Written Testimony for Submission to the Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, & Related Agencies

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INTRODUCTION

My name is Dr. Katherine Mitchell. I am an internist who is fellowship trained in geriatrics. I have over 17 years of experience within the Veterans Healthcare Administration (VHA). Since September 2014 I have been assigned to the Veterans Integrated Service Network (VISN) 18 in Gilbert, Arizona as the Specialty Care Medicine lead. Prior to this time I was the medical director of the Phoenix VA Post-Deployment Clinic for 1.5 years. I was also a Phoenix VA Emergency Department (ED) physician for a total of 9.5 years including 6 years as the ED medical co-director/director. My background also includes 5 years serving as a Phoenix VA hospital nurse.

Throughout my career at the Phoenix VA Medical Center (VAMC) I heard anecdotal comments from staff that the VA Office of Inspector General (OIG) did not conduct objective investigations and rarely, if ever, accurately reported on the serious safety and patient care problems present within the Phoenix VAMC. I was told that confidentiality was never preserved because the IG investigators would leak the names of staff discretely reporting concerns to the VA OIG Hotline. Through the hospital grapevine, I had been informed OIG investigations were closely monitored by Phoenix VA administrators who would penalize staff for answering questions honestly. I was warned by trusted co-workers that initiating an OIG investigation was equivalent to risking job loss.

Subsequent events over the last two years have convinced me that every anecdotal comment about the OIG was true. I would learn that the OIG does not maintain whistleblower confidentiality, allows VA facilities to investigate themselves, does not conduct thorough investigations, and white-washes its reports. Within the body of this written testimony I will describe the events that have led me to these conclusions.

Section I: OIG Failure to Maintain My Confidentiality or Conduct Adequate Investigation into My OIG Complaint

After years of trying unsuccessfully to have Phoenix VA administrators adequately address the deep patient safety and staffing issues within the Phoenix VA ED, I was ethically compelled to go outside the usual chain of command to protect the welfare of Phoenix VA ED patients. I decided to submit a confidential OIG complaint through my senator's office. I hoped such a congressional avenue could ensure my complaint would be investigated quickly and thoroughly.

I could not file an anonymous OIG complaint because my assistance with the OIG investigation would be key to ensuring that the depth and breadth of the Phoenix ED safety issues would be uncovered. Because I knew from personal experience that the Phoenix VA administrators were extremely retaliatory, I hoped my name would not be revealed by the investigators. Filing a complaint would easily compel the Phoenix VA administration to make my working conditions so unbearable that resignation would be the only viable option. I did not want to lose the only career I've ever cared about – working for veterans within the VA system.

When I decided to file, I knew I was risking my career if my name was released. Therefore, I organized my complaint so it would address as many patient care and safety issues as possible. I hoped this would increase the likelihood that my OIG complaint would result in significant positive changes within the Phoenix VA. I went to my fellow Phoenix VA employees with whom I had developed a trusted relationship and asked them to provide me with information regarding the most serious issues within the VA facility. The problems must be easily proven and be urgent enough that the issues could not wait for resolution by the normally ponderous VA process of change. It was equally important the information could not be traced back by management to my "sources". I wanted to be the only target if my name was not kept in confidence by the OIG investigators. As the result of the information collected as well as my first-hand knowledge of facility issues and overt backlash, I wrote a lengthy complaint detailing the various problems.

When I presented my written OIG complaint to staff at my senator's office, the seriousness of the VA situation was evident to even those staff who had no health care background. I was informed by the senator's office that the most serious safety issues listed in my complaint would be forwarded with a request for an expedited OIG investigation to address the issues and maintain the confidentiality of my name. Some of the issues in my complaint included disturbing system issues involving suicides, statistical manipulation of the wait list, failure to prioritize appointments according to national VA policy, improper distribution of complex patients, inadequate/malfunctioning police equipment including radio system, and pending waste of VA funds because of gross inadequacies of the blueprints for the proposed Phoenix VA ED construction project.

I supplemented my complaint with a document outlining inadequate response by the facility to increasing number of veteran suicides. I included the first name and last initial of some

veterans who committed suicide in order to substantiate my allegations. Those names had been obtained in the process of a work-related project on suicides that I was conducting and of which Phoenix VA medicine chain of command was aware. Those names would only be identifiable to the investigators if they pulled a list of suicide victims during the timeframe named in the document. Release of patient information to a congressman within the context of arranging an OIG oversight investigation on those patient cases is not a violation of the Health Insurance Portability and Accountability Act (HIPAA).

I was informed by the senator's office that a truncated version of my complaint would be forwarded to the OIG including my supplemental documents. The letter acknowledging VA receipt of my complaint was time/date stamped September 12, 2013. Shortly thereafter I was hauled into my supervisor's office. I was informed I was being placed immediately on administrative leave for undisclosed alleged misconduct.

After being on administrative leave at home for approximately a month, I was allowed to return to work. Upon my return, management informed me that I was being investigated for accessing the charts of the suicide victims and violating an unspecified privacy policy. While my supervisor didn't state I was being punished for reporting information to my senator's office, the only way that information could have come to the attention of Phoenix VA management was if the OIG had leaked my name to the Phoenix VA administration.

I would eventually receive a written counseling allegedly for working outside the scope of my duties as well as purportedly violating a patient privacy policy which the Phoenix VA Human Resource Service declined to specify.

I waited for the OIG report into my allegations but none came. I saw no changes implemented as the result of my OIG complaint. In February 2014 my senator's office was able to verify the OIG had been involved in an investigation of my complaint. However, the extent of OIG involvement could not be determined.

I have never seen the official OIG report on my 2013 complaint and believe one does not exist. My senator's office made attempts to locate the report for me without success. The only follow-up on the investigation the office could locate was contained in a short email containing a portion of the VHA response to my complaint. (Exhibit A) The email indicates that the "results of the preliminary fact finding investigations, as well as subsequent investigation and actions" did not substantiate the concerns I reported through my senator's office.

That email did not give answers to the troubling concerns I had raised in that truncated OIG complaint. In regards to the suicide trends and inadequate facility response to those trends, it merely stated "root cause analyses were conducted" by the facility during the timeframe in question. It also stated there were plans to staff the suicide team in 2014.

The email failed to address the issues I knew to be true through my work with the Suicide Prevention Team and other committees. It never mentioned that the facility was ignoring the

trends in suicide which were associated with inadequate pain management. It failed to highlight the fact that the Suicide Prevention Team was grossly understaffed and near-buckling under the weight of the required case management. It did not reveal that Phoenix VA administration had already informed the Suicide Prevention Team that one staff member would be moved into an unrelated area because of budget limitations/staffing shortages in the ambulatory care clinics. (This planned reduction in Suicide Prevention Team members was to be done even though the head of the team stated they would not be able to adequately manage high risk suicidal patients if the team was reduced.) The email neglected to note that the Suicide Prevention Team had no ancillary support so the team was stretched extremely thin trying to juggle administrative issues, manage cases, and handle the calls sent to the team from the VA Suicide Crisis Line. *(PLEASE NOTE: Only after the Phoenix VA scandal erupted would the Phoenix senior leadership scrap plans to transfer a social worker off the team and instead actually hire desperately needed staff members.)*

That email response also stated the Phoenix VA Healthcare System leadership "confirmed the Electronic Wait List is being used where indicated." No mention was made of my complaints regarding wait list manipulation and failure to adequately schedule veterans according to priority category. It would take until 2014 before the true depth of the Phoenix wait list manipulation would be exposed. (Eventually the wait list manipulation and associated patient deaths would lead to the OIG to reluctantly admit in a House Committee hearing that the wait lists delays contributed to veteran death.)

That email response also stated there were "no findings related to equipment" deficiencies in the police department. At that time, I knew with complete certainty that five police bullet proof vests were expired. I also knew the outdated VA police radio system had many dead zones within the building including within the highest risk areas for violence – the Emergency Department and the outpatient mental health clinic. Those dead zones meant officers would have to use a landline to request police back-up. In addition, the officers' radios had so much static at baseline that it was extremely hard for them to communicate in areas where they could get reception. *(PLEASE NOTE: Although it was an extremely slow process, the officer police radio system has since been updated to correct these deficiencies and the vests have been replaced.)*

Although the exact extent of the OIG investigation could not be determined, it was clear to me that the OIG investigation was grossly inadequate. If the investigator(s) would have scratched more than just the surface, deep issues would have been uncovered. The OIG would have had the opportunity to uncover the wait list manipulation in September 2013 and prevent the significant morbidity and mortality occurring when veterans were left to languish on unauthorized wait lists. The OIG could have intervened earlier to improve needed services for veterans who were at high risk for suicide. The OIG could have also uncovered gaps in facility security related to inadequate police equipment.

Section II: Four Examples of OIG Report Deficiencies

Example #1: OIG Report: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System – 8/26/2014

Issues: a. When evaluating patient deaths on the wait list, the OIG failed to use sound medical judgement in determining if there was an association between delayed patient care and patient death. The report was phrased so that it appeared there was no association between patient deaths and waiting on the "secret" wait list. The acting Inspector General would later admit under oath that those patient care delays contributed to patient deaths.

b. The OIG failed to adequately investigate the presence of mid-upper level management bullying and harassment within the Phoenix VA Medical Center.

As per my September 2014 written and oral testimony to the House Committee on Veterans Affairs, there were significant deficiencies in medical judgement of OIG investigators. (Exhibit D) In my opinion, based only on the information provided in its 8/26/2014 report, the OIG failed to recognize obvious associations between delays in care and patient deaths and/or loss of quality of life before death.

In its final report summary the OIG wrote "We were unable to assert that the absence of timely quality care caused the deaths of these veterans". However, in that September 2014 congressional hearing, eventually the OIG acting Inspector General reluctantly admitted that the patient care delays were contributing factors in several patient deaths. Failure to provide this information in the 8/26/14 OIG report effectively obscured the tremendous negative impact that the Phoenix "secret" wait list had on the lives of the veterans who died before they could get an appointment.

Specifically, as described in my previous testimony last year, there were 4 cases in which a causal relationship was clearly evident between delayed and/or improper care & veteran death, excluding veterans for which cause of death was not listed. Those cases are described as follows:

1. Case 29

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 results 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.

My 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 36

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.

My 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 39
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 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.

My 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 40 (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.

My 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.

In addition to the previously described cases there were 3 other cases in which a causal link was strongly suspected but could not be proven based on information given in the final OIG report. There were multiple instances of deficits in patient care that reasonably would have contributed to loss of quality of life and/or inadequate follow-up. The specifics of those details can be found in Exhibit D.

In its 5/28/2014 interim report, the OIG stated "Lastly, while conducting our work at the Phoenix HCS our on-site OIG staff and OIG Hotline receive numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility. We are assessing the validity of these complaints and if true, the impact to the facility's senior leadership's ability to make effective

improvements to patients' access to care." By making these statements, the OIG announced its intention on investigating these serious allegations further.

Unfortunately, in its final report, the investigators inexplicably failed to substantiate bullying behavior within the Phoenix VA Medical Center. This was shocking to me. As an employee within that facility for a total of 16+ years, I can unequivocally assert that bullying behavior and other harassment by mid to upper level managers permeated Medicine, Nursing, Environmental Management Service, and the Health Administrative Service at that facility for many years. Not only had I encountered bullying behavior in 4 of those services, my co-workers from each of those areas had spoken to me of extensive harassment at the hands of management. Although I described some of the harassment to OIG investigators, I was never asked to elucidate nor asked if I could refer the investigators to other staff who could substantiate bullying/harassment by mid to upper level management. If I had been asked, I would have gladly referred the team to staff who have been willing to discuss such behaviors.

Example #2: OIG Interim Report - Review of VHA's Patient Wait Times, Scheduling Practices and Alleged Patient Deaths at the Phoenix Health Care System – 5/28/2014

Issue: The phrasing/reporting in the interim OIG report allowed the VA to effectively obscure the fact that the scheduling system at the Phoenix VA was lagging behind 477 days.

The investigative team failed to include pertinent details on the NEAR list which could have disclosed exactly how long the waits had been for Phoenix VA veterans. Without explaining its statistical sampling method in its interim report the OIG investigators wrote "...our review found these 226 veterans waited on average 115 days for their primary care appointment, and an estimated 84 percent waited more than 14 days. Most of the wait time discrepancies occurred because of delays between the veteran's requested appointment date and the date the appointment was created..."

A review of an actual redacted NEAR report from Phoenix VAMC reveals there was much more information about lengthy delays that would have been damaging to the VA if released. (Exhibit B) A significant number of patients waited greater than 115 days. There were 16 pages in the Phoenix downtown clinics NEAR list with 56 names per page through page 15. The wait times slowly trended downward from 477 days. A wait time of 115 days was not found until near the bottom of page 9. Therefore, although the number of days spent waiting for Phoenix VA downtown clinic appointments ranged 0-477 days, approximately 496 veterans on the list waited more than "average" 115 days that were reported by the OIG team.

In addition, the investigators should have known it was meaningless to even list an average number of days waiting because the "average" was an artificial statistical value. According to the way in which the electronic wait list was improperly managed, only those waiting the longest would have the first opportunity for appointments. This was because patients were

scheduled according to the order in which they were placed on the unofficial wait list. In truth, the entire scheduling system was backed up 477 days which reflected the longest number of days a veteran had been waiting for an appointment. As per Exhibit B, the veteran who had waited 115 days would not be scheduled until the 496 patients ahead of him were scheduled. Barring any deliberate intervention by staff, the veteran listed on page 16 would not be scheduled until all patients on the 15 pages ahead of him were scheduled. Instead of reporting the average wait time, the OIG team should have revealed the true number of days the scheduling system was backed-up – 477 days.

For objective/impartial disclosure of pertinent information including accurate wait times, the OIG should have presented data reflecting more details of the NEAR list. At a time when the country was clamoring for an accurate depiction of the problems at the Phoenix VA, there was no reason to withhold such information.

Example #3: OIG Hotline Case #2014-00459-HL-0044 regarding St. Cloud VA Health Care System

Issue: The OIG is still suppressing at least one Hotline Report that is critical of the VA.

Last year I received a copy of the OIG Hotline Case #2014-00459-0044 that substantiated significant problems at the St. Cloud VA Health Care System including "disrespectful manner by [the facility's] senior management" and "fear of reprisal" among primary care employees. (Exhibit C) Multiple other serious issues were identified including patient panel sizes at 150% over VA recommended limits. That report was not found on the VA OIG website when I specifically searched for it last year.

Recently, with the stated goal of transparency, the OIG released over 140 reports on its website. That OIG Hotline case does not appear when I searched the website again. It remains unclear to me if the absence of this damning hotline report is a unique situation or if additional/all OIG Hotline reports have not been released. I am concerned because such OIG Hotline reports are directly relevant to the oversight and monitoring of the VHA.

Example #4: OIG Report - Health Care Inspection Alleged Quality Control Issues in Supply Processing & Distribution Carl T. Hayden VA Medical Center Phoenix, Arizona – 7/13/07

Issue: The OIG failed to consider/investigate the possibility that potentially contaminated surgical instruments may have placed veterans at risk for contracting HIV, Hepatitis B, or Hepatitis C during surgery.

In its 2007 investigation, the OIG team reported "We substantiated that SPD had ongoing problems including contaminated instruments, damp wrappers, and torn or discolored instrument wrappers, resulting in 20 orthopedic surgery cancellations from August 11, 2006, through April 30, 2007. Because OR nurses were vigilant in checking instrument wrappers during the SPD construction project, surgeries were cancelled when problems were identified. Staff never used contaminated instruments during any surgical procedure. Infection control data did not show any increase in surgical infections from August 2006 through April 2007."

However this statement did not reflect an adequate understanding of the problem scope nor potential implications of the deficiencies in SPD processing. In the body of its report, the OIG team noted repeated failures of SPD processing of surgical instruments over a prolonged period of time. SPD processing including sterilization removes both visibly soiled contaminants and microscopic contaminants. Although the nurses rejected visibly contaminated instruments, they could not monitor for microscopically contaminated surgical instruments. Therefore, it would have been impossible for the OIG team to state with any certainty that "Staff never used contaminated instruments during any surgical procedure" because only visibly soiled instruments can be detected by the human eye. Viruses such as HIV, Hepatitis B, and Hepatitis C could be transmitted via microscopically contaminated instruments.

The investigators stated there was no spike in surgical infections. However, they likely were referring only to bacterial infections because those are only type of post-operative infections for which Infection Control staff routinely monitor. There is no evidence in the report that the OIG considered the possibility of viral infection transmission. During the timeframe of impaired SPD sterilization processes, every instrument processed was potentially inadequately sterilized after being used in the operating room. For this reason, the OIG should have recommended screening all post-operative surgical patients for HIV or hepatitis infections. Each one of those patients would have been at risk for receiving viral transmission if the instruments used were microscopically contaminated with debris from patients with HIV, Hepatitis B, or Hepatitis C.

Section III: General OIG Hotline Process Exposes Whistleblowers to Retaliation

Through my current position in VISN 18, I have become peripherally aware of how OIG Hotline complaints are routinely handled. The OIG screens Hotline complaints based on criteria which are unknown to me. The OIG forwards the complaint electronically to the VISN office supervising the pertinent facility as well as copies the VA Medical Review Service onto the email. The VISN office screens the complaint and sends the complaint either to the facility for self-investigation, keeps the complaint for the VISN to investigate, or refers the complaint to another entity for investigation.

If the facility is allowed to self-investigate, the facility senior management then arranges its own investigation and forwards the results of its investigation to the VISN office. VISN office staff review the complaint response in depth for completeness and accuracy. Inaccurate or incomplete responses are sent back to the facility for revision. When the final report is approved by the VISN, the office then sends the complaint back to the OIG and copies the VA Medical Review Service onto the email. The OIG then determines if further action is needed.

To ensure accuracy and impartiality of each investigation and protect whistleblowers, individual VA facilities should not be allowed to investigate themselves or have access to whistleblower names. Because inadequacies in facility performance can affect annual reviews and bonuses, facility-level senior executives have financial and professional incentives to suppress any negative information that might be revealed in an investigation. When OIG hotline complaints are turned over to facility management, there is an opportunity for unscrupulous supervisors to retaliate against the VA employees who either reported the OIG hotline complaint or are involved in the investigation.