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May 23, 2013

Ms. Leslie Wiggins
Director, Atlanta VA Medical Center
1670 Clairmont Road
Decatur, GA 30033

Dear Ms. Wiggins:

The VA Inspector General recently issued two reports on April 17, 2013, detailing grave issues at the Atlanta VA Medical Center. The Office of the Inspector General (OIG) substantiated widespread mismanagement—particularly in regard to mental health programs—and a lack of policies to adequately address patient care. Specifically, the OIG Patient Care Issues and Contract Mental Health Program report states, "the lack of effective patient care management and program oversight by the facility contributed to problems with access to mental health care and contributed to 'patients falling through the cracks.'" The reports laid out a series of recommendations with which your predecessor concurred.

I subsequently visited the Atlanta VAMC to discuss these deeply troubling reports with facility leadership. While I was assured that certain recommendations had been implemented in keeping with the OIG reports, I still have considerable concerns, particularly in regards to contracted mental health care.

I also have questions regarding a fourth death—a suicide—at the Atlanta VAMC facility. After media reports described a fourth death, the VA OIG issued a statement detailing what happened the day of the patient's death. However, the Atlanta VAMC has refused to accept any responsibility or detail actions taken in response. As a matter of fact, the fourth death was not mentioned during my May 6th meeting at the Atlanta VAMC, despite a direct question as to whether there were additional unexpected deaths.

Subsequently, however, Dr. Petzel said, "The facility identified root causes and has either taken follow-up action or action was in process to resolve the identified deficiencies prior to the OIG hotline investigations.

These contradicting accounts require clarification. I would like to know:

1) Which statement is accurate? Did the Atlanta VAMC take action in response to the fourth death?
2) Were the follow-up actions Dr. Petzel mentioned only in response to the previously disclosed deaths? If so, why has the Atlanta VAMC not detailed any follow-up actions as to how to prevent future such deaths?

3) Why did it take media reports for the Atlanta VAMC to admit to the fourth death, despite being asked a direct question about unexpected deaths during the May 6th meeting?
4) Is there an ongoing investigation into the fourth death? If the investigation is completed, what were the findings and who issued them?

Regarding contracted mental health care, the Veterans Health Administration (VHA) recommended that the Atlanta facility develop an action plan and obtain approval by July 31, 2013 to address the contracted care issues. I would like answers to the following questions for each individual action item.

1) Are you on track to have completed an action plan and obtained VHA approval by the July 31, 2013 target date? If not, why not?
2) What progress have you made so far in each specific area of concern mentioned by the OIG report?
3) The report states that "the process for scheduling initial CSB appointments was ambiguous and not tracked by the facility." As a matter of fact, patients waited an average of 19 days for their initial mental health assessment. Have you since implemented a time requirement and follow-up procedures to ensure that patients receive care in a timely manner? What progress have you made on a tracking system to ensure that patients not only have appointments scheduled, but actually attend those appointments?
4) During my May 6th meeting at the Atlanta VA Medical Center, I was told that enhanced VA case managers would be located at each site for heightened coordination. Have these case managers been placed at the CSBs? If not, why not? If so, have these case managers contributed to better oversight in order to appropriately monitor and track patient care? As you renegotiate the short-term lease the Atlanta VA Medical Center currently has with the 5 contracted sites, how will you ensure the continued presence of VA case managers at the sites?
5) The VA frequently receives praise for its Electronic Health Records system. However, I was told at the May 6th meeting that CSBs do not have access to EHRs, and that can contribute to delays in patient care. Have you looked at ways to fix this problem?
6) VHA requires that all new contracting officer technical representatives (those responsible for day to day coordination with CSBs) have the training required to perform their duties no later than 6 months after their initial appointment. However, the report found that at least one mental health contracting officer did not receive training for more than a year. What processes have you implemented to ensure that training for all positions is completed as efficiently and effectively as possible?

Additionally, for the inpatient mental health unit, I would like assurances that the OIG's recommendations that have been implemented are still in place and functioning, and the recommendations that are in progress are on track to be completed. Specifically in terms of the inpatient mental health unit, I would like to know:

1) Are the implemented recommendations proving to be effective?

2) Have you had any instances during which the newly implemented recommendations helped to prevent an incident?
3) Are you ensuring that all relevant parties for all shifts are following the implemented recommendations?

I still wholeheartedly believe that those who were responsible for the patients who died need to be terminated. Additionally, adequate controls must be in place to ensure that patients do not "fall through the cracks" and receive the care that they need and deserve. We owe our veterans access to a health care system that works—not one where they are shuffled through different channels only to wait weeks for an appointment.

I look forward to working with you to ensure that our veterans are receiving the best possible care.

Sincerely,

Phil Gingrey, M.D.
Member of Congress