

Coburn Amendment ____: Requires the VA to publish for each VA facility its quality of care, mortality rates, mental health treatment outcomes, emergency room wait time averages, readmission rates, and other data relating to veteran health care quality and safety

S. 1982 fails to address the lack of transparency at VA regarding the agency's ability to provide timely and quality medical care.

Veterans in good faith look to Congress and the VA to maintain the promises each has made to veterans, veterans are dying waiting for care at VA or by VA staff negligence, suffer long wait times for treatment for their service-connected disabilities, and are unable to compare which VA facility provides veterans with the safest and efficient health care.

Specifically, this amendment brings transparency to VA by requiring the department to publish online—while protecting patient personal information—the following information regarding each VA facility in the country:

- Assessments of outcomes of each surgical procedure, to include:
 - Quality
 - Rate of mortality,
 - Any complications which occur
 - Patient safety
 - Average length of inpatient care
 - Descriptions of any hospital-acquired condition,
 - Rate of readmission within 30 days
- Assessments of mental health treatment outcomes including:
 - Suicide rates
 - Patient safety
- Assessment of nursing home outcomes, including:
 - Safety of patients receiving nursing home treatment

- Average wait times for emergency room treatment
- Descriptions of appointment scheduling backlog

The VA should be required to be honest with Congress, the veterans they serve, and taxpayers across the country about the timeliness and quality of the care they provide our nation's heroes.

Just this week, staff at a VA facility in Los Angeles were found to be destroying records of delayed medical appointments in an attempt to cover up their multi-year backlog.

The VA has no idea how long most patients wait to receive care, said Debra Draper, health care director at the Government Accountability Office (GAO).

“It is unclear how long veterans are waiting to receive care in VA’s medical facilities because the reported data are unreliable” because VA hospitals have tried to cover up wait times, fudge numbers and backdate delayed appointments in an effort to make things appear better than they are.¹

GAO analysts found more than half of the VA’s 50,000 schedulers did not know how to accurately report the information needed to determine wait times, which includes logging the date a veteran wants to be seen as well as the actual date of the appointment. Others admitted to changing the desired date so the time aligned with VA’s established goal of 14 days.²

ANNUAL REPORT SHOWS VA NOT MEETING TARGETS FOR PRIMARY AND SPECIALTY CARE FOR 3 OUT OF 4 VETERANS

Based on GAO recommendations to improve reliability of reported wait times for new medical appointments, in 2013 the VA changed the way it tracks and calculates its performance.

Using the new tracking method in 2013, the VA reported only 41 percent of veterans were scheduled for new a primary care appointment and only 40

¹ Scott Bronstein, Nelli Black and Drew Griffin, “Hospital delays are killing America's war veterans,” CNN, November 20, 2013; <http://www.cnn.com/2013/11/19/health/veterans-dying-health-care-delays/> .

² Patricia Kime, “VA wait times mean some die before getting care,” Army Times, March 15, 2013; <http://www.armytimes.com/article/20130315/BENEFITS04/303150016/VA-wait-times-mean-some-die-before-getting-care> .

percent of veterans were scheduled for new specialty care appointments within the 14 day standard.³

In contrast, in 2012 the VA reported that 90 percent of new primary care appointments and 95 percent of new specialty care appointments had met the 14 day standard.⁴

VETS WAIT MORE THAN TWO WEEKS FOR MENTAL HEALTH THERAPY

The VA failed to meet its 14-day goal in 34 percent of new mental health appointments in treatment categories including psychiatry, psychology, post-traumatic stress disorder and substance abuse in 2013.⁵

In nearly half of 47,700 first-time psychiatric therapy appointments in 2013, veterans waited longer than two weeks.⁶

The average time it took to start any type of behavioral health therapy was 15 days.

In Houston, Texas, veterans needing new appointments waited an average of 28 days to receive services.⁷

Approximately 22 veterans commit suicide every day.⁸

³ http://www.va.gov/budget/docs/report/2013-VAPAR_Part_II.pdf

⁴ <http://www.va.gov/budget/report/>

⁵ Gregg Zoroya and Meghan Hoyer, "Many veterans still wait weeks for mental health care, USA Today, November 4, 2013; <http://www.usatoday.com/story/news/nation/2013/11/04/veterans-mental-health-treatment/3169763/> .

⁶ Gregg Zoroya and Meghan Hoyer, "Many veterans still wait weeks for mental health care, USA Today, November 4, 2013; <http://www.usatoday.com/story/news/nation/2013/11/04/veterans-mental-health-treatment/3169763/> .

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NEGLIGENCE AT VA LEADS TO THE DEATHS OF OUR HEROES

Patient Died at New York VA Hospital: Hospital failed to notice alarm⁹

- In January 2011, registered nurses at a Manhattan Veterans Affairs hospital failed to notice a patient had become disconnected from a cardiac monitor until after his heart had stopped and he could not be revived.¹⁰
- An October 2011 VA OIG investigated the death of the patient, who was in his 80s, at the Manhattan campus of the VA's New York Harbor Healthcare System. The man had undergone several heart procedures and needed to have his vital signs continuously monitored. On his fifth day at the hospital, monitor records show that an alarm indicated a problem with the device or the patient, but there is no evidence nurses were aware of the alarm until the man was discovered unresponsive an hour and a half later. He was declared dead shortly afterward, according to the OIG report.¹¹
- The death also prompted a broader review of skills and training of VA nurses. In an April 2012 VA OIG report, OIG found that only half of 29 VA facilities surveyed by the inspector general had adequately documented that their nurses had skills to perform their duties. According to the report, even though some nurses "did not demonstrate competency in one or more required skills," there was no evidence of retraining.

VA Whistleblower to Congress: VA ignored 2,000 veterans who claimed having suicidal thoughts—some later commit suicide¹²

⁹ Charles Ornstein and Tracy Weber, "Patient Died at New York VA Hospital After Alarm was Ignored," ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

¹⁰ Charles Ornstein and Tracy Weber, "Patient Died at New York VA Hospital After Alarm was Ignored," ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

¹¹ Charles Ornstein and Tracy Weber, "Patient Died at New York VA Hospital After Alarm was Ignored," ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

¹² Jamie Reno, "VA Concedes Whistleblower's Allegations Were True, Including That it Ignored Veterans' Suicidal Tendencies", February 19, 2014, <http://www.ibtimes.com/va-concedes-whistleblowers-allegations-were-true-including-it-ignored-veterans-suicidal-tendencies>

- Former VA epidemiologist, Dr. Steven Coughlin, testified before the House Veterans Affairs Committee (HVAC) that the VA failed to follow up with around 2,000 veterans who indicated in VA surveys that they suffered suicidal thoughts.¹³
- According to HVAC, their investigators substantiated Dr. Coughlin's claims, and also found that during a study of Gulf War veterans—some of those veterans who had admitted to the VA they had suicidal thoughts—later committed suicide.¹⁴
- HVAC also found that Dr. Coughlin was admonished, bullied, and intimidated, by a number of his bosses for speaking out about ethical failings at VA.¹⁵

Equipment Collapses, Killing Patient¹⁶

- A 66 year-old veteran was undergoing a procedure using a gamma camera at the James J. Peters VA Medical Center in New York City when the apparatus collapsed and crushed him.¹⁷
- The diagnostic equipment was installed in 2006 and was maintained by its manufacturer. The equipment in the incident was a camera, Infinia Hawkeye 4 model, and can weigh more than 5,000 pounds.¹⁸

¹³ Jamie Reno, "VA Concedes Whistleblower's Allegations Were True, Including That it Ignored Veterans' Suicidal Tendencies", February 19, 2014, <http://www.ibtimes.com/va-concedes-whistleblowers-allegations-were-true-including-it-ignored-veterans-suicidal-tendencies>

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¹⁶ Tamer El-Ghobashy, Christopher Weaver, "Equipment Collapses, Killing Patient," The Wall Street Journal, June 7, 2013; <http://online.wsj.com/news/articles/SB10001424127887324798904578529103419237828>.

¹⁷ Tamer El-Ghobashy, Christopher Weaver, "Equipment Collapses, Killing Patient," The Wall Street Journal, June 7, 2013; <http://online.wsj.com/news/articles/SB10001424127887324798904578529103419237828>.

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Recalled Medical Device Killed a Vet at Seattle's VA Hospital: Eddie Creed died because of recalled device Infusomat¹⁹

- In 2012, Eddie Creed, who served in the Army in the 1950s went on to play piano for Seattle's Chamber Jazz Quartet in civilian life. On April 19, 2012, Eddie died at the Veterans Affairs hospital on Beacon Hill—his death certificate said throat cancer had killed him.²⁰
- According to A KUOW (a Puget Sound, Western Washington, and Southern British Columbia radio station) investigation, on Creed's second night at the VA, Eddie was hooked up to an Infusomat device—which was under a Class I recall—when it malfunctioned and drained all of its morphine into Eddie while he was asleep. Around 11 p.m. that night, a nurse discovered that during the malfunction Creed had received about 10 times the dose he was prescribed, and Eddie was pronounced dead shortly thereafter.²¹

AVOIDABLE VETERAN DEATHS AT VA RELATED TO APPOINTMENT WAIT TIMES

Lapses in care have resulted in patient deaths at VA medical centers—CNN investigated veterans' complaints of misdiagnosis and improper care for gastrointestinal conditions and linked the 2-year consultation delays to the deaths of three cancer patients.²² Also:

- According to CNN, at least 19 veterans died because of delays in diagnosis and treatment at VA hospitals. Delays were in simple medical screenings like colonoscopies or endoscopies.²³

¹⁹ John Ryan, "How a Recalled Medical Device Killed a Vet at Seattle's VA Hospital," KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

²⁰ John Ryan, "How a Recalled Medical Device Killed a Vet at Seattle's VA Hospital," KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

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²² Scott Bronstein, Nelli Black, and Drew Griffin, "Veterans dying because of health care delays," CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

²³ Scott Bronstein, Nelli Black, and Drew Griffin, "Veterans dying because of health care delays," CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

- Also, according to CNN, these veterans were part of 82 vets who have died or are dying or have suffered serious injuries as a result of delayed diagnosis or treatment for colonoscopies or endoscopies.²⁴
- The VA hospital in Augusta, Georgia, recently apologized for the death of three veterans at their facility, which occurred because of delays in medical care. CNN explained their “investigation revealed that military veterans are dying needlessly because of long waits and delayed care at U.S. veterans hospitals” and found that “numerous VA hospitals actively engage in cover-ups of their extensive patient wait times, including the falsifying of records. Additionally, the administrators of these hospitals are regularly rewarded with bonuses, rather than facing consequences for patient neglect.”²⁵
- In 2011 and 2012, 5,100 Augusta and Dublin, GA, VA beneficiaries who were in need of gastrointestinal procedures went without consultations.²⁶ Furthermore, VA HQ in Atlanta revealed a delay in 2,860 screenings, 1,300 surveillance and 340 diagnostic endoscopies.²⁷ According to an internal VA memo, reported on by The Augusta Chronicle, the Augusta VA sought assistance from “non-VA care partner facilities” in September 2012 for help in reducing consult delays—by January 2014, the VA was able to resolve all delayed consultations through utilizing options which existed within the Augusta community.²⁸
- *The Daily Caller* obtained audio of an internal VA meeting which confirmed that Los Angeles VA officials deliberately canceled

²⁴ Scott Bronstein, Nelli Black, and Drew Griffin, “Veterans dying because of health care delays,” CNN, January 30, 2014. <http://www.cnn.com/2014/01/30/health/veterans-dying-health-care-delays/>

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²⁶ Wesley Brown “Gastrointestinal consultation backlog reported at second east Georgia VA hospital” Stars & Stripes/The Augusta Chronicle. January 29, 2014.

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backlogged patient exam requests.²⁹ The audio from a November 2008 meeting shows how VA officials decided that backlogged patient exams over a year old “should be canceled”³⁰ and that the “Backlog should start at April 2007.”³¹ Audio shows VA officials determined that it was OK to cancel backlogged appointments because, “a lot of those patients either had their studies somewhere else, had their surgery...died, don’t live in the state...it’s ridiculous.”³² According to Marine veteran and former VA employee Oliver Mitchell, when Mr. Mitchell tried to sound the alarm on the VA’s deliberate attempt to fraudulently reduce the backlog, Mr. Mitchell was transferred out of his department and eventually lost his job.³³ Mr. Mitchell also claims he contacted Congress about the issue in January 2011—suddenly, he was fired by the VA two months later.³⁴

- Veteran Barry Coates was having excruciating pain and rectal bleeding in 2011. For a year the Army veteran went to several VA clinics and hospitals in South Carolina and was diagnosed by the VA with hemorrhoids. Aside from simple pain medication, he was told he might need a colonoscopy. Mr. Coates waited months, even begging for an appointment to have his colonoscopy, but he only found himself on a growing list of veterans also waiting for appointments and procedures. Many months later, Mr. Coates was finally told he could have a colonoscopy. However, at that point, VA delays led to drastic consequences for Mr. Coates, who is now undergoing chemotherapy in an effort to save his life.³⁵

²⁹ Patrick Howley, “Department of Veterans Affairs employees destroyed veterans’ medical records to cancel backlogged exam requests” The Daily Caller, February 24, 2014. <http://dailycaller.com/2014/02/24/va-employees-destroyed-veterans-medical-records-to-cancel-backlogged-exam-requests-audio/#ixzz2uLQ2d9OT>

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- In January 2011, registered nurses at a Manhattan Veterans Affairs hospital failed to notice a patient had become disconnected from a cardiac monitor until after his heart had stopped and he could not be revived.³⁶ An October 2011 VA OIG investigated the death of the patient, who was in his 80s, at the Manhattan campus of the VA's New York Harbor Healthcare System. The man had undergone several heart procedures and on his fifth day at the hospital, monitor records show that an alarm indicated a problem with the device or the patient, but there is no evidence nurses were aware of the alarm until the man was discovered unresponsive an hour and a half later. He was declared dead shortly afterward, according to the OIG report.³⁷
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VA FACILITIES A THREAT TO VETERANS SEEKING CARE

Feb 18, 2014 VA OIG report “-VA OIG validated claims of deficiencies in environment of care at a VA facility in New Haven, CT

³⁶ Charles Ornstein and Tracy Weber, “Patient Died at New York VA Hospital After Alarm was Ignored,” ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

³⁷ Charles Ornstein and Tracy Weber, “Patient Died at New York VA Hospital After Alarm was Ignored,” ProPublica, May 15, 2012; <http://www.propublica.org/article/patient-died-at-new-york-va-hospital-after-alarm-was-ignored>.

³⁸ John Ryan, “How a Recalled Medical Device Killed a Vet at Seattle’s VA Hospital,” KUOW, December 5, 2013; <http://kuow.org/post/how-recalled-medical-device-killed-vet-seattles-va-hospital>.

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Responding to allegations of deficiencies in environment of care at the VA in New Haven, CT, VA OIG found⁴⁰:

- Cleanliness of the operating room could not be assured due to inadequate staff resources, incomplete and inconsistent procedures, poor supervision and training of Environmental Management Services (EMS) staff, and lack of oversight.⁴¹
- Inadequate safeguards for ensuring patient and employee safety when infectious patients requiring special precautions were scheduled for OR procedures concurrently with noninfectious patients.⁴²
- Issues related to the maintenance of the Heating, Ventilation, and Air Conditioning system and insect control in the operating room.⁴³
- VAOIG investigators found that complaints were “substantiated that terminal cleaning of the OR is not performed appropriately and that a shortage of trained EMS staff assigned to the OR and an incomplete SOP and checklist inconsistent with recognized industry standards were contributing factors.”⁴⁴
- VA OIG also found that “During an unannounced evening inspection of the OR, we saw no EMS staff for almost an hour, when two staff members should have been present,” the report stated. “EMS supervisors we spoke to could not explain the absence of employees during this time.”⁴⁵

⁴⁰ VA Office of Inspector General, “Healthcare Inspection – Environment of Care Deficiencies in the Operating Room, VA Connecticut Healthcare System, West Haven, Connecticut”, February 18,2014, <http://www.va.gov/oig/pubs/VAOIG-13-03747-76.pdf>

⁴¹ VA Office of Inspector General, “Healthcare Inspection – Environment of Care Deficiencies in the Operating Room, VA Connecticut Healthcare System, West Haven, Connecticut”, February 18,2014, <http://www.va.gov/oig/pubs/VAOIG-13-03747-76.pdf>

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⁴⁴ Mark Zaretsky, “West Haven VA hospitals cited for dirty operating rooms, poor supervision, high absenteeism” New Haven Register, February 18, 2014, <http://www.nhregister.com/veterans/20140218/west-haven-va-hospital-cited-for-dirty-operating-rooms-poor-supervision-high-absenteeism>

⁴⁵ Mark Zaretsky, “West Haven VA hospitals cited for dirty operating rooms, poor supervision, high absenteeism” New Haven Register, February 18, 2014, <http://www.nhregister.com/veterans/20140218/west-haven-va-hospital-cited-for-dirty-operating-rooms-poor-supervision-high-absenteeism>

- At the time of the VA OIG inspection, the VA's EMS department had an authorized staffing of 125, with 38 vacancies, according to the VA OIG, but New Haven VA facility managers claimed "that on an average workday, 19 percent of EMS staff did not report to work." Supervisors at the hospital also told the inspectors that supervisors "acknowledged supervision problems and stated that they were 'not surprised' that OR nursing staff reported that they rarely saw EMS supervisors in the OR."⁴⁶

U.S. Vets Exposed to Contaminated Cadaver Parts: Awaiting Disaster⁴⁷

- According to Bloomberg, the U.S. Department of Veterans Affairs ordered \$241 million of cadaver tissue and other material derived from human and animal bodies in the last three years, some of it from vendors **warned by federal regulators about contamination** in their supply chain.⁴⁸
- According to federal contracting data compiled by Bloomberg, the VA ordered human tissue from the two suppliers despite previously being warned by the U.S. Food and Drug Administration for safety deficiencies -- RTI for contaminated products and processing facilities, and Musculoskeletal Transplant for distributing tissue from tainted donor bodies.
- **A Minnesota man died in 2001** after a knee surgery in which he was given contaminated cadaver bone; according to written testimony his parents gave the U.S. Senate Committee on Governmental Affairs in 2003.
- **The VA continued to purchase from RTI after the FDA warning letter**, according to online federal contracting data. The post-warning orders included a \$3,375 Achilles-tendon order in April 2013 and a \$3,355 skin-graft order in September 2013, according to the data.

⁴⁶ Mark Zaretsky, "West Haven VA hospitals cited for dirty operating rooms, poor supervision, high absenteeism" New Haven Register, February 18, 2014, <http://www.nhregister.com/veterans/20140218/west-haven-va-hospital-cited-for-dirty-operating-rooms-poor-supervision-high-absenteeism>

⁴⁷ Kathleen Miller, "U.S. Vets Exposed to Cadaver Parts From Contaminated Lab," Bloomberg, January 24, 2014; <http://www.bloomberg.com/news/2014-01-24/u-s-vets-exposed-to-contaminated-cadaver-parts-from-labs.html>.

⁴⁸ Kathleen Miller, "U.S. Vets Exposed to Cadaver Parts From Contaminated Lab," Bloomberg, January 24, 2014; <http://www.bloomberg.com/news/2014-01-24/u-s-vets-exposed-to-contaminated-cadaver-parts-from-labs.html>

- The agency's letter told RTI that it found fungus in tissue-processing and packaging areas, bacteria in its water systems, and had failed to recognize environmental-monitoring data "indicative of contamination throughout your facility."