ORAL STATEMENT OF
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BEFORE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
HEARING ON
"THE STATE OF VA HEALTH CARE"
MAY 15, 2014

Mr. Chairman, Ranking Member Burr, and members of the Committee. Thank you for the opportunity to provide testimony at this hearing. I would like to provide an overview of our ongoing review at the Phoenix Health Care System.

The OIG has assembled a multidisciplinary team comprised of auditors, healthcare inspectors, board-certified physicians, and criminal investigators from across the country to address these allegations. I have directed our team to answer two fundamental questions: (1) whether the facility's electronic wait list (EWL) purposely omitted the names of veterans waiting for care and if so at whose direction, and (2) whether the deaths of any of these veterans were related to delays in care.

To get to the bottom of these allegations, the OIG has an exhaustive review underway that includes seven components:

1. Interviewing staff with direct knowledge of patient scheduling practices and policies, including scheduling clerks, supervisors, patient care providers, management staff, and whistleblowers who have stepped forward to report allegations of wrongdoing.

2. Collecting and analyzing voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.

3. Reviewing medical records of patients whose deaths may be related to delays in care.

4. Reviewing performance ratings and awards of senior facility staff.

5. Reviewing past and newly reported complaints to the OIG Hotline on delays in care, as well as those complaints shared with us by members of Congress or reported by the media.

6. Reviewing other prior reports relevant to these allegations, including administrative boards of investigations or reports from the Veterans Health Administration's Office of the Medical Inspector.

7. Reviewing massive amounts of e-mail and other documentation of relevant VA employees.

To facilitate our work, on May 1, 2014, I asked Secretary Shinseki to place the Phoenix Director, Associate Director, and another individual on administrative leave. This was done because of the gravity of the allegations and to ensure cooperation by Phoenix staff, some of whom expressed concern about talking to the OIG team. Secretary Shinseki immediately agreed to my request.

I am confident that we have the resources and talent to complete a thorough quality review of these allegations at Phoenix. We are using our top audit experts on VHA patient scheduling from our Office of Audits and Evaluations to determine the accuracy of the facility's EWL, and board-certified physicians from our Office of Healthcare Inspections to review patient medical records, treatment, and harm that may have resulted from delays in care. OIG criminal investigators, including IT forensics experts, are also assisting the team. We are working with Federal prosecutors from the United States Attorney's Office for the District of Arizona and the Public Integrity Section of the Department of Justice so they can determine if any conduct we discover merits prosecution.

Since the Phoenix story broke in the national media, we have received additional reports of manipulated waiting times at other VHA facilities either thru the OIG Hotline or from members of Congress and the media. In response, we have opened simultaneous reviews at several other VHA facilities. These reviews are being conducted by other OIG staff to enable the team working on the Phoenix review to focus their efforts on that project. We expect that these reviews will give us insight into the extent to which these scheduling issues are present at other VHA facilities.

My staff is working diligently to determine the facts of what happened at Phoenix and who is accountable. While much has been done, much more remains ahead. Be assured, however, that this review is the OIG's top priority and that maximum resources are dedicated to bring about its timely conclusion. We intend to brief you and other members of Congress once we have reached final findings of facts and are ready to publish our report, which is projected to be in August 2014. Thanks again for holding this hearing, and Dr. Daigh and I will be pleased to answer your questions.