream and caused infection throughout the body.

Unfortunately, because of poor VA medical record documentation, it cannot be conclusively established whether or not the new “torso” pain was related to the pending bowel perforation.

However, as per the OIG report, a new location of severe pain should have warranted prompt evaluation which unfortunately was not done. It is clear the Veteran had improper triage assessment of his new pain.

In this clinical context, there should be a high clinical suspicion that the torso pain was actually early signs of chest/abdominal pain associated with pending perforated bowel. Usually patients will experience new/worsening pain for a few days prior to the actual perforation.

When the Veteran did present to the ER and was discovered to have a perforated bowel, the surgical intervention/operation required to treat this Veteran was significantly delayed for reasons not listed in the OIG report. Normally, large perforations and/or delayed surgical repair of the perforation are associated with worse outcomes including overwhelming infection and death.

The OIG concluded that “earlier diagnosis and treatment might have altered the outcome in this case.” However, assuming the new torso pain was related to the pending bowel perforation, more thorough triage & prompt assessment /treatment definitely would have prevented the course of clinical deterioration that led to this Veteran’s death. Earlier surgical intervention would have had a greater likelihood of altering the outcome in the Veteran’s favor because early surgical intervention is one of the keys to preventing complications leading to death.

Conclusion: A Veteran did not have timely access to appropriate medical care that would have enabled the earlier diagnosis/surgical treatment needed to vastly improve the outcome in this case and reduced the risk of untimely death.

2. Case 42ds

After completing a month long inpatient substance abuse treatment program, this Veteran apparently was discharged without any referral for ongoing mental health care to support his early sobriety/psychiatric issues common to early recovery. Although medical care for chronic non-psychiatric health care issues was scheduled for 3 months after discharge, the Veteran committed suicide 2 weeks before that appointment.

The OIG wrote “this patient should have had follow-up established with a PCP or mental health provider sooner than the 12 weeks that were planned [for the PCP appointment].” The OIG did not list any dates for mental health care appointment. This would indicate that there were no mental health appointments scheduled upon discharge from the PVAHCS Substance Abuse Residential Rehabilitation Treatment Program.

If the VA failed to establish an appropriate mental health follow-up plan upon discharge, then the VA missed the opportunity to support/stabilize the Veteran during the early recovery phase and went against community mental health treatment standards. Although unknown stressors likely occurred between the discharge date and the Veteran’s suicide 10 weeks later, without a mental health follow-up plan, the Veteran would have been much less likely to be able to handle the stressors and thus would have had a higher risk of suicide.

Conclusion: If there was no mental health discharge follow-up plan, then the VA failed to meet the community standards for mental health treatment. In the absence of an appropriate discharge plan, there is a relationship between inadequate mental health post-discharge care and his subsequent mental health deterioration resulting in suicide 10 weeks after last VA mental health care contact.

D. Care Delays Contributing to Decreased Quality of Life and/or Significantly Shortened Lifespan in Terminally Ill Veterans: Cases 3d, 31d, 32d, 34d, 37d

1. Case 3d

During the 4+ months this Veteran was awaiting a PCP clinic assignment, this male smoker was having persistent flu-like symptoms for which he was unable to schedule a Phoenix VA PCP appointment for evaluation. The Veteran finally went to a non-VA medical facility where he was treated for pneumonia and found to have a CT scan changes consistent with a large left lung mass/abnormal lymph nodes that were consistent with spreading lung cancer. Two weeks later he walked into the Phoenix VA PCP clinic to be seen. It would take one month to have the follow-up lung CT scan completed and another one month before further diagnostic studies were completed confirming the diagnosis of widely spread lung cancer. Because the cancer was very advanced, the Veteran was referred to hospice care services. Per the OIG, there was never any confirmation the medical chart that the Veteran actually received hospice care services or where the patient died.

The OIG was correct when it stated that even though earlier diagnosis would not have prevented the death from cancer, this Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final days/weeks/months.

Conclusion: Per the OIG report, lack of PCP appointment on VA registration “does not mean that the patient’s lung cancer would have been detected sooner. However, an earlier PCP appointment for a symptomatic male smoker would have conferred a higher chance of cancer detection than the zero probability of detection that existed without a PCP appointment. It only took one visit to a non-VA medical facility to diagnose suspected cancer.

2. Case 31d

This Veteran died of metastatic prostate cancer that was not treated during the 7 month period that the VA failed to address an abnormal lab test indicating the return of prostate cancer. By the time the lab test was repeated, Vet had persistent back pain consistent with significant spread of prostate cancer to the bones in his lower spine.

Although treatment for prostate cancer was initiated, this Veteran’s cancer had progressed too far. The Veteran eventually died in hospice after an unknown amount of time receiving prostate cancer treatment.

Earlier detection of the prostate cancer would have been possible if the Veteran had access to timely specialty care or a subsequent provider had recognized the significance of the earlier abnormality in the lab test. Although metastatic prostate cancer may not be cured, early treatment can slow down its progression by months/years and promote quality of life by slowing the down bony destruction from cancer.

Conclusion: Because of unavailability of scheduled urology appointments and subsequent missed abnormal prostate lab finding, this Veteran was denied timely access to specialty care/treatment that likely would have forestalled the patient's death by months/possibly 1+ year and certainly would have improved quality of life.

3. Case 32d

This Veteran was initially admitted to the VA hospital to work up suspicious liver abnormalities that, in retrospect, were indications of advanced cancer. The Veteran was discharged home with the expectation of an outpatient liver biopsy presumably to confirm the diagnosis of suspected cancer. The contact information was not accurate on discharge so the staff couldn't reach the patient to schedule the outpatient follow-up. Ultimately, the biopsy was not done because the patient's symptoms/presentation were consistent with widespread cancer of some type and the risk of doing a biopsy was too great in this very ill Veteran.

The OIG report is unclear but implies the Veteran presented at least once to the ER after the initial VA hospitalization and at least once to the primary care clinic. During one of those visits (site unknown) he was not admitted even though the Veteran had intractable (severe/unrelenting) abdominal pain and probable metastatic (widespread cancer) disease. The second VA visit a week later (location of visit not specified) resulted in an admission to the hospital and death in a hospice unit approximately 4 days later.

It is unclear why this Veteran with "intractable abdominal pain and probable metastatic" cancer was not admitted to the hospital during the initial VA visit (ER versus outpatient clinic) so his severe abdominal pain could be treated. There are no details to determine if the Veteran refused admission or if the admission was never offered.

His clinical presentation on the initial hospitalization must have been consistent with advanced cancer because that was the clinical presentation 2 weeks later on the second admission to the hospital. Timelier follow-up with a cancer specialist could have facilitated discussion on the prognosis as well as the benefit of hospice care for his remaining 2-3 weeks of life. As the events transpired, the Veteran was only on hospice for a maximum of 3 days before death.

Conclusion: Although earlier diagnosis/biopsy would not have prevented the death from wide spread cancer, this very ill Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final weeks before death.

4. Case 34d

While hospitalized for a new stroke work-up, this middle-aged Veteran who had risk factors for lung cancer was found to have an abnormal "large density" (a big abnormal area of tissue) on his chest x-ray. No CT scan or other study was done to determine what might be the cause of the mass. The Veteran was discharged home and readmitted 6 weeks later because of

shortness of breath. After being diagnosed with lung cancer during the second hospitalization, the Veteran was discharged to hospice and died a few days later.

Normally, a middle aged male smoker with a new large lung abnormality is presumed to have a cancer diagnosis until proven otherwise. In a non-VA facility, a physician would have initiated a work-up to include at least an initial chest CT scan prior to discharge. Significant chest CT scan abnormalities would have indicated the need for rapid referral to a specialist for evaluation. If advanced, non-curable cancer was present, the palliative care/hospice options would have been appropriately discussed with the patient.

The purpose of palliative care services for a patient with grossly advanced cancer is to manage symptoms and address the psychosocial and spiritual issues prominent in the final stages of life so that quality of life is preserved until death.

Conclusion: This Veteran was denied timely access to diagnostic studies that would have indicated advanced/incurable lung cancer. Although his life span may not have been prolonged in the setting of advanced lung cancer, earlier evaluation would have allowed more timely hospice services to preserve quality of life during the last 2 months before death.

5. Case 37d

Ten months after a questionable biopsy of a lung mass suspicious for cancer, a Veteran died of metastatic melanoma (type of cancer) that can spread rapidly throughout the body. Because there was no definitive biopsy/autopsy details to determine if the lung mass was melanoma or not, the OIG wrote “the death may not have been related to the lung mass”.

Normally, when a suspicious mass is noted on chest x-ray & lung CT scan and then 10 months later the patient is found to have metastatic cancer in the brain, the clinical suspicion is high that the original lung mass was cancer.

Although the OIG acknowledged the management of the mass was inadequate, it wasn't clear if the OIG followed due diligence to determine how likely the lung mass was cancer. In this Veteran's case, he had brain surgery in a non-VA hospital 11 months after the lung biopsy. Per community standards of care prior for surgery, the Veteran would have had at least a chest x-ray and possibly a chest CT scan at the non-VA hospital prior to neurosurgery. If there was a significant increase in lung mass size between the original VA x-rays/CT scan and those non-VA x-rays/CT scan 11 months later, then there is an extremely high probability the lung mass was melanoma also. The Veteran was also followed by PVAHCS palliative care services for 6 months prior to his death. It is unclear if there would have been a chest x-ray during that time to which comparison could be made to the original chest x-ray done prior to lung biopsy.

Because any melanoma can be aggressive, if the lung mass was truly melanoma, then the Veteran already had a terminal illness at the time of the lung biopsy. However, lack of follow-up care in the setting of this terminal illness would have meant the patient was denied the

opportunity for palliative care treatment interventions that may have slowed the cancer spread to allow more days in his life. If the timeframe of disease progression could not have been altered, palliative care/hospice services would have at least promoted higher quality of life in the days/weeks/months prior to his death.

Conclusion: This Veteran was denied timely access to follow-up medical care that may have detected a possible aggressive cancer. Assuming the lung mass was incurable melanoma, the lack of follow-up care denied him the ability to receive medical interventions that would have contributed to greatly increased quality of life in his remaining lifespan.

E. Special circumstance: Case 35ds

1. Case #35

PLEASE NOTE: The information presented in the paragraph below is given based upon limited knowledge of a Phoenix VA patient outcome that matches the details provided by the OIG for case #35. If this is the same patient then following information was a glaring omission in the OIG report. Even if it is not the same patient, this case is important to highlight how a single barrier to health care access can have cascading consequences.

A Veteran with underlying depression called his family to ask for help managing his worsening mental health symptoms. This Veteran initially presented with his family members to the walk-in mental health clinic for assessment and care. The Veteran had never been enrolled at the Phoenix VA. Because the Veteran denied having an acute crisis when he presented to the front desk, he was diverted to the Enrollment & Eligibility Clinic for “hours” . He did not have a formal nursing triage assessment prior to this diversion. The Veteran returned too late in the day to be seen by mental health staff in the clinic. He then was diverted to the ER, again waited a lengthy time to be seen, and eventually had a mental health assessment by the psychiatric nurse. By the time he was seen by the ER staff, the Veteran was tired, wanted to go home/declined admission, and denied any suicidal or homicidal thoughts. He agreed to return the next day to the same mental health clinic he had attempted to see earlier. The Veteran committed suicide the next day.

At that time Veterans presenting to the Jade-Opal walk-in mental health clinic would be diverted to Eligibility and Enrollment Clinic if they had never been enrolled in the PVAHCS before and assuming they were not deemed to be having an acute crisis like suicidal or homicidal thoughts. Those Veterans would not undergo formal nursing triage assessment prior to being sent to the Eligibility and Enrollment Clinic. Such diversion is against community standards for acute mental health treatment.

Conclusion: Although it is unknown if the suicide could have ultimately been prevented, the registration process in the mental health clinic served as an impediment to good patient care for this Veteran with self-reported worsening depression.

III. CASE REVIEWS: : Omissions Potentially Influencing the Final Context & Conclusions of the 8/26/14 Phoenix VA OIG Report

Section 2: Specific Case Reviews*

**This section was designed to be read in conjunction with the 8/26/14 OIG Report. This section was designed to expand upon the information in that report, not repeat all the OIG case details.*

The omissions or gaps in information I observed in the OIG cases are described below. In order to convey the importance of the omissions to those outside the health care field, I have given very simplified descriptions of disease states, treatment, or other Phoenix VA processes applicable to the case details found in the OIG report.

All of the case events would have impacted the Veterans quality of life but the length and degree of impact could not be established easily in most of the cases.

Abbreviations used after case numbers:

“d” = deceased

“ds” = deceased because of suicide

“dus” = deceased but unclear if from suicide attempt

blank = still living

Case #1d

This homeless Veteran presented with poorly controlled diabetes to the Phoenix VA ER. He was discharged on oral diabetic medication to await follow-up treatment with a primary care provider (PCP). Over the next 2 months during which he did not receive a PCP appointment, the Veteran had 2 non-VA hospitalizations before he died of reasons that are not specified in the OIG report.

Uncontrolled diabetes can present with a variety of symptoms including excessive thirst, weight loss, generalized weakness/fatigue, and difficulty concentrating. Severe blood sugar abnormalities can lead to coma and death.

Adequate diabetes control is much more likely to be achieved if the patient has a stable home environment, scheduled/healthy meals, close monitoring of blood sugars, good adherence to prescribed medication regime, appropriate daily exercise, diabetes education, and routine visits arranged with health care providers. Therefore diabetes management is considered challenging in a patient who is homeless and has limited access to the social/financial support system that would normally enhance diabetes control.

The Phoenix VA Health Care System (PVAHCS) has a large social work service department to address the various needs of Veterans.

The PVAHCS manages a weekday resource center for Veterans who are/are at risk for homelessness. This center can assist Veterans with access to health care (medical, mental health, & substance abuse), transitional housing, employment resources, and coordination of community services.

Omission:

1. There is no notation if this Veteran was referred to Phoenix VA homeless services and/or other social work services that could have assisted with housing, medical care, or financial/social issues. Until approximately April 2014, the ER did not have easy access to social work services because of understaffing.
2. It is unclear if the Veteran was advised to present as a walk-in to the Primary Care Clinic to arrange for follow-up diabetes management in the event a timely primary care provider (PCP) appointment was not available. Although the process can be cumbersome depending on the PCP clinic, the Veteran could have presented on a regular business day to initiate care for his medical problems.
3. It is unclear for how many days the Veteran was prescribed metformin to control his blood sugars while he awaited evaluation from a primary care provider. At the time this Veteran was seen in the ER he would have likely only received 3-10 days of diabetes medications. Without the medication, the Veteran would not have been successful controlling his blood sugar.
4. The reasons for the non-VA ER visits are not listed. Therefore it cannot be determined if those non-VA ER visits were related to uncontrolled diabetes, medication reaction, or other issues. If the non-VA ER visits were related diabetes/diabetes medication, then timelier access to the PCP appointment could have prevented those non-VA ER visits.
5. There is no admitting diagnosis listed for either of the two non-VA hospitalizations so it cannot be determined if they were related to diabetes or other worsening chronic illness. If the admissions were related to uncontrolled diabetes, then the delay in obtaining a VA PCP appointment for diabetes management could be viewed as having a significant negative impact on the Veteran's health status and quality of life.
6. There is no notation as to whether the non-VA hospitals tried to transfer the Veteran to the VA for care. Such a transfer request is commonly made for Veterans in the community hospitals. However, the VA doesn't always have inpatient beds available to accept the transfer.
7. There is no official cause of death listed. It is unknown if the death was related to a complication of diabetes or another issues unreported or insufficiently addressed during any ER visit or hospitalization.

Conclusion: Uncontrolled diabetes would have negatively affected this Veteran's quality of life. However, without a cause of death, it is not possible to determine the relationship between the Veteran's death and his lack of timely access to a VA PCP appointment for health care.

Case #2d

This Veteran with multiple medical problems including liver disease, diabetes, heart problems, and a history of homelessness was awaiting assignment of a primary care appointment after he presented to the Phoenix VA ER with weakness and diarrhea. The Veteran was discharge from the ER. Within 4 days, he had declined to the point that he required admission to a non-VA hospital. Approximately 11 weeks later he had another non-VA hospital admission after presenting with signs of severe liver failure. Neither date of death nor cause of death is listed in the OIG report. It is stated that a PCP appointment became available three months after the patient died.

Multiple co-morbidities (having 2 or more co-existing medical problems) greatly complicates the health care management of patients because any one disease process can make the individual more likely to suffer complications or worsening symptoms from any of the other medical problems.

However, multiple medical problems present in one individual does not mean that individual is terminally ill or actively dying. Many individuals have multiple medical diagnoses but, with proper management, are not expected to have shortened life spans.

Hepatic encephalopathy (confusion caused by chemical changes related to a build-up of ammonia in the body) indicates advanced cirrhosis (liver disease) but does not indicate pending death. The symptoms of hepatic encephalopathy often are controlled using a certain medication on a regular basis. While liver disease will advance, such progression can be relatively slow unless there is another contributing factor damaging the liver such as regular alcohol intake.

Omission:

1. Insufficient information listed to determine if Veteran's underlying chronic medical problems were unstable at baseline or if the delay in care resulted in acute worsening of medical problems to the point the Veteran died from the disease. It is unclear if this Veteran had multiple medical diseases in such an advanced state that death could be imminent at any time.

Nothing in the written presentation stated the Veteran had end stage cirrhosis (risk of imminent liver failure), decompensated congestive heart failure (worsening ability of the heart to pump blood properly at rest or with minimal activity), or advanced emphysema (a type of lung disease associated with air trapping in the lungs so the person becomes very short of breath with at rest or with minimal activity).

As mentioned previously, advanced disease states cause a high risk of having suddenly shortened lifespans. Chronic, compensated disease states would be associated with a longer life span.

2. There are not enough details about the initial ER presentation to determine if the ER discharge was appropriate or not. Depending upon the seriousness of his symptoms, this Veteran who presented with weakness and diarrhea could have been at risk for worsening cardiac function, worsening kidney function, electrolyte abnormalities, worsening liver function, and/or hypotension (low blood pressure).

3. There is no notation whether or not this Veteran was referred by the ER to Phoenix VA homeless services/social work services that could have assisted with housing, medical care, or other financial/social issues.

4. The origin of the second "Schedule an Appointment" consult which was placed two days after the first consult is unknown. Generally, a second consult means the Veteran presented again to some VA employee to report medical complaints and/or to request an appointment.

It would be important to note whether or not the Veteran presented for care again. If he did, it should be examined whether his complaints were triaged appropriately. These details are crucial because two days after the patient presumably had some point of VA contact, the patient became ill enough to merit hospitalization at a non-VA facility.

5. There is no indication as to whether or not the non-VA hospital tried to transfer the Veteran to the VA for care or arrange post-hospital care/prescriptions. Such a transfer request is usually standard for our Veterans in the community hospitals. Unfortunately, the VA doesn't always have inpatient beds available to accept the transfer.

6. The patient was admitted to another non-VA facility 11 weeks later for treatment of hepatic encephalopathy. Hepatic encephalopathy doesn't cause death but can lead to other complications causing death. It is not stated if the Veteran died during that hospitalization. Assuming the Veteran didn't die while hospitalized, it is unknown if that facility tried to contact the VA for transfer/discharge planning.

7. Neither the cause of death nor the date of death is listed.

8. If the Veteran was in a habit of being compliant with medical care, then the VA delay in providing a PCP appointment for medical management certainly would have had a significant negative impact on this Veteran's quality of life and total life expectancy.

Conclusion: Without a cause of death, it is difficult to draw a conclusion about whether there was a causal relationship between the Veteran's death and his lack of timely access to a VA PCP appointment for management of his chronic medical conditions.

Case #3d

During the 4+ this Veteran was awaiting a PCP clinic assignment, this male smoker was having persistent flu-like symptoms for which he was unable to schedule a Phoenix VA PCP appointment for evaluation. The Veteran finally went to a non-VA medical facility where he was treated for pneumonia and found to have a CT scan changes consistent with a large left lung mass/abnormal lymph nodes that were consistent with spreading lung cancer. Two weeks later he walked into the Phoenix VA PCP clinic to be seen. It would take one month to have the follow-up lung CT scan completed and another one month before further diagnostic studies were completed confirming the diagnosis of widely spread lung cancer. Because the cancer was very advanced, the Veteran was referred to hospice care services. Per the OIG, there was never any confirmation the medical chart that the Veteran actually received hospice care services or where the patient died.

The various types of lung cancer have specific patterns of growth and spread. Non-small cell lung cancer is described in terms of size, how far it has spread from the original tumor, whether or not lymph nodes are involved, and if there are sites of lung cancer cells in other parts of the body.

Non-small cell lung cancer can invade the tissue immediately around the tumor and/or spread via the lymph system. When spreading through the lymph system, the cancer can cause the lymph nodes to have an unusually prominent or large appearance. The more lymph node abnormalities present, the higher the risk that the cancer may have/will soon spread to other parts of the body.

Early diagnosis and treatment confer the best chance of either cancer cure or partial remission. Delays in diagnosis allow the cancer a chance to advance to the point where cure is virtually impossible. However, even when cure/remission is not possible, there are medical interventions that can prolong life while still preserving quality of life in those who are “terminally ill” (having a disease that will eventually shorten life span/cause death) but who are not yet actively dying.

Omission:

1. At the point of registration, it is unclear if the Veteran and/or family were advised to have the Veteran present as a walk-in to a PCP Clinic for evaluation of persistent flu-like symptoms. He could have presented on the next regular business day.
2. “Localized spread of malignancy” was noted on a CT (CAT) scan report describing a large left lung mass and enlarged lymph nodes. The OIG report doesn’t state if the overall appearance of the lung mass & lymph node abnormalities reported on the initial non-VA CT scan report differed from those seen on the VA CT scan completed roughly 6 weeks later. A significant difference in the location of the tumor/size of the lymph nodes those two CT scans would have indicated a rapid cancer spread during the time frame between diagnosed by a private physician and being evaluated by a VA health care provider. A rapid change would indicated

that any delay in obtaining follow-up evaluation/care likely would have negatively impacted either the quality or quantity of life for this Veteran even though the cancer was likely incurable.

3. There is no notation as to whether the CT scan in this case was ordered as “stat”, “ASAP”, or “routine” for purposes of scheduling. Chest CT scans can be done in 15 minutes or less. Unfortunately, the PVAHCS Radiology department frequently had a backlog of CT scan orders. Unless the CT is ordered as “stat” it could take 2 weeks - 8 weeks to get a CT scan done when it is ordered “ASAP” or “routine”.

4. In view of the initial CT scan presenting classically for lung cancer with metastasis (distant spread), it is not clear why there was a delay in doing a definitive diagnostic test for the cancer or evaluation of the metastasis of that cancer via PET scan.

5. The purposes of palliative care services for a patient with grossly advanced cancer is to manage symptoms and address the psychosocial and spiritual issues prominent in the final stages of life so that quality of life is preserved until death. It would have been a medical disservice not to have provided an avenue for hospice services. It is not clear what prevented VA social services from doing outreach to this family/Veteran to determine if appropriate hospice care was in place.

Conclusion: Per the OIG, there is no way to determine if the patient’s cancer would have been detected by a more timely PCP appointment. However, an earlier PCP appointment for a symptomatic male smoker would have conferred a higher chance of detection than the zero probability of detection that existed without a PCP appointment. (It only took one visit to a non-VA medical facility to diagnose suspected cancer.)

The OIG was correct when it stated that even though earlier diagnosis would not have prevented the death from cancer, this Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final days/weeks/months.

Case #4d

A “deep vein thrombosis” (DVT) is a blood clot in a very large, deep vein. DVT in the legs has the potential to be life-threatening if the clot moves via the blood stream to the lungs causing a “pulmonary embolus” (clot in the lung blood vessels).

Anticoagulant medication include several types of meds that can “thin the blood” and prevent the formation and/or enlargement of abnormal blood clots. If the clot stops growing, then the body’s natural repair process can help stabilize and/or dissolve the clot before it has a chance to spread to the lungs and cause a clot in lung blood vessels.

Although DVT can occur spontaneously, it is important to rule out potential causes of/risk factors for DVT such as certain sedentary physical activities, some medications, hidden cancer, or blood system abnormalities.

The length of treatment with anticoagulation medication depends upon the likelihood that the clot will reform sometime after the medication is stopped. Depending on the reason for the DVT formation, the length of treatment can be as little as 3-6 months or can be lifelong.

Anticoagulant medication has a high risk for side effects and must be closely monitored by trained providers in order to avoid life-threatening complications like severe bleeding/anemia. Although anticoagulant medications do not cause bleeding, those meds can cause any minor bleeding to become quite serious.

Individuals who chronically abuse alcohol are at higher risk for bleeding within the body because of the effects alcohol can have on the liver as well as the direct and the lining of the esophagus, stomach, and intestines.

Omission:

1. It is not clear if the Veteran was followed by any health care provider while he was on anticoagulation medication after hospitalization or for what length of time that medication was prescribed on discharge. In general, the length of time for such anticoagulation would have been at least 3-6 months, perhaps longer depending on the situation. However, new hospital prescriptions generally are dispensed for approximately one month.

In general, the Phoenix VA Anticoagulation Clinic closely monitors patients newly started on anticoagulants. However, the clinic will only monitor patients who have assigned primary care providers (PCP) because of the need to interact with that PCP.

2. It is unknown if a cause of the DVT was identified during the hospitalization or if such a medical work-up was delayed awaiting a primary care visit.

3. It is never stated whether the anemia (low red blood count) noted on the second ED visit was long-standing or if the anemia was newly developed since the Veteran's hospital discharge two weeks earlier. New onset anemia or sudden worsening of chronic anemia needs prompt attention. It is not stated if the Veteran or his family was made aware of the clinical significance of the anemia and the need to expedite care with a medical provider.

4. It is unclear if the Veteran was advised to present as a walk-in to the Primary Care Clinic for evaluation of his medications when he was discharged from the hospital and/or the ER.

5. The cause of death was not listed for this patient. The actual cause of death is needed to determine to what degree his death may have been forestalled by a timely care in the setting of anemia of uncertain origin, DVT, and high risk medication use in a Veteran with a presumably active alcohol use.

Conclusion: Without addition information including a cause of death, it is not possible to determine the degree to which delays in VA care were related to the Veteran's death.

Case #5dus

Chronic pancreatitis (inflammation of the pancreas) can lead to recurrent severe abdominal pain that often requires narcotics to control.

The control of such pain is more complicated when the patient has an active polysubstance abuse disorder or a history of substance abuse disorder. Active polysubstance abuse may predispose the individual to over-reliance on the narcotics to manage issues other than pain control. Former or current polysubstance abuse can place the patient at risk for needing higher doses of narcotics to control pain because he/she is habituated to the lower doses of narcotics. Higher doses of narcotics confer a higher risk for narcotic side effects including breathing difficulties and death.

Chronic uncontrolled pain is a risk factor for anxiety, stress, depression, and suicidal thoughts/actions.

Omission:

1. It is unclear to what degree the ER physician worked up the abdominal pain to determine if there was a reason for the sudden worsening of chronic pancreatitis pain.

It is not stated if the Veteran was actually having worsening of his chronic pain for unknown reasons or if the Veteran simply ran out of his usual pain meds to control his usual pain. Sudden onset of worsening pain requires evaluation and sometimes hospitalization to control the symptoms of worsening pancreatitis.

2. In the event a primary care appointment could not be assigned prior to the Vet running out of ER-issued pain meds, it is unclear if the Veteran was advised to present as a walk-in to the Primary Care Clinic for management of his medical issues including chronic pancreatitis and pain.

3. The cause of death on the death certificate was "multiple prescription medication intoxication". It is not stated whether or not that overdose was determined to be accidental or the result of a deliberate suicide act. Over-reliance on pain meds because of an acute worsening of chronic pancreatic pain would place the Veteran at risk for accidental overdose.

Uncontrolled flare of chronic pain is considered a risk factor for suicide, and overdose is a common method for suicide.

Conclusion: Without additional information, it is not possible to determine the degree to which the Veteran's physical symptoms could have been controlled and/or if timelier health care access could have forestalled this Veteran's death from accidental/intentional overdose.

Case #6, #7, #8, #9, #15, #17, #21, #22, & #25

Omission:

1. In case #6, #7, #8, #9, #15, #17, #22 & 25, it is unclear if the Veterans were advised to present as a walk-in to the Primary Care Clinic to follow-up on chronic medical issues which they could have done on the next regular business day. This would have provided timelier access to medical care.

2. In case #21 it is unclear if the hospital discharge instructions included information on what the patient should do if his primary care appointment was delayed. In general, upon discharge, Veterans are given a one month supply of medication. The Veteran should have been advised to present as a walk-in to the Primary Care Clinic for evaluation of his medications/other issues if he wasn't contacted for an appointment.

3. In case #7 & #25, it is important to note that there currently is no policy for ordering cardiac risk stratification (testing to check for blockages in heart arteries in order to prevent heart attack) when a Veteran with risk factors for heart disease is treated in the ER for non-cardiac chest pain but is found to have no VA PCP assignment. Normally such cardiac risk stratification is ordered by a primary care provider.

Conclusion: Since key information is not known, it is not possible to determine the degree to which delays or lack of quality care contributed to impaired functioning/quality of life or worsening of underlying chronic medical illness.

Case #10

Brain tumors may be malignant (cancerous) or benign (non-cancerous). Some brain tumors can take years to develop while other types can grow in a matter of months.

The symptoms of any brain tumor are dependent on where the tumor is located and to what degree it is interfering with important pathways for speech, memory, thinking ability, movement, or blood/fluid circulation within the brain.

A large brain tumor maybe silent for many years until it interferes with an important brain pathway of functioning. A tiny tumor may be readily apparent if it directly impedes a critical pathway of brain functioning. Interruptions of critical brain pathways produce noticeable symptoms quickly.

The ability of early intervention to affect the prognosis and outcome of a brain tumor is dependent on the size, type, and location of the tumor.

Omission:

1. Blood pressure checks can be done on a walk-in basis in the ambulatory care clinics and do not require a pre-arranged appointment. It is unclear if the Veteran was advised of this process.
2. It is not stated what symptoms the Veteran may have reported to the PCP or if the PCP performed a neurological exam during the first visit and/or ordered a CT head scan. Assuming the patient had reported prior symptoms of slurred speech and dizziness, both a neurological exam and a head CT scan should have been done as part of the prompt work-up needed to determine the cause of the symptoms.
3. It is not stated what type of tumor the patient had. It is unclear if the tumor was aggressive enough to have grown significantly during the delay between requesting an appointment and ultimately reporting his symptoms to a primary care provider (assuming such symptoms were indeed reported during that primary care visit) or to the ER doctor.
4. Although the patient had no recurrence of brain tumor, it is not clear if the patient had any residual effects from the brain tumor or treatment. If the tumor was of the aggressive type interfering with critical pathways, then any residual effects may have been reduced to at least some degree by earlier discovery/intervention when the tumor was smaller. In addition, the size of tumor would have affected the location/amount of brain irradiation and thus potentially increased the risk for side effects/residual effects of radiation treatment.

Conclusion: Even if the prognosis would have been unchanged, the delays in care affected the quality of life for this Veteran.

Case #11

Heart failure is when the heart doesn't pump efficiently on a regular basis.

Compensated heart failure is when the heart muscle has enlarged to pump better and/or medications are being used so that the volume of blood pumped with each heart beat is sufficient to meet the needs of the individual while doing usual, customary activity.

Decompensated heart failure essentially is when the heart cannot pump sufficient blood/fluid to meet the needs of the body's organ systems either at rest or with minimal activity.

Symptoms of decompensation can vary depending on the degree of heart failure. Such symptoms can include new or worsening lower extremity swelling, abdominal swelling, generalized edema (swelling), and/or shortness of breath.

An left ventricular ejection fraction is the percentage of blood that a healthy heart pumps out of the left ventricle (main heart pumping chamber) with each heartbeat. A normal ejection fraction is somewhere between 55-70% depending on the individual. An ejection fraction of less than 35+ % makes the individual at risk for life threatening abnormal heart rhythms. An

ejection fraction of 10% in the main heart pumping chamber essentially means only the bare minimum amount of blood to sustain life is being pumped out of the heart on a beat-to-beat basis. Patients with very low ejection fractions are at risk for sudden death from abnormal heart rhythms.

Chronic untreated hypertension (high blood pressure) can cause changes in the heart muscle and circulation that make it harder for the heart to pump in general, especially in the setting of further episodes of high blood pressure.

An echocardiogram is an ultrasound of the heart that evaluates the heart valves, the heart muscle thickness, and the pumping ability of the heart. The most common type of echocardiogram is called “transthoracic echocardiogram” meaning the test is “done across the chest wall”. The ultrasound is performed by running an ultrasound wand on the chest wall over the heart. This echocardiogram is neither invasive nor painful. It takes 40 minutes or less to complete.

Omission:

1. Three weeks for an echocardiogram appointment for a patient presenting with new decompensated heart failure is too long to wait. The community standard would have been to do the echocardiogram while the patient was hospitalized. If severe abnormalities are noted in heart structure or pumping ability, then interventions (drugs and/or implantable devices) can be initiated to greatly reduce the patient’s risk of sudden death from cardiac failure/lethal heart rhythm. Repeat echocardiograms may be done after discharge to determine if the heart has responded to the medical treatments and is pumping more efficiently.
2. The common echocardiogram takes about 40 minutes or less to complete. It is uncertain why the physicians chose not to perform the echocardiogram while the patient was hospitalized. It is unclear if the echocardiogram division of the Cardiology Clinic had sufficient staffing to do the test in a more timely fashion.
3. The date of echocardiogram interpretation was not included in the OIG report. It doesn't take 3 weeks to interpret an echocardiogram. The interpretation usually takes 30 minutes or less depending upon the nature of the echocardiogram and the skill of the interpreter. A delay of 3 weeks to have the echocardiogram result entered into the electronic health record (computerized medical chart) means that the VA cardiologist was backlogged on echocardiogram readings and/or there was a delay in uploading the dictated/written report into the computerized medical chart.
4. It is unclear if the cardiologist who interpreted the abnormal echocardiogram tried to initiate contact with the patient, establish a primary care appointment, or establish a cardiology appointment for this patient with dangerously low ejection fraction. In the community, a grossly abnormal echocardiogram finding requires that the cardiologist contact the PCP and/or call the patient immediately.

5. A heart with a left ventricular ejection fraction of 10% is pumping at the bare minimum level to sustain life. If the echocardiogram been interpreted in a timely fashion, the Veteran could have had interventions planned in a more timely fashion and most likely would have avoided decompensation.

Conclusion: Although the OIG concluded prompt medical management "might have prevented his subsequent deterioration", timely treatment had an excellent chance of preventing his subsequent deterioration. The VA did not meet the community standards for medical care.

Case #12 & #14

Localized prostate cancer (present only within the prostate gland) in older men is usually not the aggressive form of prostate cancer found in younger men. Older men can live for years with localized prostate cancer which remains curable or at least medically managed so that the life span is not significantly decreased. However, when such cancer metastasizes (spreads outside the prostate to other areas of the body) the prostate cancer can become quite aggressive and rapidly lead to loss of both quality and quantity of life if not treated in a timely fashion.

Omission:

1. It is not stated if either male was diagnosed with localized prostate cancer or prostate cancer with metastasis.
2. An 8-11 month delay in a patient with metastatic prostate cancer at the time of diagnosis would have significantly changed the course of the care/shortened the life span. An 8-11 month delay in localized prostate cancer diagnosis would not have led to a clinically significant difference for the patient's longevity or ultimate survival.

Conclusion: There was insufficient information provided to determine if the delay in treatment significantly affected the length of lifespan for these Veterans.

Case #13

Like many specialty care services within the Phoenix VAMC, there is a shortage of staffing. There was an administrative push not to establish patients within the specialty care clinics because it would further reduce availability of time slots. Therefore, there was a tendency to accept only the most serious cases for specialty consultation.

Within the VA system, prior to the Phoenix VA scheduling scandal and subsequent monies released for fee basis care, Veterans within the system had to "compete" for a specialty appointment availability and whether or not they would be followed by a specialist. Unstable patients generally were given follow-up specialty care appointments while more stable patients were managed in the primary care clinics.

Omission:

1. It is unclear if a seasoned medical provider within the cardiology service discontinued the consult or if it was closed by a cardiology fellow (in training) or other personnel who had less experience in evaluating the medical record. As per the OIG, this Veteran had “severe cardiac disease” and thus should have established care with a cardiologist.
2. It is not noted if the primary care provider tried to resubmit the consult with additional explanation of why the cardiology consultation was needed.
3. No information is given about the admitting/discharge diagnosis for the second hospitalization. There is also no information regarding what interventions/treatments were required during the second hospitalization. There is no information about whether or not the Veteran had been compliant with his heart medications.

Without details on the second hospitalization, it is not possible to determine the relationship between delayed access to specialty care and subsequent re-hospitalization. Ongoing/regular cardiology care is necessary to promote stabilization of patients with severe cardiac disease.

Conclusion: This Veteran was denied timely access to specialty care that could have prevented his re-hospitalization from worsening cardiac disease. The degree to which the Veteran was affected cannot be established because the OIG did not provide sufficient details to evaluate this case.

Case #16, #24, & #27ds

Omission:

1. After contacting the PVAHCS for an appointment, it is unclear if the Veterans were told that the electronic waiting list was only for primary care providers & not for assignment of mental health providers.
2. It is unknown if these Veterans were told by either registration staff and/or the Primary Care Clinic staff that they could self-refer to the Jade-Opal/C-STAT Clinic for any acute or chronic mental health issues.
3. In case #16, it should be known that the system for communicating between VA Medical Centers is murky and often leads to missed information on Veterans. Ideally, if the East Coast VAMC Suicide Prevention Coordinator (SPC) could not personally speak with the Phoenix VAMC SPC, then the out-of-state staffer should have contacted the Phoenix VA transfer coordinator to ensure information was received and transmitted in a reliable fashion.
4. In case #27, it is unclear if the Veteran was followed by the Suicide Prevention Team at the Texas VAMC and/or if his chart was electronically flagged as a high suicide behavior risk. Although not part of the care at the Phoenix VAMC, it is unclear if this high risk male with

history of four suicide attempts had any follow-up initiated when he missed his November 2013 Texas VA appointment. If the Veteran had been flagged as a high risk for suicide in the Texas VA, the Suicide Prevention Coordinator in Texas should have helped facilitate the transition to the Phoenix VA, assuming the Veteran's relocation plans were known by the Texas suicide prevention team .

5. In any of the cases, if the Veteran was already service-connected for a mental health disorder, he could have directly scheduled an appointment with the Phoenix mental health clinic. (Unfortunately, considering chronic understaffing, a timely mental health appointment may not have been available via that route either.)

6. In the case #27, it cannot be determined if the Veteran would have chosen to present to the Mental Health Crisis Clinic (CSTAT Clinic) prior to committing suicide because it is unclear if the Veteran even knew about the option.

7. In the case #27, it is unclear if appropriate triage was done for Veteran for "ongoing issues" when the veteran spoke to the medical services assistant. Without knowing the nature of the conversation, it is not known if the patient should have been referred to a health care provider with a higher level of triage experience/training.

Conclusion: Delays in accessing appropriate mental health & primary care would be expected to reduce functioning/quality of life. Without the additional information, it is unclear to what degree the delays care impacted each Veteran's life. Timely mental health access would have given mental health providers the chance to intervene to prevent a suicide in at least one case.

Case #18

Omission:

1. The Veteran did not need to have dual enrollment to receive care for his presenting illnesses. The traveling veteran can still get complete care services through the ambulatory care clinics including care for newly diagnosed conditions or decompensated conditions such as elevated blood pressure. The only difference for a traveling vet care is the type of administrative credit the VA receives for completing the Veteran's appointment. Although the Veteran's routine meds are still filled by the home base clinic, the Phoenix VA would have been responsible for filling any new meds, including med adjustments for hypertension.

2. The LPN error highlights some of the deficits in the training for triage nurses in the ambulatory care. An elderly male with recent urinary tract infection, evidence of kidney disease, and poorly controlled blood pressure required further assessment/medical care. A properly trained triage nurse would not have sent this veteran away.

3. There is no information to determine if the Veteran suffered any long term effects/complications his acute worsening of symptoms.

Conclusion: At a minimum, the Veteran was denied access to appropriate health care because of inadequate training of a triage nurse.

Case #19, #20, & #26

Amphetamines and cocaine have dangerous side effects including the immediate development of very high blood pressure that can cause unexpected heart attacks, strokes, or long term problems.

Competent adults have the right to make health care and lifestyle choices for themselves, even when those choices will result in decreased quality and/or quantity of life. A decision to stop substance abuse must be made by the patient. However, a health care provider should facilitate recurrent discussions about substance abuse treatment in order to encourage the patients to consider such treatment.

Omission:

1. There is no notation to determine if these Veterans were referred to Phoenix VA social work services that could have assisted with the provision of information on substance abuse treatment, obtaining medical care, mental health treatment, or other social issues.
2. It is unclear if the Veterans were advised to present as a walk-in to the Primary Care Clinic for blood pressure management or other chronic medical conditions.
3. It is unknown if these Veterans were ever told that they could self-refer to the Phoenix mental health clinic for any acute or chronic mental health issues.
4. There is a notation that the patient in Case #20 had "significant heart disease" but the presence of such significant heart disease is not stated anywhere else in the case. It is unclear if additional follow-up or heart testing was needed but not ordered because of a lack of a primary care physician.
5. For case 19 & 20, there is no notation if the Veterans were interested in following home blood pressures and/or were offered Prosthetics consults for blood pressure machines. This would have been standard treatment for a patient with history of stroke/high blood pressure (case #19) or "significant heart disease"/high blood pressure (case #20).
6. The Veteran in case #19 ultimately had 2 strokes and developed significant loss of vision in both eyes. No long-term complications are listed for the other two cases so it is unknown to what degree delays in accessing care affected their quality of life.

Conclusion: As per the OIG report, these Veterans had clinically significant delays in accessing appropriate care that placed the Veterans at significant risk for medical complications from high

blood pressure (case #19 & 20), heart disease (case #20), and/or persistent substance abuse (#19, #20, #26).

Case #23

Omission:

1. It is unclear if the hospital discharge instructions included information on what the patient should do if his primary care appointment was delayed. The Veteran should have been advised to present as a walk-in to the Primary Care Clinic for refill of his medications/other issues if he wasn't contacted for an appointment. The Veteran could not have controlled diabetes without the medication.
2. In general, upon hospital discharge, Veterans are given a one month supply of medication. It was noted that his diabetes control very poor at his new PCP visit 6 months after discharge. It was not reported if the Veteran ran out of his diabetes medications prior to seeing a primary care provider or obtained meds from a non-VA provider.
3. It is not stated if the Veteran was referred to Endocrinology for an inpatient/outpatient consult to help manage diabetes and high cholesterol. Such a consult could have facilitated follow-up care even without the assignment of a primary care provider.
4. It is not clear if the "blurred vision" the Veteran had was a temporary or permanent finding related to diabetic complications occurring sometime after hospitalization.

Conclusion: At a minimum, the VA did not meet community standards for hospital discharge because the Veteran did not have adequate access to either primary care or specialty diabetic care. The degree to which this affected the Veteran's quality of life cannot be determined by the information in the OIG report.

Case #28

Omission:

1. It cannot be determined if this patient was referred to mental health services at stand-down or if the patient declined such a referral. (Normally, mental health services are routinely offered through a stand-down outreach effort.)
2. It is not stated if the Veteran was aware of the self-referral process to the Phoenix VA mental health clinic.
3. The outcome of that mental health referral is not clear. It is unknown if it resulted in regular care for this Veteran.

Conclusion: As per the OIG report, the delays in this patient's care placed him at risk for violence towards himself or others.

Case #29d

This patient with multiple medical co-morbidities (defined as having 3+ medical problems) had a severe cardiomyopathy (disease of the heart muscle that progressively impairs the heart's ability to pump blood and to maintain a normal heart rhythm).

A patient with severe cardiomyopathy is at high risk for having his heart suddenly stop beating without any warning as the results of a life-threatening heart rhythm known as ventricular fibrillation ("v-fib").

Severe cardiomyopathy is treated with an ICD "implantable cardiac defibrillator". This small defibrillator is placed under the skin permanently with tiny wires that lie under the skin and lead to the heart. These wires monitor the heart rhythm. If the life threatening v-fib rhythm is detected, the device immediately gives the patient's heart an automatic shock which may be able to immediately restart the heart beating/stop v-fib within seconds.

In the event of sudden heart stoppage, immediate defibrillation by an ICD or other type of defibrillator has shown to greatly improve outcomes and survival for the patient. Each minute delay before defibrillation places the patient at risk for permanent brain impairment, heart muscle death, and long term organ failure. When the brain and body are starved for blood supply during prolonged heart stoppage, the chances for meaningful recovery (return to former quality of life) are extremely small.

Omission:

1. The details listed in case #29 indicated a huge delay in specialty care even though the OIG places case 29 after the statement "...OIG identified deficiencies unrelated to delays in the care of 17 patients, including 14 who were deceased."

It is not clear why the month/dates were not specified in the report. Such specificity would have made the creation of a timeline much easier. The delay between initial cardiology consultation and the Veteran's collapse appeared to be at least 4+ months.

A general timeline based on the information in case #29 shows the delay in specialty care. The echocardiogram (heart ultrasound) was done in "late summer" of 2013. Two days later a consult for an ICD was placed. "Two weeks" later a Tucson VA nurse practitioner contacted the patient to schedule the procedure but learned the Veteran wanted metal allergy testing prior to receiving the ICD. (The timeframe was now presumably Fall 2013). Five weeks later (Fall or Winter 2013 though month not specified) the allergy testing was complete. One month later (Fall or Winter 2013 though month not specified) the Veteran was still waiting for an ICD implant to be scheduled. Because of this, the cardiologist sent another note presumably requesting ICD procedure scheduling.

In early 2014 (month not specified) the Veteran had a routine follow-up appointment with his PCP. Within 3-4 days after a PCP appointment, the Veteran collapsed at home. Arriving after an unknown length of time Emergency Medical Services/paramedics diagnosed v-fib. The heart was restarted and the Veteran was transported to the hospital where he survived for 3 days before life support was withdrawn.

The withdrawal of life support indicates the Veteran did not have a good outcome even though resuscitation efforts were successful on the date he collapsed.

2. The reason for the 5 week delay to get an Allergy Clinic appointment was not clarified in the OIG report. It doesn't take 5 weeks to get an allergy patch testing done. Allergy patch testing can be completed within 72 hours. Considering the allergy testing was the Veteran's choice as a mandatory prerequisite to ICD placement, the allergy testing should have been expedited, not delayed for 4+ weeks.

3. It is not clear why the Veteran was not fee-based out to a private cardiologist who could have completed the ICD procedure the same day if Tucson VA facilities were not available in a timely fashion.

4. The whole purpose of an ICD is to immediately shock a heart out of a lethal rhythm. His chances of meaningful survival would have been greatly improved if he had an ICD in place when he went into "v-fib". An immediate ICD defibrillating shock would have lessened the time between detection of v-fib and treatment of v-fib to a matter of seconds. Without the ICD device, the v-fib wasn't treated until after the paramedics arrived in his home. Each minute the Veteran remained in v-fib increased the likelihood of brain tissue loss and/or heart muscle death.

Although OIG concluded "ICD placement might have forestalled that death", the investigators didn't draw any direct connection between delayed access to specialty care procedure and the Veteran's death.

Conclusion: The Veteran died from complications of prolonged v-fib because he didn't have access to appropriate/timely specialty care for ICD placement that would have immediately treated v-fib.

Case #30d

Chronic pain of a stable nature (chronic-continual or chronic-intermittent) is when pain symptoms are occurring/reoccurring in a predictable fashion in terms of location, intensity, duration, and associated symptoms. Although the definitions of pain can be complicated, in practical terms chronic pain is often referred to as pain that is lasts longer than 3 months and/or whose reoccurrence has been in a stable, predictable pattern over many months or years.

Chronic pain can worsen for a variety of reasons including a worsening of the underlying condition, a developing tolerance to pain medication, or a change in activity. That worsening of chronic pain is referred to as “acute on chronic” pain. There should be an evaluation of why chronic pain is getting worse.

Acute pain or “new pain” is usually defined as new onset within the last 3 months and whose description and occurrence is not yet predictable. When the new pain is severe and/or unrelenting, prompt evaluation is required to rule out any significant underlying serious medical conditions causing the pain.

One of the basic duties of nursing triage is to evaluate the common descriptors of pain including location of pain (anterior chest, upper abdomen, right lower abdomen, etc.), duration of pain (hours, days, etc.), quality of pain (sharp, dull, crampy, burning, etc.), intensity of pain (mild, moderate, or “worst ever”), and associated symptoms (nausea, vomiting, localized weakness, bleeding, etc.).

A “perforated bowel” occurs when a hole occurs somewhere in the wall of the intestines. This hole allows leaks bacteria, fluid, and air into the abdomen. This air can often be detected by x-rays of the abdomen that shows the air collection as a “black area” in the top or side of the abdominal cavity.

When bacteria leak into the abdominal cavity, infection can spread throughout the body and affect all organ systems including the heart and lungs. The body can have a shock reaction to infection and symptoms can include hypothermia (low body temperature below usual 98.6 degrees Fahrenheit), fast heartbeat, and/or low blood pressure. This widespread infection can cause become a “septic shock” syndrome” which causes failure of multiple organs in the body and is associated with a significant risk of death.

The treatment for perforated bowel is usually prompt surgical repair of the perforation as well as antibiotics to treat infection.

In this Veteran’s case, four days after starting a strong pain medication to control new “torso pain”, this Veteran died from complications related to having a bowel perforation.

Unfortunately, because of poor VA medical record documentation, it cannot be conclusively established if the new “torso” pain was related to the pending bowel perforation. However, as per the OIG report, a new location of severe pain should have warranted prompt evaluation which unfortunately was not done. It is clear the Veteran had improper triage assessment of his new pain.

In this clinical context, there should be a high clinical suspicion that the torso pain was actually early signs of chest/abdominal pain associated with pending perforated bowel. Usually patients will experience new/worsening pain for a few days prior to the actual perforation.

When the Veteran did present to the ER and was discovered to have a perforated bowel, the surgical intervention/operation required to treat this Veteran was significantly delayed for reasons not listed in the OIG report. Normally, large perforations and/or delayed surgical repair of the perforation are associated with worse outcomes including overwhelming infection and death.

Omission:

1. There should have been a better health care provider triage assessment of his new onset pain when he called his PCP requesting stronger pain medication for "torso pain". Without adequate descriptors of the pain characteristics, it is not possible to rule out a serious underlying medical condition causing the pain.

2. The patient's chronic pain was located in his neck. Presumably the "torso" pain was in a different location but the word "torso" is too vague to determine the exact location (back, upper chest, lower chest, abdomen, etc.). As per the OIG report, a new location of severe pain should have warranted prompt evaluation. There is inadequate information to determine if the "torso pain" was actually early signs of abdominal pain associated with pending/actual perforated bowel.

3. The report doesn't state why there was a 4 hour delay for the surgical consult. The delay could have been from one of several factors:
 - a. Presence of a delay in reading the CT scan of 2-4 hours, assuming the CT scan was done with oral contrast (fluid the patient drinks to help highlight the intestines) that takes 2 hours to circulate through the GI tract.(CT scan normally only takes a few minutes to interpret and the report is usually available within one hour. Radiologists usually notify ER physicians promptly if there are abnormalities like a perforated bowel.

 - b. The CT scan was interpreted in a timely fashion but competing emergencies in the ER/inadequate ER staffing to follow-up promptly on test results.

 - c. The surgical consult was ordered telephonically earlier but the ER physician was delayed in entering the actual physical order. (When I worked in the ER, there were difficulties with getting prompt surgical evaluations because of surgical staffing issues/competing surgical resident duties.)

4. It is unclear if the physical exam in the ER would have indicated the need for a 3 way abdominal series of x-rays that could have detected free air rapidly. This process would have taken a few minutes in the radiology suite to perform instead of the 2+ hours prep time needed to perform an abdominal CT scan with oral contrast.

5. The OIG concluded that "earlier diagnosis and treatment might have altered the outcome in this case." However, assuming the new torso pain was related to the pending bowel

perforation, more thorough triage & prompt assessment/treatment definitely would have prevented the course of clinical deterioration that led to this Veteran's death. Earlier surgical intervention was important because early surgical intervention is one of the keys to preventing complications leading to death.

Conclusion: A Veteran did not have timely access to appropriate medical care that would have enabled the earlier diagnosis/treatment needed to vastly improve the outcome in this case and greatly reduce the risk of untimely death.

Case #31d

This Veteran died of metastatic prostate cancer that was not treated during the 7 month period that the VA failed to address an abnormal lab test indicating the return of prostate cancer. By the time the lab test was repeated, Vet had persistent back pain consistent with significant spread of prostate cancer to the bones in his lower spine. Although treatment for prostate cancer was initiated, this Veteran's cancer had progressed too far. The Veteran eventually died in hospice after an unknown amount of time receiving prostate cancer treatment.

The prostate gland releases a chemical in the blood known as the "prostate specific antigen" (PSA). No other part of the body produces this chemical.

There are ranges of "normal PSA" level depending upon age, ethnicity, and underlying prostate size. However, in general, the average normal prostate level in a healthy male without prostate cancer is between 0-4. Localized prostate cancer can cause the prostate level to be slightly elevated. Metastatic (wide spread) prostate cancer can cause the values to rise rapidly from 10+ up to 900+.

When a man has prostate cancer only in the prostate gland, one possible treatment is to remove the prostate gland in an attempt to completely rid the body of prostate cancer. If a prostate gland is removed, then a male's PSA level should fall to zero or "undetectable" levels.

Unfortunately, sometimes microscopic amounts of the cancerous prostate cells will spread to other locations in the body but can't be detected by available medical tests. As those cancerous prostate cells multiply rapidly in other areas of the body, they eventually will produce enough PSA to produce measurable levels of PSA again.

Any increase in PSA after the prostate gland is removed indicates that prostate cancer present in other body areas such as the bones. When a previously undetectable level rises, the patient must have prompt medical evaluation by a specialist who deals with prostate cancer such as a urologist.

Although prostate cancer limited to only the prostate gland generally grows slowly, metastatic prostate cancer can rapidly spread and significantly shorten both the quality and quantity of the patient's life.

Compensation & Pension (C&P exams) are exams performed only to indicate whether or not a Veterans medical condition may or may not be related to military service. The purpose of C&P exams are not to have the C&P provider treat the underlying condition.

Omission:

1. It is unclear if the C&P provider told the Veteran the importance of seeking immediate urological care for an elevated PSA when he should have had an undetectable level of PSA.
2. It is not stated whether or not the C&P provider attempted to notify the Veteran's VA PCP about the abnormal/unexpected PSA elevation.
3. Earlier treatment of the prostate cancer before it aggressively spread to multiple bones could have forestalled the patient's death by months/years and certainly would have improved quality of life.

Conclusion: Because of unavailability of scheduled urology appointments and subsequent missed abnormal prostate lab finding, this Veteran was denied timely access to specialty care/treatment that likely would have forestalled the patient's death by months/possibly 1+ year and certainly would have improved quality of life.

Case #32d

This Veteran was initially admitted to the VA hospital to work up liver abnormalities that, in retrospect, were indications of advanced cancer. The Veteran was discharged home with the expectation of an outpatient biopsy to confirm the diagnosis of suspected cancer. There is no reason given for why the biopsy was not done while the patient was hospitalized. The contact information was not accurate on discharge so the staff couldn't reach the patient to schedule the outpatient follow-up. Ultimately, the biopsy was not done because the patient's symptoms/exam were consistent with widespread cancer of some type and the risk of doing a biopsy was too great in this very ill Veteran.

The OIG report is unclear but implies the Veteran presented at least once to the ER after the initial VA hospitalization and at least once to the primary care clinic. During one of those visits (site unknown) he was not admitted even though the Veteran had intractable (severe/unrelenting) abdominal pain and probable metastatic (widespread cancer) disease. The final VA visit a week later (location of visit not specified) resulted in an admission to the hospital and death in a hospice unit approximately 4 days later.

Omission:

1. Staff are supposed to confirm the patient's contact information on admission and at discharge. Unfortunately, per the case details, the "listed contact information was incorrect" which prevented scheduling a follow-up appointment.

2. Based on the case details, this Veteran had advanced/aggressive cancer when he was admitted to the VA hospital initially. Although biopsy was not done for unclear reason, his clinical presentation must have been consistent with advanced cancer because that was the clinical presentation on an outpatient visit (ER versus primary care clinic) within 2 weeks.

Timelier follow-up with a cancer specialist could have facilitated discussion on the prognosis as well as the benefit of hospice care for his remaining 2-3 weeks of life. As the events transpired, the Veteran was only on hospice for a maximum of 3 days before death.

3. It is unclear why this Veteran with “intractable abdominal pain and probable metastatic” cancer was not admitted to the hospital when he presented with these symptoms on an outpatient visit so this severe abdominal pain could be treated. There are no details to determine if the Veteran refused admission or if the admission was never offered.

Conclusion: Although earlier diagnosis/biopsy would not have prevented the death from wide spread cancer, this very ill Veteran was denied the timely opportunity for palliative care services that could have ensured better quality of life in his final weeks before death.

Case #33d

When IV iron is given, a patient usually has severe iron deficiency. A common cause of iron deficiency in middle-aged males is chronic bleeding located somewhere in the gastrointestinal tract (esophagus, stomach, or intestines).

When severe anemia is noted and/or there is significant blood in the stool, the patient requires special tests to locate the site of the bleeding inside the GI tract. Upper GI endoscopy and colonoscopy allow the physician to see inside the GI tract to locate a source of bleeding.

This Veteran had an aortic valve replacement which required long term use of blood thinners to stop clots from forming on the valve. If he stopped the blood thinner, he would be at risk for dying from a clogged valve or having strokes from clots moving to the brain.

This Veteran received an IV iron infusion during hospitalization for unclear reasons but presumably was related to severe anemia based on the case context. He was on a medication that thins the blood and will cause bleeding to be prolonged. He was at high risk for having further significant bleeding episodes because of his self-described blood in the stool.

Low blood pressure and dizziness are symptoms that can have many causes. However, both of these symptoms can be seen with sudden, severe bleeding.

Omission:

1. There is no notation if and/or when the patient sought non-VA care for the low blood pressure reading and dizziness. It is unknown if the patient appropriately contacted a non-VA physician even if the patient was not contacted by the VA health care provider.

2. It is not clear why this Veteran did not have the upper GI endoscopy or the colonoscopy while he was hospitalized. Assuming the Veteran would consent to the procedure while hospitalized & he was medically stable, those procedures would not have been delayed in the community for patients with this presentation.

3. The cause of death is not listed. It is unclear if the cause of death was related to GI bleeding or other problem. Based on his blood thinner use and presence of blood in the stool, this patient was at high risk for future significant GI bleeding.

4. It is unclear if the PCP had sufficient staffing to be able to contact the patient in a timely fashion.

Conclusion: I agreed with the OIG's opinion that this Veteran should have received at least immediate telephone follow-up. However, without the cause of death and other details, it is not possible to determine if there was any clinical significance between care delays (including the lack of GI procedures while hospitalized) and this Veteran's death 5 weeks after reporting feeling weak and dizzy.

Case #34d

While hospitalized for a new stroke work-up, this middle-aged Veteran who had risk factors for lung cancer was found to have an abnormal "large density" (a big abnormal area of tissue) on his chest x-ray. No CT scan or other study was done to determine what might be the cause of the mass. The Veteran was discharged home and readmitted 6 weeks later because of shortness of breath. After being diagnosed with lung cancer during this second hospitalization, the Veteran was discharged to hospice and died a few days later.

Advanced non-small cell lung cancer can be aggressive and lead to rapid deterioration in later stages.

The purpose of palliative care services for a patient with grossly advanced cancer is to manage symptoms and address the psychosocial and spiritual issues prominent in the final stages of life so that quality of life is preserved until death.

Omission:

1. Normally, a middle aged male smoker with a new large lung abnormality is presumed to have a cancer diagnosis until proven otherwise. In a non-VA facility, a physician would have initiated a work-up to include at least an initial chest CT scan prior to discharge. If significant chest CT scan abnormalities were discovered, there would be a need for rapid referral to a specialist for evaluation. If advanced, non-curable cancer was present, the palliative care/hospice options would have been appropriately discussed with the patient.

2. Although his lifespan likely would not have been prolonged, earlier evaluation would have allowed more timely hospice services to ensure the highest quality of life/symptom control was preserved during the final weeks, not just days, of this Veteran's life.

Conclusion: This Veteran was denied timely access to diagnostic studies that would have indicated advanced/incurable lung cancer. Although his lifespan may not have been prolonged in the setting of advanced lung cancer, earlier evaluation would have allowed more timely hospice services to preserve quality of life during the last 2 months before death.

Case #35ds

Potential Omission/Comment: *The information presented in the paragraph below is given based upon limited knowledge of a Phoenix VA patient outcome that matches the details provided by the OIG for case #35. If this is the same patient then following information was a glaring omission in the OIG report. Even if it is not the same patient, this case is important to highlight how a single barrier to health care access can have cascading consequences.*

A Veteran with underlying depression called his family to ask for help managing his worsening mental health symptoms. This Veteran initially presented with his family members to the walk-in mental health clinic for assessment and care. The Veteran had never been enrolled at the Phoenix VA. Because the Veteran denied having an acute crisis when he presented to the front desk, he was diverted to the Enrollment & Eligibility Clinic for "hours". Apparently he did not have a formal nursing triage assessment prior to this diversion. The Veteran returned too late in the day to be seen by mental health staff in the clinic. He then was diverted to the ER, again waited a lengthy time to be seen, and eventually had a mental health assessment by the psychiatric nurse. By the time he was seen by the ER staff, the Veteran wanted to go home/declined admission and denied any suicidal or homicidal thoughts. He agreed to return the next day to the same mental health clinic he had attempted to see earlier. The Veteran committed suicide the next day.

At that time Veterans presenting to the Jade-Opal walk-in mental health clinic would be diverted to Eligibility and Enrollment Clinic if they had never been enrolled in the PVAHCS before and assuming they were not deemed to be having an acute crisis like suicidal or homicidal thoughts. Those Veterans would not undergo formal nursing triage assessment prior to being sent to the Eligibility and Enrollment Clinic. Such diversion is against community standards for acute mental health treatment.

Conclusion: Although it is unknown if the suicide could have ultimately been prevented, the registration process in the mental health clinic served as an impediment to good patient care for this Veteran with self-reported worsening depression.

Case #36ds

This Veteran with multiple medical problems had both depression and a history of chronic pain that was not well controlled. When his pain significantly worsened, he made statements to various VA health care providers indicating his pain was severe that he was feeling like “it might make him suicidal” and that he “could cry [because of pain]”. However, the Veteran denied having any overt suicidal thoughts. The OIG did not give any indication that the PCP provider responded to this Veteran’s message(s) regarding the worsening pain control.

When the Veteran did present in person to the walk-in PCP clinic to get treatment for the pain, the Veteran apparently was only referred to mental health to address the side effect of pain (depression) and did not get medical interventions to relieve the pain. The same day, the patient called the National Suicide Prevention Hotline to complain of “severe and chronic pain unresponsive to treatment” and complained that his PCP was not responding to his requests for contact. A consult was placed to the suicide prevention coordinator but the consult was closed, presumably because the Veteran indicated the issue was related only to severe/unrelenting pain and denied having suicidal thoughts. Within one week the Veteran committed suicide without ever having any medical intervention to control his unrelenting, severe pain.

As previously mentioned, chronic pain of a stable nature (chronic-continual or chronic-intermittent) is when there is a condition causing pain where the symptoms of that pain are occurring/reoccurring in a predictable fashion in terms of location, intensity, duration, and associated symptoms. Although the definitions of pain can be complicated, in practical terms chronic pain is often referred to as pain that lasts longer than 3 months and/or whose reoccurrence has been in a stable, predictable pattern over many months/years.

Chronic pain can worsen for a variety of reasons including a worsening of the underlying condition, a developing tolerance to pain medication, or a change in activity. That is referred to as “acute on chronic” pain. There should be a medical evaluation of why chronic pain is getting worse.

As noted earlier in this section, part of basic nursing triage is to evaluate the common descriptors of pain including location of pain (anterior chest, upper abdomen, right lower abdomen, etc.), duration of pain (hours, days, etc.), quality of pain (sharp, dull, crampy, burning etc.), intensity of pain (mild, moderate, or “worst ever”), and associated symptoms (nausea, vomiting, localized weakness, bleeding, etc.).

Although pain is felt physically, chronic uncontrolled pain is associated with increased risk of sustained anxiety, stress, depression, and increased risk of suicide. In addition, psychological factors play a role in the perception/sensitivity to pain. However, for individuals with uncontrolled pain, any implication that the pain is “just in their head” is demoralizing.

Omission:

1. The data from the triage assessment by the registered nurse was not clarified in the OIG report. However, an initial response to refer the patient to a mental health provider is not appropriate for new acute-on-chronic pain issues.
2. As per the OIG, this patient should have been identified as having a high risk for suicide because of underlying depression. However, even if this had been done, it is clear that the impetus for the suicidal thoughts was unremitting, severe pain which was never addressed by the PCP.

The OIG did not draw a connection between the lack of PCP response/treatment of acutely worsening unrelenting pain and the Veteran's subsequent suicide.

Conclusion: The Veteran did not receive appropriate/timely care for his unrelenting, severe pain that served as the impetus for his suicidal thoughts and ultimate suicide.

Case #37d

A lesion is essentially an abnormal area of tissue in the body that can occur because of injury, disease, or other factor that causes change in the formation of the tissue. A lesion can be of any size.

A benign (non-cancerous) lesion in the lung often will remain relatively stable in size over the course of 3 months, 6 months, or 12 months. A cancerous lesion in the lung will often grow rapidly in size during that same time frame because the cancer cells are constantly multiply at faster rates than healthy cells. When following a "lung lesion", repeat chest x-rays or chest CT scans are done at intervals to detect any abnormal changes in size that may indicate a higher likelihood that the lesion is cancer.

Although melanoma is commonly referred to as a "skin cancer", it is actually a cancer of nerve cells. Nerve cells are present throughout the body. Although melanoma is classically described by its appearance on the skin, it can actually occur in almost any area of the body where there are nerve cells including the lung and brain.

Melanoma is extremely aggressive and even a small lesion can spread very rapidly throughout the body. Aggressive evaluation and treatment is needed to prevent melanoma from becoming widespread.

In the case of this Veteran, ten months after a questionable biopsy of a lung mass suspicious for cancer, a Veteran died of metastatic melanoma (type of cancer) that can spread rapidly throughout the body. Because there was no definitive biopsy/autopsy details to determine if the lung mass was melanoma or not, the OIG wrote "the death may not have been related to the lung mass".

Omission:

1. There are no autopsy details to determine if the lung mass was melanoma or not. However, when a suspicious mass is noted on chest x-ray and then 10 months later the patient is found to have metastatic cancer in the brain, the clinical suspicion is high that the original lung mass was cancer.
2. Although the OIG acknowledged the management of the mass was inadequate, it wasn't clear if the OIG followed due diligence to determine how likely the lung mass was cancer. The private hospital likely would have done a chest x-ray and a CT scan of the lungs prior to taking the patient to surgery. A comparison of the radiology reports from the private hospital to the x-ray/CT scan of lungs from the VA hospital 10 months earlier should have been done. A significant difference in the appearance of the lung lesion would be indicative that the lung lesion was most likely cancerous.

The patient had comprehensive palliative care at the PVAHCS for 6 months prior to his death. If a chest x-ray or CT scan of lungs was done during that timeframe, a comparison could be made to determine if the original site of the lung lesion had enlarged consistent with cancerous growth.

3. If the lung mass was melanoma, then the prognosis was terminal and death was inevitable from the melanoma. Although his lifespan may not have been prolonged in the setting of advanced cancer, earlier diagnosis would have allowed timelier referral to palliative care/hospice services to increase quality of life during the Veteran's remaining lifespan.

Conclusion: This Veteran was denied timely access to follow-up medical care that may have detected a possible aggressive cancer. Assuming the lung mass was incurable melanoma, the lack of follow-up care denied him the ability to receive medical interventions that would have contributed to greatly increased quality of life in his remaining lifespan.

Case #38d

Comment: *Until recently, the PVAHCS mental health clinic has been grossly understaffed for years. Timely follow-up calls for missed appointments were generally not possible. The OIG described many of the mental health care deficiencies in its report.*

Case #39ds

This homeless Veteran had a history of PTSD, 3 suicide attempts requiring hospitalization in the prior 2 years, and schizoaffective disorder which is a serious psychiatric diagnosis predisposing him to irrational thoughts, paranoia, and hallucinations.

At the time of presentation to the ER, this patient was having intense emotional stressors as evidenced by the comment that he “ hates life and it is so stressful that he doesn’t want to be in it”. He also reportedly felt suicidal because he could not afford to stay at his motel. While inability to pay for a motel is normally not a reason for suicidal thoughts, this Veteran was predisposed to irrational thoughts based on his psychiatric diagnoses and could have easily felt overwhelmed at the thought of living on the streets again.

Despite his psychiatric history and intense current social stressors, the Veteran inexplicably was rated as having a low risk for suicide. Since the Veteran was not appropriately admitted to an inpatient unit where he his risk of completing suicide would have been almost zero, the Veteran found himself again in an unstable environment. He committed suicide the next day.

Recognizing the Veteran’s risk factors for suicide and acute psychiatric instability, the OIG wrote psychiatric admission “...would have been a more appropriate management plan” for this patient with a history of “multiple suicide attempts, psychosis, homelessness”. However the OIG failed to draw a connection between inappropriate discharge from the ER and this unstable Veteran’s suicide the next day.

Omission:

1. It is unclear why the mental health consultant rated the Veteran’s risk for suicide as low. As evidenced by the OIG’s written comments, the Veteran did not have adequate protective factors to prevent suicide and had multiple risk factors for committing suicide. The patient should have scored higher on the standard suicide risk assessment that is done for patients with suicidal thoughts at the Phoenix VA.

2. Admission to the inpatient psychiatric unit would have enabled the Veteran to have a safe, therapeutic environment where the risk of committing suicide would have been low. While admission may not have prevented suicide in the longer term, more appropriate disposition to an inpatient mental health bed would have prevented the suicide in the immediate short-term timeframe. It is unclear if admission was offered to the Veteran at any point.

3. Even though he was not admitted, it is not stated if this Veteran was offered/received social work services to assist with social/financial/housing resources to deal with his obvious, self-reported stressors.

Conclusion: Lack of appropriate psychiatric admission for a patient with multiple risk factors for suicide enabled a death from suicide within 24 hours from point of last VA mental health/ER contact.

Case #40ds (almost certainly a suicide but OIG phrasing vague)

This Veteran had a history of suicidal thoughts, 7 former psychiatric hospitalizations for mental health instability, and a history of hurting himself. He had been admitted to the Phoenix VA

inpatient psychiatry unit because of suicidal thoughts, thoughts of harming his brother, and self-reported difficulty controlling his rage.

Although the Veteran denied suicidal/homicidal thoughts on the day of discharge, his behavior/demeanor on the inpatient ward and at the family conference indicated the Veteran was not yet stabilized on psychiatric medication.

The Veteran was discharged home presumably by his insistence. Neither the family nor the VA inpatient psychiatry staff tried to block this discharge by requesting the Court grant permission to keep this patient involuntarily until his meds could be stabilized.

Two days later, the Veteran was found dead from a “possible overdose on medication” which in this context is consistent with suicide. Even if this was an accidental overdose, the Veteran’s psychiatric presentation indicated very poor impulse control that often predisposes an individual to make irrational decisions such as overuse of medication.

The OIG wrote it “would have been prudent” to continue the inpatient hospitalization (either voluntary or involuntary) for this Veteran. However, the OIG did not draw a connection between lack of “prudent” continued psychiatric inpatient care and the death of this unstable Veteran from suicide two days later.

Omission:

1. Failure to prudently continue inpatient psychiatric care resulted in discharge of a Veteran to an unmonitored outpatient setting wherein the Veteran died from overdose 2 days later. If the Veteran would have remained on the inpatient psychiatric unit, his risk of intentional death would have been almost nonexistent.
2. No explanation was given to determine why petitioning was not attempted by the mental health staff. Psychiatric petitioning for involuntary admission is a routine procedure for mental health providers. Petitioning is done if the Veteran who is refusing psychiatric treatment is deemed a danger to himself or others. While the petition is being officially reviewed by the proper legal authorities/court, the patient can be placed on temporary medical hold that will prevent the patient from leaving the mental health ward until the ruling on the petition is made.

Conclusion: Premature discharge from a psychiatric ward for an unstable patient with multiple risk factors for suicide enabled a death from suicide within 48 hours from point of last VA mental health contact.

Case #41d

In the OIG report, this Veteran is described as having “significant dementia” and “severe cognitive impairment” (severe loss of ability for higher levels of thinking). His cause of death

was from chronic “hypertensive and arteriosclerotic cardiovascular disease”. This means he died from heart disease caused by chronic high blood pressure and chronic cholesterol disease.

There are various types of dementia with different patterns of presentation & progression.

Mild dementia can have very minor symptoms such as some forgetfulness. Symptoms of severe dementia can include loss of ability to remember simple details/events, understand concepts, and make good, rational decisions.

Adult Protective Services (APS) in each state are charged with the responsibility of protecting at risk/vulnerable adults who have diminished physical, mental, and/or financial capacity to protect themselves against abuse, exploitation, neglect from others, or self-neglect. The goal is to help the at-risk/vulnerable adult live as independent a life as possible by connecting the adult with appropriate community resources & services.

Omission:

1. Based upon the description given by the OIG, the Veteran did not have the capacity to access long-term medical services that may have forestalled his death from chronic disease. The Veteran likely would not have been able to seek short-term or emergency medical services needed to treat new onset of heart disease symptoms.

2. It is not reported if this Veteran with “severe cognitive impairment”/significant dementia was ever reported by any VA employee to the Arizona APS. That agency could have assessed the Veteran’s welfare and evaluated what services the Veteran might have needed to live safely & appropriately access medical services. Because the Veteran had not been seen by case manager since 2008, then diagnosis of significant dementia and his lack of usual resources were known at least 5 years prior to his death because his chart had not been updated after 2009. During those 5 years, it is expected that any type of dementia would have worsened.

Conclusion: Without additional information, it is unclear if the VA case manager/other VA staff fulfilled a mandatory obligation to place a report to Adult Protective Services so that this vulnerable adult with severe dementia could access community resources to enable a higher quality of life and receive medical care for his chronic medical problems.

Case #42ds

After completing a month long inpatient substance abuse treatment program, this Veteran apparently was discharged without any referral for ongoing mental health care to support his early sobriety/psychiatric issues common to early recovery. Although medical care for chronic non-psychiatric health care issues was scheduled for 3 months after discharge, the Veteran committed suicide 2 weeks before that appointment.

Patients with substance abuse disorders have a high rate of concurrent psychiatric disorders such as PTSD, major depression, anxiety, or bipolar disorder. Having both a substance abuse problem and a psychiatric diagnosis is commonly referred to as “dual diagnosis”. The patients

often use the substance (alcohol, cocaine, methamphetamines, etc.) to order to self-medicate and control the symptoms of the underlying psychiatric issue.

Successful remission of substance abuse problems requires a detailed plan to address the immediate, short-term needs. It also requires a complex plan to maintain long term recovery. Mental health follow-up/mental health crisis numbers would have been a standard part of mental health discharge at non-VA facilities.

The highest risk of relapse is often in the immediate phases of recovery especially when the Veteran has dual diagnosis. If the Veteran abstains from the drug, he is no longer self-medicating for the psychiatric disorder. In the absence of appropriate mental health support, the Veteran is at risk for acute worsening of his underlying psychiatric symptoms. The high degree of self-blame/guilt with relapse can also lead to profound depression/suicidal thoughts.

Omission:

1. It is unknown if this Veteran had a co-existing mental health disorder such as PTSD, anxiety, major depression, etc. that would have made him at higher risk of acute worsening of mental health issues during early recovery phases/sobriety.
2. The OIG wrote “this patient should have had follow-up established with a PCP or mental health provider sooner than the 12 weeks that were planned [for a PCP appointment].” The OIG did not list the timeframe for any type of appointments for mental health care. This would indicate that there were no mental health appointments scheduled upon discharge from the PVAHCS Substance Abuse Residential Rehabilitation Treatment Program.
3. It is not noted if the written discharge plan included information on the self-referral process to the Phoenix VA mental health clinic for issues such as anxiety, depression, and substance abuse relapse.
4. If the VA failed to establish an appropriate mental health follow-up plan upon discharge, then the VA missed the opportunity to support/stabilize the Veteran during the early recovery phase.
5. At the time this Veteran likely had the Suicide Risk Assessment form completed, a suicide risk of “low or nil” did not require any suicide prevention plan to be established. Even though the Veteran was rated to have “nil or low” suicide risk at discharge, a mental health provider should have anticipated that ongoing mental health services would have been necessary to support the patient’s recovery. Although stressors had to have occurred between the discharge date and the Veteran’s suicide 10 weeks later, without a mental health follow-up plan, the Veteran would have been much less likely to be able to handle the stressors.

Conclusion: If there was no mental health discharge follow-up plan, then the VA failed to meet the community standards for mental health treatment. In the absence of an appropriate

discharge plan, there is a relationship between inadequate mental health post-discharge care and his subsequent mental health deterioration resulting in suicide.

Case #43 & #44

No gaps in information noted.

Case #45

The OIG described this Veteran as “ill hypertensive patient” who had multiple risk factors for complications including diabetes, high blood pressure, and heart disease.

Urosepsis is a widespread infection of the blood that occurs when a urine/kidney infection spreads to the blood stream. The risk of urosepsis can be reduced by early treatment for a urinary infection. There is a higher risk of complications including death in older patients and/or diabetic patients who develop urosepsis.

Performing basic vital signs should be done as part of a nursing triage assessment when the patient arrives for a walk-in appointment to the PCP clinic.

Comment:

There is a disparity between the primary care providers training and skill sets based upon whether the provider is a physician (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A.). Physicians must complete a 4 year physician doctorate program and 3+ years of continual training in medicine. Depending upon the program, nurse practitioners complete 2+ years of training via a master’s degree in nursing. Physician assistants generally complete a 2+ year program.

In the VA system, these providers are considered to be independent practitioners regardless of training. All providers should be equally qualified to manage simple, uncomplicated problems or stable, chronic problems. Unless there has been additional study/training completed, primary care for complicated patients with multiple co-morbidities or urgent care of extremely complicated ill patients is outside the scope of practice for many nurse practitioners and most physician assistants.

Patients in the VA are assigned according to availability of the provider with no regard to the ability of a provider to handle the complexity of the patients.

Omission:

1. This Veteran had diabetes that placed him at risk for serious infection. No details were provided regarding the training/skill level of the nurse who didn’t do vital signs or the provider who didn’t record a complete physical exam or order studies for this “ill hypotensive” patient.

Conclusion: As per the OIG, this Veteran denied adequate evaluation of his medical illness. Appropriate triage and evaluation could have prevented his subsequent deterioration and hospitalization.

Persistent PVAHCS Issues Having Implications for Other VHA Facilities

The 8/26/14 VA OIG Report has given the Phoenix VA Health Care System (PVAHCS) the opportunity to re-examine itself and identify areas needed for improvement. Invariably the new influx of Veterans will strain resources within the PVAHCS. These deficiencies need to be proactively addressed so the Phoenix VA can meet and exceed its obligations to our nation's current and future Veterans.

Just as the scheduling irregularities and Electronic Wait List (EWL) issues were not unique to the Phoenix VA, other problems within PVAHCS have the potential to be mirrored in sister facilities throughout the nation. The information included in this section is intended to serve as a potential springboard for further discussion and positive change in not only the Phoenix VA Health Care System but also throughout the Veteran's Health Administration (VHA).

1. Patients in at the Phoenix VA usually are assigned according to availability of the provider with no regard to the ability of a provider to handle the complexity of the patients.

There is a disparity between the primary care providers training and skill sets based upon whether the provider is a physician (M.D. or D.O.), nurse practitioner (N.P.), or physician assistant (P.A). Physicians must complete a 4 year physician doctorate program and 3+ years of continual training in medicine. Depending upon the program, nurse practitioners complete 2+ years of training via a master's degree in nursing. Physician assistants generally complete a 2+ year program.

In the VA system, each of these providers are considered to be an independent practitioners regardless of training. As an independent practitioner, the provider can practice without the oversight of a physician. All providers are qualified to manage simple, acute problems or limited/ stable chronic problems. However, unless there has been additional study/training completed, primary care for very complicated patients with multiple co-morbidities is outside the scope of practice for many nurse practitioners and most physician assistants.

Patients in the VA are assigned by non-medical staff according to availability of the health care provider's time slots with no regard to the ability of that provider to handle the complexity of the patients.

2. There is no standardization of triage nurse training anywhere in the VHA system including the Phoenix VAMC.

Appropriate nurse triage is a cornerstone for high quality patient care. The triage skills of the nurse are used to assess patient complaints and requests in order to help the patient access the

next appropriate step in health care. In addition, nursing insight can be a valuable key to understanding the psychosocial needs of the patients and families.

Currently, the quality of the nurse triage is variable at the Phoenix VAMC. Some nurses are highly skilled through many years of nursing practice and have excellent clinical insight and judgment. Other nurses do not have the experience or training to appropriately triage complex patients or recognize when reported symptoms may require urgent/emergent intervention by other health care providers.

Therefore, when patients come to the mental health clinic, emergency department, or primary care clinics to be seen, the variable quality of triage means there is no consistently applied standard of assessment and thus no consistency in patient outcomes. Patients will potentially encounter significant barriers to accessing the next level of proper care efficiently.

3. Appointment requests generated over the phone or in person at the PVAHCS Eligibility Clinic are not evaluated by a health care professional to determine urgency.

When appointment requests are received, the decision for scheduling is in the hands of Health Administration Service (HAS) employees who do not usually have any health care background. There is no process of routinely reviewing the requests to triage/prioritize appointments on the basis of medical need/urgency. As a result, some Veterans who require more urgent scheduling based on medical need are not identified or scheduled in a timely manner.

4. Within the PVAHCS the primary responsibility for chronic pain medication management is commonly left to the primary care provider and not a pain management specialist.

Narcotics for chronic pain control are considered high risk medications to use on a regular basis. Health care providers are obligated to closely follow patients on high dose narcotics. Chronic pain control management includes continual patient education, appropriate narcotic selection, dose adjustments with titration, and evaluation of pain control and side effects.

The Phoenix VA has an amazingly talented pain management team. However, it is not staffed to be able to handle the large number of Veterans on chronic narcotics who require the team's expertise and direct, face-to-face services. By default, the primary care providers, many of whom are already overwhelmed with high acuity patients, must manage those patients.

In the community setting, patients on high dose/chronic narcotics are followed by a pain management specialists.

5. Within PVAHCS, primary care providers are struggling to manage oversized patient panels (a group of patients that are assigned to a provider) or with panels that do not have a balanced mix of patients.

Outpatient medical acuity is essentially the intensity of medical care needed on a regular basis to meet the patient's day-to-day the health care needs and promote quality of life.

Overall, the Veteran population is a very complex/high acuity group of patients to manage because of unique exposures/injuries during military service as well as significant frequency of medical co-morbidity (having 2+ significant medical problems in one patient). Multiple co-morbidities greatly complicate medical management of patients because any one disease process can make the individual more likely to suffer complications or worsening symptoms from his/her other medical problems. The clinical decision-making process is often extremely intense in order to effectively manage a cluster of medical problems presenting in one patient.

VA recommended panel limits can be up to 1200 patients per primary care provider (physician, nurse practitioner, or physician assistant). Within the PVAHCS as well as sister facilities, some provider panels can be 10-20+% over the recommended limit and effectively very thinly stretch the provider to cover the increased load.

Additional patients over the recommended panel size greatly increases the daily clinical workload. Inevitably, the provider has to address a higher number of patient requests/telephone messages, meet increased numbers of potential walk-in requests, fill more medication refills, review greater quantity of labs, follow more consults to completion, process significantly more electronic chart alerts daily, and perform a greater number of screening & annual exams.

Many times, even if the provider panel is near recommended sizes, the complexity of the panel requires that the provider must dedicate more time during/after each visit to address the needs of each complex patient. By necessity, high acuity patients with diabetes, strokes, autoimmune disorders, heart disease, kidney failure, liver disease, widespread joint disease, chronic pain syndromes, and/or other chronic disease states are given more provider attention. The providers screen for multiple potential symptoms, gather information on current daily functioning/symptom control, and review medications/labs to determine if the medical conditions are stable. Any needed studies or consults will require additional time to order, evaluate, and communicate to the Veteran and family.

In theory there should be an equal mixture of low, moderate, and high acuity patients to avoid overloading the provider. However, Phoenix VA primary care patient panel size is not routinely adjusted to reflect the high complexity of the patients on that panel. Many of the patient panels are stacked with a significant percentage of high acuity patients who compete for the provider's time. This results in the providers being overwhelmed trying to meet the needs of all the patients.

6. PVAHCS needs to provide more support for suicide prevention & outreach.

Although there is recruitment to hire additional staff, Suicide Prevention Team still doesn't have the full manpower needed to meet the needs of our PVAHCS population in terms of outreach, education, follow-up of Suicide Hotline calls, and case management of a group of Veterans deemed high risk for suicide.

Several years ago senior administration made the decision to stop taking quarterly reports from the Root Cause Analysis committee that reviews suicide cases to determine system processes that could be improved to prevent future suicides. After that time, the senior administration only got reports on the demographics of the suicide victims, not the underlying PVAHCS process that were involved in the case. Although the demographics are needed, it is important that senior administration have awareness of pertinent PVAHCS system issues.

Although the completion of Suicide Risk Assessment form (SRA) is mandatory in the mental health clinic, not all charts have updated/completed SRA. There have been 5 suicides of mental health patients with no SRA even though they were followed by a mental health provider at the time of suicide.

7. Service-connected Veterans who only desire specialty appointments for their service connected diagnoses are needlessly waiting PCP assignment for specialty care referral.

At the Phoenix VAMC, Veterans who are service connected frequently don't understand the process for accessing specialty care services. Not all service-connected Veterans want a VA primary care provider. If a service-connected (SC) Veteran only desires a specialty appointment for a specific service-connected medical problem, that Veteran does not need to wait for/have a VA primary care provider (PCP) assignment to obtain a specialty referral. Instead the SC Veteran only needs to contact the specialty clinic to arrange an appointment for evaluation of the service-connected medical problem.

V. Additional Comments on OIG Report

The VA Office of Inspector General (VA OIG) dedicated a tremendous amount of resources to explore allegations of pervasive problems within the Phoenix VA Health Care System (PVAHCS).

In so doing, the VA OIG uncovered numerous problems involving scheduling irregularities, unofficial wait lists, culture goals emphasized at the expense of patient care, safety issues, and systemic obstacles to the proper provision of care in multiple areas.

Overall, the VA OIG investigation of PVAHCS produced massive systemic VA scheduling changes and led to a tremendous positive impact on the health care of our nation's Veterans. The Phoenix VA OIG inspection also revealed multiple problems that were outside the narrower focus intended for the original OIG investigation. As a result the Veterans Health Administration (VHA), Office of Medical Inspection (OMI), Office of Special Counsel (OSC), & Federal Bureau of Investigation (FBI) have since launched inquiries to explore those problems further.

In general, the clinical cases in the report are written so that those with a healthcare background would find it easy to evaluate the results. Unfortunately, the details and their implications often are not written in terms the layperson can understand.

The case study investigation limitations are implied but generally not directly identified by the investigators. I have no reason to believe that any information gaps in the 8/26/14 report were intentional. As I read the cases, I simply felt that there was more data needed to understand the implications and conclusions.

Not familiar with the basic OIG process, I was somewhat confused by the OIG's stance that bullying behavior was "unsubstantiated". They only reviewed 26 complaints. During my interview with investigators, I described behavior consistent with bullying. If I had been asked to provide the names of colleagues with direct knowledge of such behavior, I immediately could have provided the names of 3 current or former mid-level managers with first-hand accounts of numerous episodes of bullying or other workplace stress. The OIG had ample opportunity to ask each VA employee they interviewed about the PVAHCS environment and whether the employee was a victim of bullying or other intimidation. It should have been a routine part of the investigation, even if just to ascertain if an employee was afraid of repercussions for speaking with the OIG.

Although the investigation process was detailed in the 8/26/14 report, the basic OIG investigation process used in other investigations is unclear for those of us outside the OIG. For example, I turned in an OIG complaint in 2013 through my senator's office. My complaint dealt with serious issues including scheduling problems, suicide trends, facility safety issues, and other topics. Although I was told one OIG investigator was involved, there was never any official OIG report of the investigation into my complaint. The single email sent to my senator's office outlined a response from senior administration at the Phoenix VA. Within that 2013

response, they denied any abnormalities in the scheduling processes, suicide trends, & safety equipment. The OIG website has no record of any investigation conducted on the basis of my complaint.

I have been told that the VA OIG has discretion over which reports it places on its website. I am in possession of one such VA OIG case that is not listed on its website. This report is unfavorable to the VA and speaks of patient panels up to 50% over the recommended size, significant provider staff turn-over, and a negative administrative culture.

If the goal is transparency, then the VA OIG should place all summaries/full reports on its website.