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for submission to the

SENATE COMMITTEE ON VETERANS' AFFAIRS

12/14/15 Field Hearing

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Section I: Introduction & Summary

My name is Dr. Katherine Mitchell. I am a VA physician who worked within the Phoenix VA Emergency Department (ED) for almost 10 years until I involuntarily was transferred to a defunct VA clinic in retaliation for repeatedly identifying dangerous ED patient safety deficits. After years of having my reports of life-threatening conditions ignored by internal Phoenix VA mechanisms I publically became a whistleblower in April 2014 in an attempt to have the VA resolve those many serious problems. I alerted the public and Congress to unsafe conditions in the Phoenix VA Emergency Department, whistleblower retaliation, facility scheduling irregularities, and other issues. After the Veterans Health Administration (VHA) formally acknowledged the workplace retaliation against me, I accepted a position within the VA Veterans Integrated Service Network (VISN) 18 office as a Specialty Care Medicine coordinator. Although I continually advocate for improvements at the Phoenix VA ED and Mental Health Clinic, in my current position I have been told by VA administrators that I am not allowed to actively address the known dangerous conditions that still exist there.

The presence of these dangerous conditions was substantiated in a September 2015 Office of Special Counsel (OSC)/ VA Office of Medical Inspector (OMI) report that was released internally to the VHA in March 2015. This official report called the Phoenix VA Emergency Department triage "a significant risk to public health and safety" and detailed substandard nursing care in the Phoenix VA ER and Mental Health Clinic, a significant lack of nurse triage training, and inadequate nursing triage protocols. The report also substantiated "that nurses failed to perform EKGs when ordered, and…failed to act upon orders for serious patient complaints such as chest pain".

After the OSC/OMI report's March 2015 internal VHA release, Phoenix VA ED triage nurses were trained in a triage algorithm called Emergency Severity Index (ESI). Unfortunately, while the ESI is a valuable adjunct to triage care, this ESI training does not convey triage symptom knowledge nor imply a mastery of triage skills.

The Phoenix VA has misled the public into believing that ESI training resolved the safety deficits in the ED. In fact, there has been no significant standardized triage training that would actually give the nurses the knowledge base to effectively evaluate patient symptoms. There are no minimum qualifications formally required for a nurse to work in triage and no definitive policy regarding triage standards. Nurses who chose not to follow patient care orders for serious patient complaints still remain within the ED. Issues with patient elopement still occur.

Unlike the private sector, there is a lack of standardized triage nurse training within the entire VA system, no minimum qualifications to be a triage nurse, and an absence of standardized VA triage nursing protocols. Therefore, the problems present within the Phoenix VA Emergency Department and Mental Health Clinic are likely mirrored at VA medical facilities throughout the nation.

There are recent cases where a Phoenix VA veteran died potentially because of lack of timely follow-up appointment or consult. I encountered these cases after being alerted to the method of Phoenix VA

closure of consults for deceased veterans. Although the VA is supposed to disclose situations were a delay in care could have contributed to a patient's death, there was no evidence on the charts to indicate the charts had ever been reviewed by Phoenix VA quality management staff.

Since the Phoenix VA access scandal erupted there has been no significant change in the dysfunctional institutional culture of the Phoenix VA Medical Center or sister VA facilities. In Phoenix and elsewhere administrators who are known to retaliate still occupy positions of leadership. Based upon conversations I have had with VA staff throughout the country, VA employees today still risk backlash for bringing up patient care problems, identifying misuse of facility resources, and questioning violations of VA policies and procedures.

Therefore, the purpose of my written testimony is to outline the dangerous conditions that still exist in the Phoenix VA Emergency Department and Mental Health Clinic, emphasize the potential for these deficiencies to be mirrored in VA ERs and mental health clinics throughout the nation, cite examples of Phoenix VA patient care delays potentially contributing to veteran death, and highlight the persistent culture of retaliation against whistleblowers at the Phoenix VA and other VA facilities.

By focusing on these issues, I am hoping Congress and the public will demand that national VA correct these deficiencies immediately in order to reduce the imminent risk of patient harm in Phoenix as well as other VA facilities, improve employee recruitment and retention efforts in our grossly under-staffed VA system, and enable the VA to meet and exceed the standards of high quality health care.

Section II: Dangerous Conditions Persist within the Phoenix VA Emergency Department

Background

Emergency Department (ED) nursing triage should be the first step in patient assessment upon arrival to an ER. Such triage will determine how soon the patient will be referred for medical care in the Emergency Department setting. It is vital that nurses who perform initial triage have adequate training and follow standardized protocols for evaluating patients. Without adequate nurse triage training or standardized triage protocols, significant medical complaints will not be recognized or evaluated properly on arrival to the ER. As a result, serious ill patients may not be treated in a timely or appropriate manner resulting in potentially life-threatening delays in care.

The need for appropriate nurse triage extends into urgent mental health clinics. Symptoms of psychological crises must be recognized by the triage nurse so the patient's care can be expedited.

<u>Long-standing Phoenix VA triage deficits in the ER and Mental Health Clinic</u>.

For the last 6 years, there have been significant patient safety issues within the Phoenix VA Emergency Department (ED) triage. During the years 2006-2012 when I was a Phoenix VA ED co-director and director, nurse triage mistakes were rampant during high volume patient flow because of inadequate nurse staffing and inadequately trained and/or overwhelmed triage nursing staff. Hundreds of actual serious triage nursing errors were reported by me through the Phoenix VA nursing and medicine chains of command without any significant attempt by the facility to correct the clearly identified gaps in nursing triage knowledge or lapses in triage judgment. Though not all ED patients suffered actual harm from those nurse triage mistakes, there were serious negative consequences for many veterans and the potential for irreversible patient harm was ever-present.

After I was transferred from the Phoenix ED for retaliatory reasons, the nursing mistakes continued but were not consistently reported because the remaining staff did not want to suffer retaliation. In my new position, I became aware of continuing triage errors and significant delays in care related to poor nursing triage. One example was a patient who was sent from clinic with stroke-like symptoms and was told to just sit in the waiting room because the nurses were too busy with other patients.

Although a few Phoenix ED triage nurses were sent to triage nurse training in either late 2011 or early 2012, there have been no attempts to provide structured, formal didactic training for the majority of Phoenix VA ED triage nurses since that time. Those nurses who received formal training classes in 2011/2012 eventually left the ED. In 2015 the Phoenix VA did initiate Emergency Severity Index (ESI) training for its ED triage nurses in response to an investigation. However, ESI training is merely a very brief step-wise tool for assigning triage priorities and doesn't teach nurses how to recognize when symptoms are serious.

In the interim since I was Phoenix VA Emergency Department medical director, the facility has not enacted any in-depth standardized triage nurse training even though it has improved overall VA ED staffing and expanded the quantity of patient care rooms. While the Phoenix ED may state it has hired experienced triage nurses, a recent investigative report from the VA Office of Medical Inspector indicated there may be a significant absence of formalized didactic triage training among those new hires. Mistakes and lapses in nursing care still occur.

Problems with mental health nursing triage became obvious to me in 2013 when I was assigned to the Phoenix VA Post-Deployment Clinic. Unenrolled patients who presented for mental health triage were referred to the Eligibility Clinic for enrollment prior to a nurse triage screening exam. Patients who presented to the Walk-in Mental Health Clinic would often leave because of extended delays either before or after nursing triage. There were many occasions I noted that the triage nurses did not appear to notify any physician regarding patients in mental health crisis who left prior to being seen by a provider. There remains no routine follow-up for patients who leave the clinic without being seen.

There was a particularly egregious mental health clinic nurse triage case where a veteran seeking help reported in triage that he was randomly shooting at individuals whenever he was inebriated. Without escalating his care or immediately notifying the physician on duty, the triage nurse told the veteran not to own a gun and then simply gave him the Substance Abuse Clinic phone number. Alone in the lobby, the veteran eventually left prior to being seen by the mental health physician. The mental health clinic triage nurse also never alerted any provider to this patient's complaint or initiated any follow-up. Unfortunately, this veteran did not return for any mental health care because he was arrested shortly thereafter by community police investigating a rash of random shootings.

When I raised concerns regarding the quality of his triage care, the Phoenix VA nursing service inexplicably stated the triage nurse met the standard of care. This stance is ridiculous because a well-trained triage nurse or, frankly, even a lay person with common sense nurse would have recognized this veteran was in obvious mental distress and would have escalated his care so the patient could be seen immediately to a provider. Any individual with common sense also would have known to initiate follow-up for this patient if the patient left without being seen by a mental health provider.

<u>Subsequent disclosure of safety deficits to federal agencies after internal Phoenix VA mechanisms failed.</u>

In 2013 I filed an Office of Inspector General complaint (OIG) regarding these serious Phoenix VA nurse triage issues, other safety concerns, and scheduling irregularities. Phoenix VA administrators denied the existence of any problems and the truncated OIG investigation subsequently was closed. I publicly became a VA whistleblower in April 2014 and openly discussed the dangerous triage conditions at the Phoenix VA as well as other issues. I disclosed the Phoenix patient safety deficits the Office of Special Counsel (OSC) which subsequently requested that the VA Office of Medical Inspector (OMI) investigate.

OMI investigation into my allegations of unsafe conditions in Phoenix VA triage areas & other issues.

That OMI investigation into my allegations occurred over 2 site visits in late 2014 and early 2015 at the Phoenix VA. The investigative team reviewed more than 110 examples of potentially life-threatening nurse triage errors that I identified. Although the overall quality and depth of that OMI investigation was extremely poor, it still substantiated 3 out of 4 of my allegations and stated the fourth allegation was true at the time of my complaint but had since been corrected. That OMI report was released internally to the VA in approximately March 2015 so that the VA could start remedying the severe deficits noted.

September 2015 public release of Phoenix VA OSC/OMI report identifying dangerous conditions in Phoenix VA Emergency Department triage and Mental Health Clinic triage.

On 9/17/15, the Office of Special Counsel (OSC) publicly released a key letter, summary OSC report, and related Office of Medical Inspector (OMI) reports regarding the conditions found within the Phoenix VA Emergency Department (ED). Despite the significant deficits involving the depth of the OMI investigation and the nature of some of its recommendations, the OMI still verified the presence of extremely poor nursing triage at the Phoenix VA ED as well as the presence of nurses who "failed to perform EKGs when order, and…failed to act upon orders for serious patient complaints such as chest pain". (The entire report as well as my analysis of the report deficits can be found at osc.gov in the 2015 public files.)

As per the OMI investigation based on 110+ cases presented to it, the OMI concluded there was "a significant risk to public health and safety" because of poor triage in the Phoenix ED. (Please note that the phrase "significant risk to public health and safety" is a direct quote from the OMI investigative team.) The investigators also found evidence of poor triage in the walk-in mental health clinic, inadequate local triage protocols, and inadequate staffing of the vascular lab.

The report findings indicated only 11 out of 31 nurses had any training in Emergency Severity Index (ESI), a common triage tool used in the VHA. The report did not specifically list whether any of those nurses had completed any didactic training for triage skills but the wording appeared to imply none of the nurses had completed any type of formal classroom triage training. The report did not analyze the triage training of nurses in the Mental Health Clinic.

The OSC summary report not only recommended ESI training but also stated that the OMI "further recommended a review of training and educations records to assess whether nurses have appropriate training and experience necessary to work in the ED , in accordance with Emergency Nurses Association (ENA) guidelines. " Those ENA guidelines recommend that a triage nurse complete a formal, didactic training course prior to being placed in a triage role.

Phoenix VA misleading response to OSC/OMI report.

The Phoenix VA publicly responded to the September 2015 OSC letter/OMI report by stating that it has since completed training of ED triage nurses in ESI as recommended in the OMI report to

which it had internal access since March 2015. Because the ESI training has been completed, the Phoenix VA indicated to the media that the issues have been addressed. By implying all ED triage nurses are now adequately trained to be in the triage role, the Phoenix VA is grossly misleading the public. (In fact, any VA facility that cites ESI training as "proof" of adequate triage nurse training is being deliberately deceptive.)

In actuality, the ESI found is merely a very short algorithm or brief step-wise guide used to classify a patient by assigning a number of 1 to 5 inversely based on the number of interventions (labs, x-rays, IV fluids, etc.) that the triage nurse estimates that the patient will require. In general, the more resources that a patient is estimated to require, the lower the number and the more critically ill the patient. As a rule of thumb, patients assigned a 1, 2, or 3 have much more serious complaints than patients assigned a 4 or 5. If all relevant aspects of a patient's complaint are identified, patients that are rated with a 4 or 5 should never require hospitalization. However, if the triage nurse doesn't understand that a symptom is serious or doesn't have the experience to elicit relevant symptoms, the nurse will misinterpret the algorithm and grossly underestimate the number of resources the patient will require. As a result, patients will be assigned an inappropriate ESI number and potentially experience serious delays in medical care.

Because the ESI tool cannot be used to determine the potential seriousness of a symptom, ESI training is never a substitute for in-depth triage training or triage expertise. If the triage nurse doesn't understand that a symptom is serious, the ESI number will be inaccurate and critically ill patients potentially will wait hours for care while their medical condition deteriorates. In fact, the agency that developed the ESI specifically writes in its ESI Implementation Handbook "The ESI is intended for use by nurses with triage experience or those who have attended a separate, comprehensive triage educational program." (It should be noted that the number of years in triage does not equate with mastery of triage skills. If a triage nurse is poorly trained, then there will likely be deficits throughout his or her career.)

The need for standardized formal Phoenix ED nursing training is evident. Based on my 10 years of working at the Phoenix VA ED, many of the nurses who have spent years in Phoenix VA ED triage have continued to make the same triage mistakes because they were never properly trained and never completed formal, didactic triage training. Unfortunately, at least for those trained within the Phoenix VA ED, the triage nurses doing the training were grossly inexperienced and thus produced trainees who were underprepared for the role of ED triage nurse. (I do not know the training background for the mental health triage nurses at the Phoenix VA Mental Health Clinic.)

<u>Failure to timely address key nursing issues identified by the OMI report</u>.

The OMI report on my Phoenix VA allegations was released internally within the VA in March 2015, 6 months before the public September 2015 release. The Phoenix VA should have had ample opportunity to address the all issues identified. However, to the best of my knowledge, the Emergency Department only remedied the lack of ESI training and did not address the fundamental lack of standardized triage training. Most importantly, administration has not addressed the complicit willingness of certain nurses there to commit retaliation against physicians by withholding/slowing down the completion of physician orders. The Phoenix VA

remained silent on the state of mental health triage training or the qualifications of the triage nurses there.

Based on Phoenix VA employee anecdotal reports to me, there are still pervasive issues with the Phoenix ED nursing triage and elements of basic ED nursing care. Ill patients frequently wait excessive amounts of time in the waiting room. Telemetry monitors remain without a dedicated staff member to monitor them. Alarms still ring while nurses, blocking out the sound of those alarms, fail to investigate. Although the majority of ED nurses conduct themselves professionally, anecdotal stories indicate there is a group of nurses who are still routinely rude to patients, fail to follow procedures, and are willing to retaliate against physicians who report improper care.

The OSC/OMI report with grave implications nationally for every VA Emergency Department & VA mental health clinic.

The Phoenix VA ED is not unique. The national VA has never set minimum standards for nurse triage qualifications, instituted standardized triage training, nor developed national standardized nursing triage protocols. Therefore the quality of nursing triage can vary widely on arrival to any VA Emergency Department depending on the time of day, day of week, and nursing staff present. As a result, veterans are at high risk for receiving substandard care. Although every veteran who presents to a VA Emergency Department deserves high quality care, in reality receiving proper nursing triage care can be a matter of pure chance.

In contrast, Emergency Department nursing triage care outside the VA is quite different. The Emergency Nurses Association, the professional body representing emergency room nurses, has set minimum recommended training standards required before a nurse can perform ED triage. In community hospitals, triage nurses have in-depth ER experience in addition to focused, standardized triage training. In the private sector, triage nurse protocols are quite common. In conjunction with adequate triage training, such protocols ensure a standardized, expedited approach to patient symptom evaluation.

Community standards for ED nurse triage training and triage qualifications.

The Emergency Nurses Association (ENA) has minimum criteria set for ED triage nurse training. Within its guidelines is written “A specific amount of time and experience in emergency care alone may not ensure that a registered nurse is adequately prepared to function as a triage nurse. To perform triage with a high level of accuracy and competence, registered nurses should complete a triage-specific educational program, as well as other appropriate courses and certifications, and should demonstrate qualities...that facilitate successful triage... Emergency nurses should complete a standardized triage education course that includes a didactic component and a clinical orientation with a preceptor prior to being assigned triage duties.”

To ensure that veterans have access to appropriate nurse triage processes, the VHA needs to recognize and adopt the community standards for triage nurse qualifications. The VHA also needs to prioritize the development of standardized nurse triage protocols.

VHA failure to prioritize the standardization of nursing triage.

The VHA has not responded to multiple avenues by which I have emphasized the importance of implementing standardized triage training, establishing minimal nurse qualifications, and developing triage protocols. Conversations with VA administrators locally and nationally have not resulted in any known actions. My Phoenix ED nurse triage training suggestion never received a response. Most recently, I even submitted the idea through the MyVA Idea House. The feasibility was rated as "easy", the effectiveness was rated as "extremely", and veteran/employee/outcome categories were rated as "high". Unfortunately, the idea was not elevated to the next level of VHA consideration because it was rated low at only a "3" on a scale of 1-10 in terms of "urgency" and given only a "6" on a scale of 1-10 in the category of "importance". Because the VA mission is to care for "those who have borne the battle" it is inconceivable to me that triage nursing care, a critical element in patient care, is ranked so low on the priority list.

Availability of inexpensive online triage training modules & nursing triage protocols.

Within the private sector market there are many face-to-face and online triage training modules that cover the ED nurse triage basics and separate courses that teach that teach geriatric ED triage and psychiatric emergency triage. To my knowledge, despite the availability of these courses, neither the local VA nor national VA administration has attempted to make those modules available for triage nurses. The VHA has not developed its own triage training modules. Ironically, while ignoring nurse triage training, the VHA remains the leader for physician resident training.

(One example of inexpensive on-line training courses are those produced by the ENA. The ENA fee for general nursing triage review is $500 total for a group of up to 20 nurses who would then be able to take the intense online triage training modules. It would take $1000 total to provide modules to the 34 nurses at the Phoenix VAMC. The fees for geriatric and psychiatric emergencies are reasonable but substantially higher because those costs are on a per nurse basis.)

Standardized nursing triage protocols are quite common in the community. Unfortunately, VHA has never adapted any for use within VA facilities. The OMI found deficiencies in the Phoenix VA ED nurse triage protocols. These deficiencies would likely be mirrored in the triage protocols in other VA facilities because there are no national VA standardized triage protocols.

Specific strategies to ensure Phoenix VA and other VA medical centers review & improve ED triage nursing care.

In order to promote safe, consistent care in VA Emergency Departments across the nation, the VA should formally define VA ED nurse triage qualifications in order to perform triage, implement standardized triage training, and establish standardized ED nurse triage protocols. This is the best method to ensure that veterans presenting to VA Emergency Departments receive high quality care.

In the interim, based on the 2015 OMI Phoenix VA ED report recommendations, Exhibit A contains items that would serve as positive steps toward swiftly and proactively ensuring the safety and

quality of care for patients presenting to the Phoenix Emergency Department or walk-in Mental Health Clinic.

In addition, elected officials have the ability to evaluate how well his or her respective home state VA facilities/VA Emergency Departments are performing. Initial strategies for monitoring VA ED performance at Phoenix and elsewhere are listed in Exhibit B.

Section III: Phoenix VA Consult/Appointment Delays Contribute to Deaths

The VHA has stated that any consult not completed after 90 days be reviewed if a veteran has died before that consult could be completed. The purpose of the review is to determine if the delay in consult completion could have contributed to a patient's death. When a delayed consult does contribute to the death of a veteran the local VA facility is supposed to disclose this information to the family.

The national VA has offered no guidance on what to do with consults less than 90 days old if the veteran has died. Some facilities will do a review to determine if the delay in consult contributed to the veteran's death. Other facilities simply close the consult and never look deeper to see if the delay in consult care contributed to the veteran's death.

In the event of a patient's death there is no quality mechanism at the Phoenix VA that automatically reviews consults less than 90 days old.

When a Phoenix VA patient dies with a recent consult (<90 days old) that has not been completed, the consult is administratively closed. There is no automatic review of those consults to determine if the veteran's death could have been delayed or prevented had he or she had the consult completed.

There are recent cases where Phoenix VA veterans potentially died because of lack of timely follow-up appointment or consult.

The VA Office of Inspector General issued a 2015 report regarding the life-threatening delays in Phoenix urology consults. When I reviewed the OIG's Phoenix VA 2014 report regarding deaths on the waiting list, I found several instances where delays in care reasonably contributed to a patient's untimely death. However, these are not the only areas that were affected. I recently have found cases where a consult delay potentially appeared to have shorted patients' lifespans.

I became aware of these cases a few months ago when I was contacted privately by a Phoenix VA employee who was concerned about the closing of recent consults (<90 days old) belonging to deceased patients without actually ever reviewing the chart. Based on information received, I reviewed 78 charts wherein a pending consult was discontinued because a veteran died. None of the charts appeared to have been reviewed by quality management staff or a clinical reviewer.

Based on my review, in 74 cases a delayed consult did not appear affected the veteran's lifespan. However, there were 3 cases where the consult, if done in an appropriate time frame, potentially could have delayed or prevented death. There was one additional case where the delay may not have affected lifespan but certainly constituted inhumane/callous treatment. Those cases are as follows:

Case 1: A veteran with severe heart disease/cardiomyopathy was eligible for an ICD (implantable cardiac defibrillator) that would prevent death by shocking his heart back to a normal rhythm if he developed a life-threatening heart rhythm. The original consult for the ICD placement was ordered on in late Spring 2015 to be done at Tucson VA. However, per Tucson consult note done 5 days later, the

patient was symptomatic from abnormal heart rhythms yet the VA could not place the ICD in a timely fashion. The vet opted to have Fee Basis consult for ICD placement so it could be placed sooner. The Tucson provider indicated the Phoenix provider would order the Fee Basis/non-VA care consult.

However, there was no evidence of the fee basis consult/non-VA care consult ever being ordered in the chart. As a per a chart note about 16 days after the Tucson appointment, the patient had a pending cardiology appointment but doesn't specify where the appointment was to be done. Unfortunately, the patient died on about one week later with no evidence of a cardiology follow-up appointment having been done and no evidence of a non-VA care consult for ICD placement even though he clearly was symptomatic with heart arrhythmias 25 days earlier. (I don't have access to TriWest portal to confirm that there was no private ICD appt.)

Issues of Concern: The community standard would have been to place the ICD within one week at the latest if no symptoms were present. When a patient is symptomatic from arrhythmias, the community standard would be to place the ICD within 24 hours. Unfortunately, this high risk cardiology patient at risk for life-threatening arrhythmias died one month after his cardiologist first recommended ICD placement that could have treated those arrhythmias immediately and prevented death.

Case 2: A veteran had a cardiac catheterization in Spring 2015 that showed significant abnormalities which would indicate he needed cardiac bypass surgery (CABG). The veteran was told the results/options at a cardiology clinic appointment 2 weeks later. Because the patient desired surgery, a consultation to discuss CABG surgery with Tucson VA surgeons was placed at that appointment. For reasons not entirely clear, the patient stated it was a burden to travel to Tucson and desired a surgery locally. A non-VA care consult was ordered about 9 days later. The patient died the next day, about 3 weeks after the initial cardiac catheterization that clearly identified the need for CABG surgery to prevent death.

Issue of Concern: In the community the CABG surgery would have been discussed at the time of the heart catheterization and a consult would have been placed immediately for the patient to have the surgery. There would not have been a 3+ week delay to refer him to a community provider who could perform the CABG.

Case 3: A very elderly male with new onset aflutter (heart arrhythmia), worsening ejection fraction (ability of the heart to pump), and bilateral blood clots in his legs was discharged from the hospital and scheduled for a post-hospitalization cardiology follow-up in a reasonable time frame in Spring 2015. The cardiology provider was sick so the post-hospitalization follow-up appointment was re-scheduled for almost a month later for this high risk patient. The patient died about 2 weeks before that follow-up appointment.

Issue of Concern: In the community a post-hospitalization visit for such a high risk patient would have been completed sooner and may have been able to address/prevent medical complications that ultimately led to the patient's death.

Case 4: A veteran with newly discovered gastrointestinal cancer mass died before he had the work-up completed for the cancer and before he was ever told his prognosis. A large cancerous tumor was seen on VA endoscopy in midsummer but a VA staging CT scan was not done for 2 weeks. There was no evidence of an oncology appointment for the patient. The veteran was doing poorly at home from a physical standpoint with difficulty eating/drinking fluid/caring for self. The wife pleaded with VA staff to have the patient admitted for work-up/cancer treatment. In desperation, the wife finally took the veteran to a private hospital 10 days after the CT scan. The VA was notified by the private hospital and approved stat non-VA care consults for radiation and surgery to be done at the private hospital. Unfortunately the patient died on the same day those stat consults were ordered.

Issue of Concern: Cancer staging work-up was not expedited/completed for this patient with gross evidence of cancer nor did he have timely referral to oncologist prior to his death. Without actual work-up results it is unclear if a timelier work-up would have changed the course of this suspected advanced disease but it is clear that such a work-up/oncology appointment would have been a more humane method of dealing with this veteran/family instead of leaving them in limbo for 3+ weeks until the wife initiated taking the veteran for private care.

(In general, because the system is so complicated to navigate, the national VA should recommend the facilities have a cancer care coordinator to expedite appointments/work-ups. Such a coordinator would help prevent patients from needless delays in care and stop patients from “falling through the cracks” in the VA system.)

Section IV: Persistent Culture of Whistleblower Retaliation within the Phoenix VAMC and Other VA Facilities

Publicly coming out as a Phoenix VA whistleblower in April 2014, I reported many Phoenix VA issues including unsafe conditions in the Emergency Department, whistleblower retaliation, and facility scheduling irregularities. I eventually was able to transfer away from the Phoenix VA senior administration that condoned years of retaliation against me.

I currently work within the VA Veterans Integrated Service Network (VISN) 18 Gilbert, Arizona office as a Specialty Care Medicine coordinator. I have been able to freely report serious patient care safety deficits to the VISN leadership who have been receptive to such notifications. Unfortunately, I am not told the outcome of the care situations I report. Although I have not been allowed to be involved in Phoenix VA ER/Mental Health Clinic issues, I have been able to do other quality management projects to help improve patient care elsewhere.

<u>My interaction with Phoenix VA employees amid persistent culture of retaliation within the Phoenix VA</u>.

Although I do not physically work inside the Phoenix VA, I have maintained communication with Phoenix VA employees. Over the last 20 months since the access scandal broke, I have been contacted privately by staff in the Phoenix VA service lines of medicine, nursing, social work, mental health, and environmental management. The information they have shared has varied upon the circumstances, but the common concern remains a strong fear of facility administrator retaliation for reporting patient safety deficits, inappropriate staff behavior, policy violations, and consequences of delayed care.

Although I have not been allowed to actively address the known deficits at the Phoenix VA Emergency Department or the Mental Health Clinic, I peripherally have dealt with patient care issues inside the Phoenix VA in both an official capacity and as a private citizen. I have provided some Phoenix VA employees with suggestions on how to address issues for those who fear retaliation if they openly report conditions to Phoenix VA administration. For immediate patient care concerns I rapidly notify VISN leadership of the patient care issues while keeping anonymous the identity of the Phoenix VA employee.

VISN 18 leadership has been receptive to my notifications and have stated they will investigate. However, in my current position I am not routinely privy to the outcome of those investigations. Some issues I have reported include inadequate stroke care for veterans in the ED, deliberate understaffing of a busy mental health clinic for the convenience of supervisor's personal schedule, inappropriate actions of ER nurses, and patients whose deaths may have been prevented if their consults had been completed in a timely fashion.

Phoenix VA administrators who retaliate remain in key positions.

I am not surprised that there remains persistent Phoenix VA front-line employee fear of senior management's willingness to retaliate. Several of the offending senior administrators have voluntarily left the Phoenix VA without ever facing any consequences for their retaliatory behavior. Other unscrupulous Phoenix VA administrators and supervisors remain in positions of power.

Within the last 20 months, Phoenix VA employees in mental health, medicine, and social work service have described to me ongoing retaliation for reporting poor patient care and violations of policy. Brandon Coleman, a Phoenix VA mental health specialist, has remained on administrative leave for most of this year. Based on all available evidence, it appears he was placed on that leave in retaliation for publically reporting the series of patient elopements from the Phoenix VA ER.

The case of which I am most aware involves the senior executive who flatly declined in April 2012 to ever investigate the overt ED nursing retaliation against me that greatly impeded my ability to care for ill veterans. He refused to investigate even though five other ER physicians and I simultaneously told him that nurses were delaying my orders, not giving me verbal reports, refusing to hand me EKGs, and not answering my questions in the nurses' station. Not only did that his refusal to investigate violate local and national VA policy, but it also violated basic medical ethics.

An internal VA Office of Accountability and Review (OAR) investigation in August 2014 cited this same administrator as retaliating against me. Unfortunately, the OAR team never interviewed any of the physician witnesses to the administrator's actions during that April 2012 meeting so the OAR report listing his retaliatory behaviors is grossly incomplete. I subsequently learned that this administrator had retaliated against two other Phoenix VA physicians who reported patient care deficits in other areas of the Phoenix VA. Unfortunately, this senior administrator has not been held accountable and remains in a position of power. It is concerning that this unethical and ineffective executive is making daily decisions that affect the quality of medical care for all Phoenix VA veterans.

In December 2014 Jose Riojas, VHA Chief of Staff, sent a letter to the Office of Special Counsel stating that an administrative board of investigation (AIB) would be convened "to resolve leadership accountability issues presented in the [November 2014 OMI] report and in related retaliation claims". I have not been notified of any such AIB.

(Please note that the OAR investigators also concluded that two mid-level management physicians had also retaliated against me when they were my supervisors. Although these individuals enacted retaliatory measures, I believe they were simply following orders from their respective senior administrator in a system that did not allow these physicians to do anything other than carry out such orders from senior executives. If they had refused to do those orders/perform those retaliatory actions, both physicians immediately would have jeopardized their own VA careers and risked suffering a cascade of events leading to their own termination. They had no practical avenues to seek help. Although I did not agree with their actions, I truly believe both

men are deeply dedicated to the VA system and are extremely effective administrators except on those rare occasions when their superiors backed them into an untenable situation. I do not believe it is either just or wise to discipline these physicians who were at the mercy of unethical senior executives.)

Phoenix ED nurses who retaliate remain in the Emergency Department.

Phoenix VA ED nursing retaliation against me is not a pressing issue by virtue of my transfer from the area. However, it remains very disconcerting that several nurses who compromised patient safety via retaliation against me are still actively working within the Phoenix VA Emergency Department (ED). Their demonstrated willingness to jeopardize patient care poses an inherent danger to all future Phoenix VA ED patients if those nurses choose to penalize a particular physician or colleague for identifying ED triage issues. In addition, lack of accountability for their retaliatory actions has a chilling effect on physician willingness to call attention to those ED nursing care problems which are still present today.

National VA investigation into Phoenix VA retaliation against me deliberately obscures evidence of nursing retaliation.

Despite a VA Office of Medical Inspector (OMI) investigation, I have never been asked by any VA administrator or investigator locally or nationally to identify the nurses who retaliated against me. While the OMI report substantiated nurses' complicit disregard for my orders, it failed to substantiate my allegations of nurses withholding verbal report from me or other types of retaliation.

Unfortunately, even though the VHA restructured the OMI in July 2014, the VA OMI investigation into those nurses' behavior appeared to be deliberately geared not to find any results of such retaliation. The VA OMI investigators failed to ask any pertinent questions of the Emergency Department (ED) physicians with whom I had worked closely for 3+ years and who had first-hand knowledge of the retaliation I experienced. Although the original investigative team spoke with 4 of these physicians during a September 2014 investigation, I was informed by some of those witnesses that no questions were asked about specific retaliatory actions toward me. On the second site visit, none of these physicians were interviewed even though locating these ED physicians should have been a very simple task – all of them are still currently employed within the Phoenix VA ED. On both site visits for the OMI investigation, the OMI team did not interview ED front-line nursing staff including any of the nurses with whom I worked for up to 10 years prior to my involuntary transfer from the ED. Many of those nurses are still employed by the Phoenix VA and were witness to the retaliatory actions of a select group of ED nurses. Investigation witnesses on the second site visit told me that no questions were asked about the retaliation against me.

In stark contrast, the VA OMI investigators did take the time to interview 6 nursing administrators and executives, all of whom were part of the nursing chain of command that repeatedly failed to halt the overt retaliation against me that was impeding the care of ill patients in the ED. That nursing chain of command was also the group that refused to launch any systematic improvements in nurse triage care despite the hundreds of cases of serious triage mistakes that I

reported to them. Those nursing administrators have a strong motive to deny that such retaliation occurred. The OMI team also accommodated interviewing 3 other VA executives who were directly responsible for retaliatory actions against me through the chains-of command for medicine and human resources.

"Sham" professional peer reviews at VA facilities nationwide discourage/discredit actual VA physician whistleblowers and prevent appropriate physician retention and recruitment.

In the private health care arena, a professional peer review board is initiated by a health care facility only when there is legitimate concern a particular physician may not be following medical standards of care. The impartial members of this peer review board complete a formal, lengthy review done of a physician's cases to determine if the medical care was appropriate. The physician who is the subject of the peer review has the opportunity to review all cases in advance and appear in front of the peer review board to answer questions or explain medical decision-making. The final outcomes are based on objective findings of the peer review board, not subjective opinion or hearsay.

If the professional peer review board determines the physician's professional practice constitutes substandard care or grossly inappropriate behavior, the physician often will lose some or all privileges to practice at that medical facility. When the medical performance deficits are significant, the professional peer review board will report a physician to the state medical licensing board. In either case, the consequences for the physician are severe and can impede further employment opportunities in any setting.

In the VA system, illegitimate professional peer reviews are used to strategically punish physician whistleblowers and discourage other physicians from openly identifying facility care issues. For instance, if a physician has repeatedly reported facility safety issues, the physician's supervisor may suddenly announce the physician's practice is substandard and place the physician on administrative leave. The peer review board will be assembled and usually consists of an unscrupulous administrator and his or her cronies. Without having any legitimate care concerns identified, a crooked professional peer review board will pull a random assortment of the physician's patient charts and state those charts contain evidence of substandard care even though no violations of care exist.

Even though no legitimate medical care issues found in the patients' charts, this board will still hold a hearing. The physician is often not provided the patient records in advance and cannot prepare any defense. At the board hearing, patient cases are generally not reviewed but instead there is discussion of problems reported by unnamed employees. Without any objective evidence of substandard care or legitimate testimony of improper physician conduct, the professional peer review board then concludes the physician is "unsafe" or "undesirable" and can no longer be employed by the VA. In many cases the peer review board reports the physician to a state medical licensing board.

The purpose of the "sham peer review" is to sabotage a physician's credibility/professional reputation, scare the physician into silence, and, in the extreme, prevent future employment in

any facility. Although a physician can overturn a sham peer review, the process can take years during which the physician is professionally and financially devastated. I am aware of 5 instances of such sham peer reviews over the past few years with Dr. Huttam's case being an example from the Phoenix VAMC. (Of note, Dr. Huttam's case involved the same administrator who retaliated against me.)

Unfortunately, such sham peer reviews are not defined by legal statute as a prohibited personnel practice so the Office of Special Counsel generally does not intervene. VA supervisors and peer review board members face no VA repercussions for participating in such reprehensible and overt retaliation against whistleblowers.

There are many other common tactics commonly used against physicians and other VA employees in order to discourage the reporting of serious VA problems and ostracize/fire employees who dare voice concerns. The end result of physician retaliation is that veterans are denied the skills of talented, well-qualified physicians when those providers are relieved of patient care duties or fired due to unjustified accusations of poor medical skills or substandard conduct. Patient care is delayed as yet another VA physician chooses to resign or retire instead of facing a sham peer review. VA physician vacancies go unfilled as promising physicians avoid the VA's well-known reputation for retaliation against employees.

<u>Sham professional peer reviews and other tactics endanger patient safety by suppressing legitimate care concerns</u>.

In a system where there is rampant whistleblower retaliation or fear of such retaliation, qualified, dedicated VA employees from all service lines are prevented from providing high quality care and services for veterans. Every veteran suffers when legitimate patient care safety concerns in the medical facility are ignored or suppressed by dishonest administrators. Potentially dangerous health and safety problems perpetuate when front-line advocates for quality care are removed from clinical settings.

The VA will only be able to fulfill the mission to "care for him who has borne the battle" when employee whistleblower retaliation ends and supervisors are held accountable for their actions.
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Exhibit A: Specific Steps to Ensure the Phoenix VA Compliance with OMI Report Recommendations

The following actions, based on OMI Phoenix VA report recommendations, would serve as positive steps toward swiftly and proactively ensuring the safety and quality of care for patients presenting to the Phoenix Emergency Department or walk-in Mental Health Clinic:

1. Request the facility formally verify that it has followed the OMI recommendation to perform "a review of training and educations records to assess whether nurses have appropriate training and experience necessary to work in the ED, in accordance with Emergency Nurses Association (ENA) guidelines. " (Those ENA guidelines require that a triage nurse complete a formal, didactic training course prior to being placed in a triage role.)

   While the OMI did not specifically state the mental health triage nurse training records/qualifications should be reviewed, the OMI identified unsafe conditions in the mental health clinic triage. Therefore, it the training and qualifications of nursing triage staff there should be reviewed.

2. Request that the Phoenix VA provide specifics regarding the number of ED and Mental Health triage nurses that currently have completed a formal didactic triage training course (other than ESI training) and the dates/types of those training courses. (This allows baseline assessment of triage training in those high risk areas. This specifically should not include any TMS or ESI training because neither type of course confers basic triage assessment skills.)

3. Request that the Phoenix VA leadership verify and provide evidence of a concrete plan with an actionable time table for providing timely, standardized training to all triage nurses in the Phoenix VA ED and Mental Health Clinic who have not completed formal, didactic triage training. (This forces the Phoenix VA to develop a specific, concrete action plan instead of allowing it to brush off the inquiry by stating the issues are "being reviewed". The management still has not come up with a plan even though it has had access to the OSC/OMI report internally since March 2015.)

   (They do have a proposal to have out-of-state VA personnel come to "assess" triage in likely December 2015 but that is an extremely limited/slow plan considering the magnitude of the problem and there has been internal assess to the OSC report for 8+ months. Phoenix VA leadership have known that the OMI called the Phoenix VA ED a "significant risk to public health and safety" since at least March 2015 and yet have done nothing significant to improve the triage skills except to have the nurses complete a short ESI training module. As previously stated, ESI training is ineffective if the nurses aren't able to recognize serious symptom presentation.)

4. Request that the Phoenix VA provide proof that it has updated all nursing triage protocols to address the inadequacies noted by the OMI report, specifically following the OMI

recommendation to “revise all diagnosis-based protocols to make sure they are symptom-based”.

5. Request that the Phoenix VA verify and provide evidence that it has established a local performance metric for ED nurses on timeliness of procedures, e.g., EKGs and medication orders, to make sure that ED nurses adhere to standards of care.

6. Request that the Phoenix VA verify and provide evidence that it has established a local performance metric for ED staff on proper specimen labeling procedures to eliminate processing errors, and repair the label printers to prevent labels from being improperly printed.

7. Request that the Phoenix VA provide verify and provide evidence of 24-hour coverage of the Vascular Service by qualified vascular technicians as recommended by the OSC/OMI report.

8. For any negative responses to items 4-8, request that the Phoenix VA provide a detailed explanation why it hasn’t completed the recommendations of the OMI report that has been available internally to the VHA/Phoenix VAMC since March 2015.

Exhibit B: Evaluating Nurse Triage Care & Staffing in VA Emergency Departments Nationwide

In order to promote safe, consistent care in every VA Emergency Department (ED) across the nation, I urge Congress and the public to demand that the VA to establish minimum qualifications for VA ED nurse triage, define appropriate triage training, and develop ED nurse triage protocols. These are the best methods to ensure that veterans presenting to any VA Emergency Department consistently receive high quality triage care.

In the meantime, each elected official has the ability to evaluate how well his or her respective home state VA facilities/VA Emergency Departments are performing. Initial strategies include:

1. Ask the facility to provide the number of patients with an ESI rating of "4" and "5" who were admitted to the hospital each month. According to the ESI system, only patients with ratings of 1, 2, or 3 are considered to have symptoms severe enough to potentially require admission. According to the ESI, patients assigned a "4" or "5" rating should have only minor medical problems and, with extremely rare exceptions, never require admission. If a patient rated as a "4" or "5" was admitted, then quality management should review the case. This could indicate a severe problem with ED nurse triage symptom evaluation.

2. Ask the facility to provide the number of ED patients who "left without being seen". This represents the number of ED patients who were triaged but left without seeing a medical provider. This number can easily be generated on a daily basis by the facility. It indicates that patients were waiting so long that they chose not to remain. Although this may not be reflective of poor quality triage, this does indicate an issue with ED patient flow and capacity. Typically, in poorly staffed Emergency Departments this number flares on weekends, the day before a holiday, and the first business day after a holiday. With the exception of Thanksgiving and Christmas, most holidays will also have a high number of patients who left without being seen if that ED hasn't specifically prepared for the onslaught of veterans presenting for care.

3. Ask the facility to provide the number of patients who waited "more than 6 hours". This number is tracked on a daily basis and is easy to obtain. Large numbers of patients waiting greater than 6 hours indicates problems with flow and capacity either within the ED or within the hospital. Often, when this number is high, the quality of triage deteriorates and seriously ill patients can wait hours for treatment. As noted above, flares in this number will occur during peak flow times such as weekends, the day before a holiday, the first business day after a holiday, and on most holidays except Thanksgiving and Christmas.

4. Ask the facility to provide the number and type of patient advocate complaints regarding any aspect of care in the Emergency Department. If the patient advocates are documenting patient complaints appropriately, those complaints are logged into tracking software and can be recalled by specific clinic name including "Emergency Department".

5. Ask the facility to report any ED complaints logged into the EPERS (Electronic Patient Event Record System). EPERS reports include actual bad outcomes as well as "near misses"

reported by ED staff. While not all staff use the EPERS system for fear of retaliation, the EPERS system may still contain valuable reports about ED problems. Ask for a briefing of how each ED EPERS investigation was handled. Please be aware that the Quality Management department may be months behind in investigating/uploading such EPERS reports to a national database.

6. Ask the facility's police department to provide the number of ED elopements each month. Elopements occur when mentally unstable or confused patients leave before receiving appropriate ED evaluation or treatment. Ask for a briefing of how the facility investigated the circumstances surrounding each elopement and what corrective actions were taken.

7. Ask constituents to report details of any negative experiences they have had within the local VA emergency departments. Constituent reports often mirror recurrent problems occurring in the ED but which may not be reported to the Patient Advocate Office. (Many veterans are so frustrated with the slow patient advocate system that they no longer bother to report significant complaints.)