United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

WASHINGTON, DC 20510–6250

April 24, 2018

William Patterson, MD
Director, VISN 15
U.S. Department of Veterans Affairs
1201 Walnut Street, Suite 800
Kansas City, MO 64106

Dear Dr. Patterson:

I am writing regarding a recent audit of Veterans Integrated Service Network (VISN) 15 by the Department of Veterans Affairs (VA) Office of Inspector General (OIG), which found deficiencies in the accurate recording of wait time data, veterans' access to care through the Choice program, and the management of specialty care consults.[1] As you are aware, VISN 15 includes VA medical centers in Missouri, including the VA St. Louis Health Care System, Harry S. Truman Memorial Veterans' Hospital in Columbia, John J. Pershing VA Medical Center in Poplar Bluff, and the Kansas City VA Medical Center.

OIG found that VISN 15 facilities did not record accurate wait times. OIG estimated that staff at the facilities entered an incorrect clinically indicated date 47% of the time for appointments with wait times greater than 30 days. Veterans Health Administration (VHA) policy required a minimum of ten audited appointments, biannually, per scheduler. OIG found that none of the facilities in VISN 15 were compliant with this national policy. Of the appointments with incorrect wait time data, OIG estimated that about 82% were cases where the veterans should have been offered care through the Choice program, based on real wait time data.[2]

However, according to OIG, the Choice program has its own deficiencies in regards to patient care in VISN 15. In VISN 15, the Choice program is managed through a contract with TriWest. VA's contract with TriWest requires that the contractor provide an appointment through the Choice program within 30 days of the clinically indicated date. OIG estimated that 41% of the time, veterans waited more than 30 days for an appointment through the Choice program.

I am very concerned about any delays or deficiencies in veterans' health care, particularly in my home state of Missouri. Research has shown that lack of access to critical mental health

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[1] Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Audit of Wait Time Data, Choice Access, and Consult Management in VISN 15* (17-00481-117) (Mar. 13, 2018).

[2] *Id.*

services may lead to suicidal behavior, especially among those who have completed multiple deployments.[3] VHA's Office of Mental Health and Suicide Prevention released a report in 2016, after examining millions of records to determine veteran suicide rates in each state and across the country. For Missouri, the results were extremely troubling; the veteran suicide rate in Missouri was nearly three times the national suicide rate and significantly higher than the national veteran suicide rate.[4]

Additionally, OIG found that VISN 15 has issues sharing information with TriWest. According to VA's contract with TriWest, the contractor must provide medical documentation of the services provided through the Choice program to the VA within 75 calendar days. OIG estimated that TriWest provided medical documentation for about 49% of all appointments within this time frame, with VA staff receiving medical documentation directly from non-VA providers 22% of the time. This has been an ongoing issue with the Choice program. OIG found that TriWest had not submitted medical documentation for about 35% of veterans who received care through the Choice program in 2016, and that medical documentation for about 33% of Choice appointments in 2015 is still missing.[5]

VISN 15 implemented a series of efforts to manage the implementation of the Choice program in its medical centers. However, without a comprehensive monitoring program to track authorizations, medical centers were left to determine their own tracking methods, which hindered the VISN's visibility into systemic problems with the Choice program. For example, OIG discussed the decision by leadership at the Kansas City VA Medical Center to designate three nurses to solely work on obtaining medical documentation from non-VA providers. According to OIG, "staff stated that these positions could have been used more productively if TriWest provided documentation timely."[6]

OIG also found that VISN 15 did not properly manage specialty care consults according to VHA policy. VISN 15 medical facility staff inappropriately discontinued or canceled an estimated 27% of specialty care consults during the first quarter of FY 2017. OIG found that inappropriately discontinued or canceled specialty care consults led to veterans not receiving medically necessary care or experiencing unnecessary delays.[7]

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[3] Ronald D. Hester, *Lack of Access to Mental Health Services Contributing to the High Suicide Rates Among Veterans,* International Journal of Mental Health Systems (Aug. 18, 2017).

[4] Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention, *Missouri: Veteran Suicide Data Sheet* (https://www.mentalhealth.va.gov/docs/data-sheets/Suicide-Data-Sheet-Missouri.pdf) (accessed Apr. 17, 2018).

[5] Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Audit of Wait Time Data, Choice Access, and Consult Management in VISN 15* (17-00481-117) (Mar. 13, 2018).

[6] *Id.*

[7] *Id.*

As a result of the audit, OIG made 11 recommendations – three recommendations made to the Office of the Under Secretary for Health and the remaining eight to VISN 15. Nine of the recommendations are still open; OIG and VHA agreed to close two of the recommendations after VHA initiated processes to solve these issues. OIG's recommendations to the Office of the Under Secretary for Health include automating the use of clinically indicated dates when scheduling appointments and implementing monitoring mechanisms to effectively manage Choice referrals. For VISN 15, OIG recommended improved processes for managing and tracking Choice referrals, conducting and communicating audit results to all network facility staff, ensure consults are managed according to VHA policy, and to evaluate and rectify any gaps in patient care identified in the audit.[8]

In order to better understand how VISN 15 is implementing these recommendations and improving timeliness and quality of care at facilities in the network, I request that you provide a response to the following questions on or before May 15, 2018:

1. OIG's audit included patient examples detailing the real-life impact of the problems outlined in the report; each of the six patient examples that were cited in the report were associated with VA Medical Centers in Missouri.

    a. What have you done to rectify the lapses in care identified in these patient examples?

    b. Is it correct that only one of these patient examples rose to the level of an institutional disclosure?

    c. How did VISN 15 determine which examples required an intuitional disclosure and which did not?

2. How do you plan to address deficiencies in the management and performance of the Choice program?

3. What additional support do you need from VHA to ensure that VISN 15 facilities have the tools to monitor veterans' medical data and wait times?

4. What changes are needed to ensure that veterans referred to the Choice program in order to more effectively care for our veterans in a timely manner?

5. How has the ability to provide timely and accurate care to veterans in the Heartland Network been impacted by vacancies at VHA, specifically the Under Secretary for Health and the Secretary?

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[8] *Id.*

6. What are current vacancy levels within VISN 15? How have you worked to address these vacancies?

7. OIG's audit detailed a number of ways in which VISN 15 attempted to work with TriWest to effectively implement the Choice program. However oversight of the contract was hindered by a lack of oversight controls at the VISN level and deficiencies in TriWest's execution of the contract requirements.

    a. What is VISN 15 doing to ensure that TriWest complies with contract requirements?

    b. How has VISN 15 held TriWest accountable for lack of or late submission of medical documentation and increased wait times for appointments?

    c. How can VHA improve these processes and procedures to ensure that VISN 15 can effectively share information and monitor authorizations with TriWest?

8. In the audit, OIG provided an example from the Kansas City VA Medical Center where three nurses were reassigned to solely work on obtaining medical documentation from non-VA providers.

    a. Are the nurses at this facility still working on obtaining medical documentation rather than providing nursing care?

    b. As the VISN 15 Director, what are you doing to ensure that nurses are able to carry out the duties that they are trained for, rather than duties that are the responsibility of TriWest?

9. What specific steps has VISN 15 taken to implement the eight recommendations outlined by OIG and what are the estimated dates of completion?

If you have any questions about this request, please contact Hannah Berner of my staff at (202) 224-5065. Please send any official correspondence related to this request to Rina Patel at Rina_Patel@hsgac.senate.gov. Thank you for your prompt attention to this matter.

Sincerely,

Claire McCaskill
Ranking Member

cc: Ron Johnson
Chairman