VA Office of Inspector General Releases Scathing Report of Phoenix VA

The long-awaited Office of Inspector General's (OIG) report on the Phoenix VA Health Care System (PVAHCS) was released on August 27, 2014 (1). The report was scathing in its evaluation of VA practices and leadership. Five questions were investigated:

1. Were there clinically significant delays in care?
2. Did PVAHCS omit the names of veterans waiting for care from its Electronic Wait List (EWL)?
3. Were PVAHCS personnel not following established scheduling procedures?
4. Did the PVAHCS culture emphasize goals at the expense of patient care?
5. Are scheduling deficiencies systemic throughout the VA?

In each case, the OIG found that the allegations were true. Despite initial denials, the OIG report showed that former PVAHCS director Sharon Helman, associate director Lance Robinson, hospital administration director Brad Curry, chief of staff Darren Deering and other senior executives were aware of delays in care and unofficial wait lists.

Perhaps most disturbing is the OIG finding that scheduling deficiencies are systemic throughout the VA. The OIG is currently investigating 90 VA facilities. The findings prompted Rep. Jeff Miller, House Veterans' Affairs Committee chairman to comment "We have seen no evidence that the corrupt bureaucrats who created the VA scandal will be purged from the department's payroll anytime soon. Until that happens, VA will never be fixed," (2).

Though whistleblowers alleged veterans died while awaiting care in Phoenix, acting Inspector General Richard Griffin did not draw any conclusions about criminal culpability and declared that he was "unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans." Phoenix whistleblowers Drs. Sam Foote and Katherine Mitchell, said the OIG standard made no sense because 45 examples described in the OIG report showed that delayed care likely resulted in premature deaths or harm to patients' quality of life. It is the later standard that is usually applied to physicians.

The day prior to the release of the report the Deputy VA Secretary Sloan Gibson was interviewed noting that more veterans are being sent to private doctors for care reducing waiting times (3). "The fundamental point here is, we are taking bold and decisive action to fix these problems because it's unacceptable," said Gibson. It is unclear whether these reports of improved waiting times are any more reliable than the initial denials of prolonged patient waiting times from both the Phoenix VA and VA Central Office.

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References

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3. Associated Press. Watchdog report details 'systemic' problems at VA facilities. Available at: http://www.foxnews.com/politics/2014/08/26/no-proof-delays-in-care-caused-vets-to-die-va-says/ (accessed 8/25/14).