STATEMENT OF ANDREA C. BUCK, MD
CHIEF OF STAFF FOR
HEALTHCARE OVERSIGHT INTEGRATION
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
FIELD HEARING ON
EXPLORING THE VETERANS CHOICE PROGRAM'S PROBLEMS IN ALASKA

AUGUST 25, 2015

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify before the Committee today on veterans' access to care in Alaska and our recent report, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska*, which highlights the challenges some veterans have faced in receiving timely access to care in Alaska.[1] I am accompanied by Ms. Sami O'Neill, Director of the Seattle, Washington, Office of Healthcare Inspections.

BACKGROUND

Alaska has a chronic shortage of physician providers, ranking 17th lowest in the Nation in its physician-to-population ratio, with 2.05 doctors per thousand residents compared to the national average of 2.38 per thousand. Further, it is one of six states without an independent in-state medical school. Thus, it funds 20 state-supported "seats" at the University of Washington's medical school. By 2025, some estimates are that Alaska will need nearly twice as many physicians as practiced in the State in 2004. This estimate translates to potentially needing an estimated 1,347 physicians within the next 10 years.[2]

VA as well as private health care systems will be affected by this shortage. The Alaska VA Healthcare System (VAHCS) serves veterans throughout the State of Alaska and is part of Veterans Integrated Service Network 20. Primary, specialty, and mental health outpatient care is provided by the parent outpatient clinic located in Anchorage; at community based outpatient clinics (CBOCs) in Fairbanks, Kenai, and Wasilla; and at an Outreach Clinic in Juneau. Inpatient services are provided through fee basis arrangements with community hospitals and a joint venture (JV) with Department of Defense Joint Base Elmendorf-Richardson, located adjacent to the parent outpatient clinic in Anchorage.[3]

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[1] http://www.va.gov/oig/pubs/VAOIG-14-04077-405.pdf, published July 7, 2015.
[2] *Adequate Number of Physicians for Alaska's Needs: Report of the Alaska Physician Supply Task Force*, April 2006.
[3] "Fee-based care" is a term that refers to purchasing health care outside the VA system. This term has been replaced by non-VA medical care or purchased care. When this care is obtained through a provider placing a consult, it is called a Non-VA Care Consult.

PRIOR REVIEWS RELATED TO ACCESS TO HEALTH CARE IN ALASKA

The OIG has reviewed challenges faced by Alaska veterans in accessing this health care network in two previous reports. In 2005, the OIG published the report *Healthcare Inspection – Surgical Service Issues, Alaska VA Healthcare System*, which examined timely access to VA patients' surgical needs.[4] The OIG found that VA patients' surgical needs were not being effectively met by the JV hospital arrangement with Joint Base Elmendorf-Richardson, particularly for patients awaiting orthopedic surgery. Our report also substantiated lack of compliance with Veterans Health Administration (VHA) directives and The Joint Commission (JC) standards requiring the Chief of Surgical Services to be a physician (this position was being filled by a Physician Assistant). The OIG received documentation that the facility had implemented recommendations from this 2005 report and closed those recommendations in November of 2005.

Then, in 2010, the OIG conducted a review of patient referrals and transfers from the VA system in Anchorage to VA specialty care providers outside of Alaska and published the report *Healthcare Inspection – Review of Patient Referrals to Lower 48 States at the Alaska VA Healthcare System, Anchorage, AK*.[5] The vast majority (96 percent) of patients were able to receive health care directly through the Alaska VAHCS or indirectly through Department of Defense JV agreements and community-contracted and fee-based services in Alaska. Approximately four percent of patients received specialty care outside of Alaska, primarily for orthopedic, neurosurgery, neurology, oncology, and cardiology specialty care services. The OIG made no recommendations.

VHA has also reviewed veterans' access to health care in Alaska. In response to our oversight reports addressing serious scheduling and access to care issues at the Phoenix VA Health Care System, VHA conducted a system-wide audit of scheduling and access management practices; this audit included the Alaska VAHCS in Anchorage. Of the 216 sites visited in VHA's Phase One Access Audit, 81 (37 percent) were identified as needing further review; the Alaska VAHCS was not one of the sites identified as needing further review. VHA reported as of May 15, 2014, the Alaska VAHCS reported scheduling 91 percent of appointments in 30 days or less. Also according to VHA, as of December 5, 2014, the Alaska VAHCS was able to schedule 99 percent of appointments in 30 days or less. We did not independently verify the results of VHA's work.

OIG 2014 ALASKA VAHCS INSPECTION

While the Alaska VAHCS as a whole reported overall good access to care, our recent inspection revealed that there were significant access to care problems at the Mat-Su clinic in Wasilla, Alaska. The OIG conducted the inspection in August 2014 at the request of Senator Lisa Murkowski to assess the merit of the following allegations:

- The Mat-Su clinic in Wasilla, Alaska, did not have adequate staffing or security.
- The lack of staffing led to poor access to care and poor quality of care for Wasilla veterans.

[4] http://www.va.gov/oig/54/reports/VAOIG-05-02527-205.pdf, published September 20, 2005.
[5] http://www.va.gov/oig/54/reports/VAOIG-10-01509-241.pdf, published September 9, 2010.

- The Alaska VAHCS had engaged in improper scheduling practices and failed to provide follow-up care for veterans after the Alaska VAHCS's only urologist left.

Inspection Results
OIG's inspection results are described below:

Allegation: The Mat-Su clinic in Wasilla, Alaska, did not have adequate staffing or security – The Mat-Su VA clinic opened in March 2009. VA successfully recruited a physician to staff the clinic within 6 months. VA hired a second physician in April 2011, but the second physician left a year later, leaving only one doctor to care for 1,700 patients. VA policy recommends that a primary care provider should not be responsible for more than 1,200 patients. The second physician, citing excessive workload, left the Mat-Su clinic in May 2014. Between 2012 and 2014, the clinic was open 66 days without a licensed independent practitioner onsite. The nurses, medical assistants, and other staff were left to care for patients with only intermittent back-up from Anchorage providers, *locum tenens* physicians, and contractors.[6] VA took steps to obtain care for these patients at the Southcentral Foundation, an Alaska Native-owned non-profit community health organization, but the delays in obtaining that care left veterans without consistent care during the transition. In short, we substantiated that the Mat-Su clinic in Wasilla did not have adequate staffing. VA policy requires facilities to maintain contingency plans for providing continuity of care during periods of understaffing or limited resources. The Anchorage VAHCS had no such plans in place. However, we did determine that security procedures at the Mat-Su clinic complied with VA policy.

Allegation: The lack of staffing led to poor access to care and poor quality of care for Wasilla veterans – To determine the impact of inadequate staffing on patient care, we reviewed the care of all patients assigned to the Mat-Su clinic who died between July 24, 2013, and July 31, 2014.[7] We determined that 40 patients assigned to the Mat-Su clinic died during this time interval. Of those patients, we found that nine received poor access to care. We further determined that this poor access to care resulted in poor quality of care for seven of those nine patients. All nine patients are described in the report. For purposes of our testimony today, I highlight one of those cases.

This veteran, referred to as Patient 8 in the report, was in his 70s. He had a history of malignant melanoma on his shoulder. He had surgery to remove the cancer and had a teledermatology appointment in spring of 2013 for follow-up care. The dermatologist recommended that he be seen every 6 months for his condition. In fall of 2013, he went to the Mat-Su clinic complaining of shoulder pain. The Mat-Su provider did not consult

[6] *Locum tenens* is a Latin phrase that means "to hold the place of, to substitute for." *Locum tenens* staffing began in the early 1970s with a Federal grant to provide physician staffing services to rural health clinics in medically under-served areas of the western United States. The program proved so successful that today *locum tenens* companies provide physician staffing services for hospitals, outpatient medical centers, government and military facilities, group practices, community health centers and correctional facilities. http://www.locumtenens.com/about/locum-tenens.aspx. Accessed August 19, 2015.
[7] We selected this date range for review because it began exactly 1 year after the first provider left, allowing us to assess the impact of the clinic's understaffing through the departure of both the first and second providers at the clinic.

the dermatologist for follow-up care, but instead sent him to an orthopedic surgeon. The orthopedic surgeon gave him a steroid injection.

A few weeks later, the veteran called the Mat-Su clinic complaining of continued shoulder pain. He received instructions on how to take anti-inflammatory medications. He returned to the clinic in spring of 2014, about 6 months later, for routine bloodwork. He still had not received a follow-up appointment with a dermatologist.

One month later, he presented to a non-VA emergency department with complaints of ongoing, worsening shoulder pain. The emergency department physician, worried about a recurrence of his cancer, ordered a chest CT scan.[8] This scan identified multiple lesions throughout the chest. The patient was diagnosed with metastatic melanoma, admitted to hospice, and died a few weeks later.

If this veteran had received regular follow-up care from a dermatologist or his primary care physician, the recurrence of his cancer may have been discovered earlier. Early detection increases the chances for successful treatment, however, there are many significant factors beyond early diagnosis and treatment that impact oncology patient outcomes. As a result, we cannot say with certainty whether earlier detection alone would have extended his life without question.

During the course of our review, we identified multiple deficiencies in the Alaska VAHCS that hampered the ability of system leaders to respond to the ongoing access to care challenges at the Mat-Su clinic in a timely and effective way. We found gaps in the reporting of peer review results to system leadership, and in the ongoing professional practice evaluations of medical staff. For example, VA policy requires that the practice of all physicians be reviewed every 6 months to ensure ongoing competency. The results of these reviews must be reported to and approved by certain medical center committees. Our review determined this was not being done regularly. We further found deficiencies in the reporting of information to the Alaska VAHCS's leadership, in part because of a culture of distrust between management at the Anchorage facility and staff at the Mat-Su clinic. Patient care was compromised by a lack of communication, care coordination, and follow-up in addition to outright delays in the provision of care.

Allegation: The Alaska VAHCS had engaged in improper scheduling practices and failed to provide follow-up care for veterans after the Alaska VAHCS's only urologist left – We also substantiated that the Alaska VAHCS had inappropriate scheduling practices, but determined these practices had been discontinued in 2009. We further found that the Alaska VAHCS did not ensure appropriate follow-up care for one patient following the departure of the Alaska VAHCS's only urologist in September 2008. In addition, we reviewed consult data for the quarter immediately following the urologist's departure. During this timeframe (October 1–December 31, 2008), 123 consults were completed. 39 were completed in less than 30 days; 50 were completed in 30-60 days; and 34 took longer than 60 days to be completed.

[8] A computed tomography (CT) scan is an imaging method that uses a series of computer-processed x-rays to create pictures of cross-sections of the body.

In sum, we made nine recommendations for improvement addressing access to care, lack of staffing, and management issues in the Alaska VAHCS. The Veterans Integrated Service Network and System Directors concurred with our recommendations and provided an acceptable action plan.

OTHER OIG INITIATIVES REGARDING ALASKA OR ACCESS TO HEALTH CARE

The OIG has several oversight projects planned or underway that focus on the Alaska VAHCS and/or issues related to veterans' access to health care. Just this month, the Office of Healthcare Inspections (OHI) conducted a Combined Assessment Program (CAP) review of the Alaska VAHCS as well as a CBOC review in Fairbanks. CAP and CBOC reviews evaluate selected health care facility operations and patient care activities at VA facilities on a cyclical basis. We are in the process of analyzing the data, and we expect to issue our reports in the next 3 months. In addition, we are returning to assess access issues at other locations in the Alaska VAHCS next month.

The Office of Healthcare Inspections has also reviewed staffing shortages nationwide as required by the *Veterans Access, Choice, and Accountability Act of 2014*. The first report, published in January of this year, ranked the physician occupation as the occupation with the largest staffing shortage in VHA.[9] The second report will be published by September 30, 2015, ranked the physician occupation as the occupation of most critical need in VHA.

Other components of the OIG are commencing work on the Veterans Choice Program. In August 2015, the Office of Audits and Evaluations began a review of VHA's implementation of this program. The objective of the review is to determine whether VHA staff have sufficient knowledge of the Veterans Choice Program to inform veterans of their non-VA care options. We plan on publishing a report of our findings and recommendations in early 2016. This is in addition to the requirement in the *Veterans Access, Choice, and Accountability Act of 2014* for the OIG to provide a report on the timeliness and accuracy of payments once 75 percent of the funds have been expended.

CONCLUSION

Meeting the health care needs of Alaska veterans must remain one of VA's highest health care priorities. Although factors related to Alaska's location and geography pose challenges to providing health care services, the Alaska VAHCS must work to address the issues we have identified to ensure all of Alaska's veterans have access to timely and high quality health care. We look forward to continuing our oversight work of these important issues. Mr. Chairman, this concludes my statement. I would be pleased to answer any questions you or other Members of the Committee may have, and to working with you in the future on these challenging issues.

[9] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages*, published January 30, 2015, http://www.va.gov/oig/pubs/VAOIG-15-00430-103.pdf.