CASE STUDY ON U.S. DEPARTMENT OF VETERANS AFFAIRS QUALITY OF CARE: W.G. (BILL) HEFNER VETERANS AFFAIRS MEDICAL CENTER IN SALISBURY, NORTH CAROLINA

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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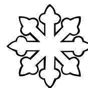

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CASE STUDY ON U.S. DEPARTMENT OF VETERANS AFFAIRS QUALITY OF CARE: W.G. (BILL) HEFNER VETERANS AFFAIRS MEDICAL CENTER IN SALISBURY, NORTH CAROLINA

THURSDAY, APRIL 19, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Filner, Space, Walz, Rodriguez, Brown-Waite, Bilbray.

Also present: Representatives Watt, Coble, and Hayes.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning. This is an Oversight and Investigations Subcommittee hearing for April 19, 2007. This particular hearing will be a Case Study on the U.S. Department of Veterans Affairs (VA) Quality of Care at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina.

I want to thank our colleagues from North Carolina for joining us today. I know they have been very active on this issue. I know the people of their great State appreciate their hard work on behalf of veterans in North Carolina.

Of course, we are here today to explore the quality of care available to our Nation's veterans. We know there have been significant problems in the Salisbury VA Medical Center in North Carolina and we will be using Salisbury as a case study so we can better learn if the problems there are indicative of quality of care throughout the VA medical system. We will explore management accountability and leadership issues within the VA medical system.

Today's hearing will revolve primarily around three issues. Firstly, how does the VA ensure access to the medical system that is timely and is delivering proper quality of care? Second, what is the process the VA uses in determining whether the quality of care is proper? And third, are the problems that occurred in Salisbury indicative of a larger set of issues that affect other VA medical facilities as well?

More than 2 years ago, in March 2005, an anonymous allegation that improper or inadequate medical treatment led to the death of veterans at Salisbury prompted the VA Office of the Medical Inspector to conduct a review of medical care delivered to both medical and surgical patients. The OMI report, issued 3 months later, found significant problems with the quality of care that patients were receiving in the surgery service of the Salisbury facility. Unfortunately, we learned that Salisbury leadership had already been notified of many of the shortcomings in surgery service through an earlier root cause analysis.

I know that all of us on the Subcommittee are particularly troubled to hear about the story of a North Carolina veteran who sought treatment at Salisbury and died. He went in for a toenail injury. And even though doctors knew he had an enlarged heart he was not treated. It was ignored. And the morning after he had surgery on his toe, he died of heart failure. According to media reports, this veteran received excessive intravenous fluids in the O.R. and postoperative as well. The medical officer of the day wrote orders for the patient without examining him and the patient did not receive proper assessment and care by the nursing staff.

More recently, we learned through the media of another incident: a wrong site surgery at another VA medical facility on the west coast. The list goes on and on.

We hope to hear today how the VA is working to ensure that these types of incidents do not happen at other facilities around the country and how the VA is working to deliver the best quality of care throughout the system. We also hope to hear from the VA how its leaders reacted to these problems, worked to solve these problems, and what lessons it learned to ensure that this never happens again.

[The prepared statement of Chairman Mitchell appears on page 47.]

Mr. MITCHELL. At this time I ask unanimous consent that Mr. Watt, Mr. Coble, and Mr. Hayes of North Carolina, be invited to sit at the dais for the Subcommittee hearing today. Hearing no objections, so ordered.

Before I recognize the Ranking Republican Member for her remarks, I would like first of all to recognize the Chairman of the Veterans' Affairs Committee, Congressman Filner.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Chairman Mitchell, thanks so much for doing this and having this hearing. It is very important.

When we got the letter from the North Carolina representatives, and we take requests from our colleagues very seriously, because we know, from our own personal experience, that we know what is going on in our own districts. I was struck by the fact, Mr. Hayes, since you represent the three, that your letter dated March of 2007 talked about getting a report from June of 2005 and September of 2006 that you had not seen before. That set off some bells right there, that reports of what is going on in the VA hospital in your area were unknown to you. That should not be the case. When we looked further into the situation, we looked at the report of 2005 that outlined a lot of the problems in the hospital. Then in 2006

the Inspector General did a report basically looking at facilities, and with no reference to the 2005 report. And then, as you know, the VA Secretary commissioned a report of all facilities just recently in the wake of the Walter Reed scandal, and there did not seem to be any connection between that report and the previous reports. So that started us thinking, since the paper trail is so clear, that this would be not only in and of itself an important hospital to look at, but also serve as a window into the process when there are problems and how we exercise accountability. And that is why we are here today under Chairman Mitchell's leadership.

I happened to meet with the Inspector General soon after we got your letter. And I asked him about this report and why it did not have any reference to the earlier report. He said, "We did not know about it." I thought that was odd. But as we looked further, these reports, which are so important, are not public. I am not sure we will find out if they are sent to this Committee, or whether there is just some summary, or whatever, but this was not a public report. Without a public report, there is no real accountability. And what we saw with these three reports, from 2005, 2006, 2007, was that there was no indication that any of the previous recommendations were ever done, ever fulfilled.

Now we will talk to the folks today and they say, "Well, of course we did those improvements." But we are not sure, and you are not sure, based on your letter, that this was done. So you have what the Office of the Medical Inspector does in 2005, it is not public, we do not know if the recommendations were even carried out. We get an Inspector General report in 2006, and we do not know if that has been carried out. And we get a new one in 2007. There is something broken about the accountability system and we are going to fix it with your leadership, Mr. Chairman. And this is a good example of what we have to deal with.

There are problems that come up. It took somebody anonymously to mention them. I do not know why that should occur. There were twelve deaths, I think, over a period of time. Not everybody knew it. There was no investigation done since somebody actually did something. I know from my hospitals and other places I have been in the country, there is a, I will use the word "fear." There is a fear about talking about the problems in your own hospital or in your own system. We have to get away from that culture. If there is fear, there is no honesty. And if there is no honesty, we cannot fix it. And if people are scared for their jobs because they are talking about problems with the patients they care about, there is something wrong with the system. So we are looking forward to fixing that, to making sure there is accountability.

One last statement, if I may. In the last 60 days, three budget bills went through Congress. We were able to add, as a Congress, $13.5 billion over last year to the healthcare of our veterans in this Nation. That is about a 30 percent increase in healthcare, bigger than any in the history of this Nation. Now we have to make sure that those resources are spent wisely, that they are spent for the proper care of our veterans, and that the legislative branch of government knows what is happening, exercises oversight, and produces excellent health services for our veterans. I thank the Chairman.

Mr. MITCHELL. Thank you. Before we get started and I ask for opening statements, I would like to have all of the panels, the witnesses and the aides to the panels, to please rise and I would like to have them sworn in please. So if they would all please rise?

[Witnesses sworn.]

Thank you. And now I would like to recognize Ms. Brown-Waite for opening remarks.

OPENING STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. I thank the Chairman very much for holding this hearing and for also yielding time.

Mr. Chairman, on March 28 through March 31, 2005, at the request of the VA's Inspector General in September of 2004, the Office of Medical Inspector conducted a site visit to the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina, focusing on the facility's delivery of surgical services. This report presented some serious inadequacies of care at this facility. On March 21, 2007, three members of the North Carolina delegation, my colleagues the Hon. Howard Coble, the Hon. Mel Watt, and the Hon. Robin Hayes, wrote to the Committee expressing concern about this report. Mr. Hayes is with us today, and I am sure the other members, as their schedules permit, will also be with us.

You know, the members asked us to look into additional oversight into patient safety at the VA. I am looking forward to hearing from our witnesses today to learn how these inadequacies have been addressed. I am particularly looking forward to Dr. Daigh's testimony providing the results of the Facilities 2006 OIG Combined Assessment Program (CAP) Review of the VA Medical Center in Salisbury, North Carolina, and the results of the OIG's inspection last week of the facility. I also look forward to hearing from Dr. Steinberg, the current Chief of Staff, and the former Interim Director, on how the facility is continuing to work to address these issues. And also, how the lessons that were learned at Salisbury can be used to implement safer delivery of healthcare services throughout the entire veterans system. It is my contention that this hearing is not to single out one facility, but to take lessons learned as a case study in patient care and the implementation of better patient safety across the entire VA system. I plan to continue to work with you, Mr. Chairman, to continue this oversight of patient safety at VA facilities throughout the Nation. Quality of care, everywhere, is my goal, and I believe the goal of members on both sides of the aisle. Again, I thank you Mr. Chairman. I yield back the balance of my time.

[The prepared statement of Congresswoman Brown-Waite appears on page 47.]

Mr. MITCHELL. Thank you. At this time, I would like to ask Congressman Walz for his opening statement.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Well, thank you, Mr. Chairman, and thank you to the Ranking Member for those words. I appreciate and thank all of the witnesses who are here today. Please make no mistake about it, the reason for this hearing, and the sole reason, is to make sure that we are providing the best medical care possible to our vet-

erans. Our responsibility in this Congress is to make sure we are doing that in the most efficient, effective manner, and the use of taxpayer dollars is obviously a part of that. But I think it is very critical that as we are pointing out and trying to find areas that we can improve upon, the reason for that is to learn from past mistakes and it is not simply a scapegoat or trying to find reasons to point fingers. It is trying to improve across the spectrum.

So I want to thank each of you for the work you do. I want to thank you for being here. I want to thank you for the open, honest dialog that we are going to get to because I think all of us on this Committee do believe that proper oversight and learning from past mistakes and implementing best practices is the best possible way to get to those solutions. So this is not a hearing to point out simply errors or simply weaknesses in the system for the sake of pointing them out. It is here to try and learn from this, to have you help us understand what we can do to implement those best practices or to help you with the resources and get the best possible care for these veterans, and that is the sole purpose of being here.

So I want to thank you for taking time to be here with us, and thank you for your expertise to help us understand this better. I yield back.

Mr. MITCHELL. Thank you. Mr. Bilbray?

OPENING STATEMENT OF HON. BRIAN P. BILBRAY

Mr. BILBRAY. Yes, Mr. Chairman. Mr. Chairman, the full Committee Chairman and I, have for 15, I guess almost 20 years ago, have worked together doing oversight at different agencies. I just ask as we go through this process, I understand that when we are talking about people dying it is human nature to focus on those deaths from the humanitarian point of view. But we need to have the discipline to focus on the systemic problems that led to those deaths, and sort of pull back and say, "There is a terrible tragedy here, and we can focus on that." But if we focus on the deaths and not on the process that led up to the problem, or may have led up to that problem, then we are negating our responsibility of oversight. And more than the problem that Chairman Filner pointed out, about the fact of the whistle blower concept, the employee, because we always have had that. I mean, Bob and I know that, I do not care if it is a police officer saying a procedure was wrong or a county hospital saying that handling was done wrong, you will always have those in the system that always can point out faults and problems.

What I really see of concern here is that, and I would ask those who are testifying to address this process where we do an assessment, a formal assessment of the operation, and that assessment is not made available. And why is it not made available for general review? Now, in certain situations, like when I was working with the trauma system in San Diego County, there was certain information we did not put out for liability reasons, for exposure reasons. And we tried to address the problem with the general public, because every lawyer in the world would be showing up to sue the hospital. And you cannot provide healthcare once the hospital has been shut down because of litigation. But this one, I do not understand why it was not made public. And I think Chairman Filner

points out rightly that we ought to be addressing the issue as, is there a process here that we need to change? Even if it is a process that says, "We are not going to make it public directly, but we may hold it for 6 months to give the system the ability to respond to it so that when the report comes out there are answers, there has been time to address the concerns, whatever."

So I would ask that we really look at the systemic problem. It seems like a breakdown, that when you had a report that was out there a year ahead of the other report, and no one knew about it, what good is a report if there is not some review and action taken on that report? And so, again, I think that is where we can, rather than finding fault, find answers to be able to address the item.

And I yield back, Mr. Chairman.

Mr. MITCHELL. Thank you. Mr. Hayes?

OPENING STATEMENT OF HON. ROBIN HAYES

Mr. HAYES. Thank you, Mr. Chairman, and Chairman Filner. Let me begin by thanking you, Chairman Mitchell, for making this hearing possible, and Ranking Member Ginny Brown-Waite. Bob Filner, we have been here for a long time. When this came to our attention, there was absolute confidence on my part that you and this Committee would look into this. And my point is, for not the members and others that are here, but the larger audience, leadership comes from all levels. But this Veterans Committee has provided the leadership. And today I think among other things, and Congressman Bilbray is right, we are reinforcing from the top the attitude that first, foremost, and always, the veteran/patient is what we are here to work on.

Again, thank to all of you for making this possible. Quality, affordable, and accessible healthcare services to our Nation's veterans has been a top priority for me and for you as well. That is why I have been so concerned by recent media reports investigating the quality of patient care some of our veterans have received at the Salisbury Medical Center.

While there are different deficiencies ranging in various levels of severity, I found it most troubling that a nurse employed by Salisbury reportedly falsified care reports on seriously ill veterans housed in private nursing homes and did not properly monitor them. This nurse's infractions included listing a patient in stable condition 12 days after he died. She was also cited in the VA Office of Inspector General's September 2006 report for not having visited some patients under her charge for over 2 years. Yet, the unnamed nurse is apparently still employed by the Salisbury VA. That is why I wrote to the Veterans Integrated Services Network (VISN) 6 Director, Dan Hoffman, to express my concerns and to ask how this could happen. There have also been allegations that more than 12 deaths of surgical patients at the Salisbury VA had occurred in the last 2 years which may have been prevented. I do not think that all Department of Veterans Affairs healthcare is bad. There is excellent care being provided. I do not think the majority of VA healthcare employees are irresponsible or providing inferior care. The majority of our veterans are getting quality care from dedicated staff. The Veterans Affairs healthcare system is one of the best in the Nation, and continues to strive to provide better patient

care. But even if one veteran has been or is being neglected, then that is one too many. If one employee is being negligent in their care, then that person does not need to be a part of the VA system.

During this hearing, I look forward to hearing more about specific incidents and the overall situation at Salisbury so that we can take these lessons learned and apply them to VA healthcare across the country. I am also interested in how this relates to leadership and management within the VA, what is being done to ensure that their best care practices are being utilized.

Caring for our older veterans and giving them the best access to quality healthcare is our duty as a nation. As we continue to sustain operations in support of the Global War on Terrorism, it is also imperative we send a strong signal to the active duty forces that our Nation will indeed care for them when they return home.

I appreciate each of the witnesses from the Department of Veterans Affairs Office of the Inspector General, leaders of the Salisbury VA Medical Center, and the Department of Veterans Affairs Health Operations and Management for taking the time to appear. I believe your candor and insight can and will shed light on the issue for all of us. I look forward to continuing to work with my colleagues on this critical issue and on behalf of our Nation's veterans and servicemembers, again, thank you Mr. Chairman.

Mr. MITCHELL. Thank you. Congressman Rodriguez?

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you very much, Mr. Chairman. Let me first of all thank you for holding this hearing. My concern is that as we look at the VA, that what happened up here and other hospitals, that this might not be just an isolated situation, but that it might be widespread. I look forward to hearing from the Inspector General, and to see, if he can give us some guidelines as we move forward regarding how we might be able to help out.

I understand also that the VA has not received the appropriate resources for so many years, and that they have had to cut staff. And I do not know if that nurse had a caseload that just was impractical to deal with, or what the situation might be. But I do know that we are going to do our best to begin to fund the VA appropriately with $3.6 billion additional moneys for 2007, and the supplemental holds some additional resources there. And we are going to work hard for 2008, to provide that $6.6 billion. But as we do that, maybe the Inspector General can help us out in the process to make sure we begin to, and the VA begins to, streamline the process that is needed in order to provide good healthcare. I know I get criticism back home from the fact that if you look at the private sector and what they do in certain areas, the number of patients that they view and then the number of patients that the VA views, it is day and night in comparison in some of those same situations. And so, we have to make sure we hold the system accountable, especially as we try to do the right thing.

And I concur with the fellow colleagues that have indicated that this should be about making sure we have a system that is held accountable for our veterans and that we have a process there that can provide the appropriate care. And if it is not there for them to come forward, and to feel comfortable to come forward to tell us,

"There is no way we can deal with a waiting list unless we are provided this, this, and that." We have not had that kind of a process. And that is the process that we need, that if they cannot handle it, for them to come forward and tell us: "Unless you provide this, this, or that, we cannot do that." And so, I am hoping that these types of hearings can allow us to begin to get to that level where the administration can come forward with those requests from us, and that we also come forward with whatever is necessary in order to make that happen.

So Mr. Chairman, thank you very much for holding these hearings.

Mr. MITCHELL. Thank you. At this time we will proceed with Panel One. Dr. John Daigh is the Assistant Inspector General for Healthcare Inspections in the Office of the Inspector General (OIG). He is accompanied by Ms. Victoria Coates, the Director of the Atlanta Office of Healthcare Inspections, which covers Salisbury, North Carolina, as part of its regional mandate. Dr. Daigh, you have 5 minutes.

STATEMENT OF JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY VICTORIA H. COATES, DIRECTOR, ATLANTA OFFICE OF HEALTHCARE INSPECTION, OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. DAIGH. Thank you, Mr. Chairman. I appreciate the opportunity to testify in front of this Subcommittee today. I prepared some written statements for the record that I hope can be accepted into the record.

I and the members of the Office of Healthcare Inspection take very seriously our legal challenge and mandate to ensure the veterans receive quality healthcare. We do that through several mechanisms, two of which I will talk about today. One is a Combined Assessment Program (CAP) inspection, whereby my office inspects major hospitals, there are about 158 of them, on a 3-year cycle. So about once every 3 years we go to each facility. We concentrate during that inspection on the processes at the hospital that should ensure that patients receive quality healthcare: the peer review process, the patient notification process if there is a bad outcome, those internal business processes that have to be successful.

A second mechanism that we use to try to ensure patients receive quality healthcare is through our hotline. My office publishes about 50 hotlines a year. In 2004 we were publishing about 30 hotlines a year. The VA OIG maintains a hotline that accepts complaints through a variety of mechanisms. If those complaints deal with quality of healthcare issues, they are brought to my office. And in our office we try to triage those complaints and address the ones we think have systemic impact or are most serious. Those that we cannot directly review because of manpower limitations, we refer back to a level of command at VA higher than the level of the complaint.

I would like to refer to a fiscal year 2006 summary that we published this year of the quality management of VA as a result of the

CAP inspections. And in that publication we noted weaknesses systemically in the peer review process; the adverse event reporting process, which is the process whereby the hospital would notify a patient that there had been an adverse event; and in the utilization review process.

Let me turn specifically to the events surrounding Salisbury. The IG received through its hotline on August 30, 2004, an anonymous complaint alleging 12 individuals had died on the surgery service over the prior 2 years through improper healthcare. That complaint was brought to my office, and the next day my office accepted that complaint as one that we, the Office of Healthcare Inspections, would review. Upon looking at our workload and the cases that we were carrying at that time, I determined I could not investigate this case. That is, look at 12 deaths intensively in the timely fashion. So I, therefore, referred this case to the Office of the Medical Inspector (OMI), who said he did have the resources to look at this case in a timely fashion. And so, 3 weeks after I received the hotline, it was referred to the Medical Inspector (MI) on September 24, 2004.

The Medical Inspector then went to Salisbury in March of 2005, and published a report in June of 2005. Between those two timeframes the Director of Surgery for VHA visited the facility in May. The effort that the Medical Inspector made at Salisbury was discussed in monthly meetings that my staff has with the Medical Inspector. The Medical Inspector's report notes that I referred the case to them and notes that I reviewed the draft of this report. So I was well aware, as the people in my office were, of the issues surrounding this report. And we are aware of all the Medical Inspectors' reports.

In June of 2006, my CAP team led by Ms. Coates, went to Salisbury to conduct a CAP inspection. I did not make them aware of that report. In retrospect, it would have been better had I made them aware of that report. But in the CAP report they noted some problems. One, the contract community nursing home program did not have a Committee that it was supposed to have to organize and supervise its activities. They also found difficulties with the peer review process and the management of internal board of investigations and Root Cause Analyses (RCAs). They also found some deficiencies in the cleanliness of the kitchen.

We went back in early April 2007 in preparation for this Subcommittee's hearing to review again whether or not the findings of OMI and the recommendations of OMI had been implemented and whether or not the findings and recommendations of the CAP had been implemented.

And as my time is out, I will indicate that both the OMI findings and the defects that we found in our CAP report have been adequately addressed currently by the facility. I thank you for the opportunity to testify, and Ms. Coates and I would be glad to take further questions.

[The prepared statement of Dr. Daigh appears on page 48.]

Mr. MITCHELL. I have a couple questions I will start off with. Firstly, are there any patients currently in the community nursing homes that are on the watch list?

Ms. COATES. I would like to answer that question. There is one nursing home that Salisbury has that is currently on the watch list. However, the facility has increased the monitoring and the visitation of the clinical staff to that nursing home to our satisfaction.

Mr. MITCHELL. Is your microphone on, Ms. Coates? Is your microphone on?

Dr. DAIGH. Yes, I believe it is on.

Ms. COATES. It says it is on. Is that better? Would you like me to repeat my answer? Salisbury has one nursing home that is on the watch list right now. That facility is being monitored, visitation has increased, and we believe that it has satisfactorily been addressed.

Mr. MITCHELL. Thank you. I have two other questions. Why did the OIG send the hotline to the Medical Inspector to begin with?

Dr. DAIGH. Well, sir, when we get an allegation we are never sure what we will find in the exploration of that allegation. So if there were 12 cases to review, that takes a significant amount of manpower to do an in-depth review of the care of 12 patients. And, at the time, in 2004 I had a full plate of very significant issues I was working on. So in discussing with the MI, the MI had staff that could look at this in a more timely fashion than I could, so I referred this case to the MI.

Mr. MITCHELL. One last one, what are your roles and responsibilities in overseeing the MI?

Dr. DAIGH. Well, sir, in law when the MI was created, my office was charged with overseeing the Medical Inspector's Office and with ensuring that VA provides quality care by looking at the mechanisms by which VA ensures that they have quality care. From a practical point of view, the Medical Inspector works for the Under Secretary of Health and in my eyes is an agent of the Under Secretary of Health. I work for the Inspector General and do not work for the Under Secretary of Health. We cooperate in the sense that we are aware of where each of us is working. We are aware of the significant issues that we are each dealing with. We try very hard not to duplicate our efforts. And I think we have been pretty successful in recent years at working together.

For example, the MI published a report in Chicago a couple of years ago in which there were three surgical cases of retained instruments. That case was the basis for which my office set out to do a national review of patient safety in the operating room, which was published in March of this year. Again, trying to emphasize that these same-sided surgery mistakes should not occur, that facilities need to go through the policies and the procedures that VA has set up to make sure those things do not happen.

Two Under Secretaries ago, the MI came to me and indicated that he had a report that he had written that he could not get VHA to act on. So having that information, I then wrote a letter and went to the Under Secretary for Health and said, "You need to act on this report." It turned out that there was then legal intervention which sort of took over in terms of the issues of that particular case. But if the MI feels that he is not being listened to then I am an outlet to try to make sure that he is. And we work together cooperatively as we can to try to ensure veterans get quality healthcare. Thank you.

Mr. MITCHELL. Ms. Ginny Brown-Waite?

Ms. BROWN-WAITE. Thank you, Mr. Chairman, for yielding, and thank you Dr. Daigh for being here. If there is an Inspector General's Office, which certainly there should be in this agency and every agency, and there also is the OMI group, how does that overlap? How does that delay the process? Or is having both of these groups, one of which, I believe your office, is somewhat understaffed, is there a tug there of territory? That is question number one. And question number two relates to why do you think that it took an OMI investigation, your IG CAP review, and a review over a 2-year period to finally shake up some senior management lethargy to finally remedy some pretty serious shortcomings? And I look forward to having your answers.

Dr. DAIGH. Yes, ma'am. With respect to the first, I believe that my office has an independence that the OMI does not have. I believe that the Under Secretary of Health needs an individual or a group of individuals that can act as his agent should an issue arise that he can send out and look at episodes of care that might not be appropriate. The size of the group that he has performing that task I have not made a study of and I am unsure of how many people he needs to do that. I believe that we have a significant workload in my office and that we are running flat out right now.

As to the second issue, I believe that when we did the CAP inspection in 2006, that we were content that the leadership at that facility had in fact set course to make the changes we thought necessary to ensure that veterans receive quality care. We commented that there were problems with peer review and they made those changes. We commented that there were problems with nursing homes, and once pointed out, they made those changes. The disappointing fact or feature is that there would be a problem with peer review at all. They know we are coming to look at their peer review Committee, we know they have a peer review Committee, or should have one, they know it should meet on a regular basis, and they know that it needs to do its work in a timely fashion. So, yes, we wish that we did not have to repeatedly find some of the same problems across the system.

Ms. BROWN-WAITE. On a scale of 1 to 10, how truly effective to protect patients is the peer review group, in your opinion?

Dr. DAIGH. I think that it is extremely important that episodes of poor care be appropriately commented upon by physicians' and nurses' peers to allow the administration to decide whether or not the care provided was quality care or not. This information is essential to allow the hospital's leadership to decide who should have credentials and privileges to practice in that hospital. So the peer review process is integral to the safe functioning of a facility.

Ms. BROWN-WAITE. I do not think that is what I asked you.

Dr. DAIGH. I am sorry.

Ms. BROWN-WAITE. I asked you how effective you think it really is. Because the problem with a peer review group is, that I have found when I chaired the Health Care Committee in the Florida Senate, is that nobody wants to say anything questioning another medical provider's level of expertise or lack thereof, or even problems with substance abuse. So, you know, peer review is something that when it works, it works very well. But I also found that it is

a great opportunity for intimidation. For example, nurses that see something that really say that this doctor is a danger to the patients, that nurse frequently will lose her job and the peer review group will then do nothing. So I think I would like you to tell me, on a scale of one to ten, in reality, and remember you are under oath here. How effective is the peer review in the VA?

Dr. DAIGH. Well, I think I would like to parse my answer if I could. I think that there are places where the peer review process does not work as designed, that is by policy. It does not meet regularly and it may not effectively get the data that it needs to make decisions. And where it does not meet effectively, I would agree with you entirely. There are places, however, that do have effective peer review. And, where it does work well, I think it does make an important contribution to healthcare. I believe that in the VA peer review would be, on 10 being excellent, I would give it probably a 7 to 8 grade in terms of its functioning across the system.

I will say that when we do hotline reports, and clinical cases are addressed, we go out and seek comments from both physicians within the VA and physicians outside the VA to help provide the technical expertise that my office needs in certain complex cases to determine whether the care met standard or not. And we have had no difficulty getting quality input to our reports to suggest that poor care was delivered in the VA. So from a personal experience, asking for VA and non-VA physicians, for their input, where they know the report is going to be put on the web, as all of our reports are put on the web, available to the country, we get very good, high-quality input.

Ms. BROWN-WAITE. Thank you, Dr. Daigh. I yield back the balance of my time.

Mr. MITCHELL. Thank you. Mr. Filner?

Mr. FILNER. Thank you, Mr. Chairman. Dr. Daigh, I was a little troubled by your testimony, both in some of the things that you said and also things you did not say, especially since some of us asked questions that we want to know and you did not address them in your remarks. I mean, we make these opening statements not just to hear ourselves talk but so you know what we are interested in.

Let me tell you a couple things. Number one, you said you did not have the resources. I mean, your first response to the hotline was you could not do it yourself. I doubt if that was made known to the Congress, that you did not have sufficient resources to do things that you should be doing. I do not think so. Was any statement made to Congress that you would have liked to do a report of 12 deaths, but you did not have the resources to do it? Did anybody know about that?

Dr. DAIGH. No, sir. That is an internal prioritization in my office.

Mr. FILNER. Right. But if you do not have enough resources to do the job that you are set up to do, it is no longer internal, Dr. Daigh.

Dr. DAIGH. Yes, sir.

Mr. FILNER. It is a job for some of us. Now, then you said you took 3 weeks and you asked OMI and they got to it. You said in March when you asked them in September, if I recall. Come on, that is 6 months with 12 deaths. If it were my family, and my chil-

dren, or my spouse, I would be in there the next day. So the speed of the bureaucracy worries me. That what you think is reasonable is forever, especially to the families that are trying to figure out what is going on here. So they did not even get to it for 6 months. It took another, what, 3 months to do or something like that. And then as I understand it, correct me if I am wrong, it is not published. Your stuff is published on the web. I do not think you made clear to the Subcommittee that the OMI stuff is not published on the web. Is that true?

Dr. DAIGH. I believe that is true, sir, but the Medical Inspector will be here and you can ask him about that.

Mr. FILNER. Come on, you are the Inspector General. You should know this stuff. You do not know? You told me in private that it was not public. So tell us here. I mean, come on——

Dr. DAIGH. I believe their material is not public on the web.

Mr. FILNER. All right. But come on, how long have you been in the Inspector General's Office?

Dr. DAIGH. About 5 years, sir.

Mr. FILNER. And you do not know whether the OHI report is public or not? Okay, and you said you were aware of the report but your CAP team was not. Is that not a weakness in your system?

Dr. DAIGH. That is a weakness, sir.

Mr. FILNER. Okay. I mean, we need to have that, I mean, how can the CAP team go in and report when they did not even know what was wrong before? So OMI, did anybody do a followup of the OMI report within a reasonable amount of time? Is there any provision for a follow up to their report in your office or any office?

Dr. DAIGH. I would offer, sir, the example of our published report on patient safety in the OR is——

Mr. FILNER. I want to know if the 2005 report by the OMI was ever followed up to see if the recommendations were in fact carried out.

Dr. DAIGH. Not specifically until last week, in preparation——

Mr. FILNER. For this hearing?

Dr. DAIGH. Yes, sir.

Mr. FILNER. Now we are 2 years later, great show. Now, you said you thought there was an adequate response. Since nobody actually checked down their list of recommendations, was anyone fired for this stuff? I mean, we had a nurse who did not know what to do. We had, I was told a doctor was sort of let go but then rehired under a different category or a different thing. Did anybody, was anybody held accountable for errors in terms of being fired?

Dr. DAIGH. I am not sure of the answer to that, sir. That is a personnel issue that the facility would deal with.

Mr. FILNER. You are the Inspector General. We are relying on you for an independent analysis of this and we do not know if it was followed up on, and we do not know if anybody was fired. How did you follow up on your CAP report that is done every 3 years? Is there a formal followup on that?

Dr. DAIGH. Yes, sir. There is a process by which we keep record of the recommendations that we make. We, in person, follow up those recommendations that we think are very significant, and those that we do not have the manpower to follow up on we, if the plan put forward and through the written correspondence of docu-

ments justifies to us that that issue has been closed, then we close it.

Mr. FILNER. But you do not know that that is being done in OMI, that same process?

Dr. DAIGH. I am uncertain of that.

Mr. FILNER. So you follow up the CAP reports in some organized fashion. Is there any report issued on the report? For example, within 6 months all these things were taken care of, or not?

Dr. DAIGH. Well sir, we report to Congress all recommendations not completed within 1 year.

Mr. FILNER. Okay, my time is up. But the process bothers me. The OMI report is not public. The OMI does not seem to have any notion of speed. Six months later, 9 months later to do stuff, and then we do not even know if they were carried out because our colleagues from North Carolina write us a letter and tell us that it does not look like they have done anything. The system is very weak, it seems to me. And what bothers me even more is the bureaucratic attitude on this stuff. I have said this before in public meetings, I do not know if you were at those meetings. We are talking about the deaths of human beings. People ought to figure out what is going on, do it fast, and make corrections. Here we get a bureaucratic thing that takes forever and then by the time it is done everybody forgot who died anyway. I do not see a passion for figuring out what is going on. And I do not see any accountability in personnel. There are some serious personnel problems here. It is hard to believe that that nurse is still there. Your report states that the nurse is still there, she was just transferred to administrative duties. What the hell is she still doing there? Or he, I do not know if it was a he or a she. So I think we need a far better system with a little bit more direct passion about carrying it out.

Mr. MITCHELL. Thank you. Next, Mr. Walz?

Mr. WALZ. Well, thank you Mr. Chairman and Dr. Daigh, thank you for your time. I represent the district of southern Minnesota that includes the Mayo Clinic, so I spend a lot of time talking about healthcare, talking with experts, especially on the delivery of quality care and how to improve that. And I think as a world renowned expert as Mayo is they have some insights on this. I am also concerned and spend a lot of time looking at organizational design and how organizations function or do not function, and where those gaps are. I have a couple questions here and I do know these questions are going to be a little bit subjective. But that is the nature of leadership, to make subjective judgments and put them into place at times. I know we do not always have those quantitative measures to judge things by, but I want you to give me your best impression as you see this.

Is it your opinion, Dr. Daigh, is the Office of Inspector General seen as an integral part of delivering quality care? Or is it seen as a watchdog to appease and keep at arms' length? How do you see it, from the perspective of the VA facilities? How would you see that? And I know it is subjective.

Dr. DAIGH. I think we are an integral part of providing quality care, and I believe that we are perceived that way. I believe there are people that do not perceive us that way. I mean, clearly we are here to help you. When we can write reports that have significant

impact on leaders' ability to perform and people's jobs, people are certainly concerned when they talk with us. But I believe that we speak the truth, we try to lay out the issues as we see them. We have access to senior management and we hope that people will do the right thing in terms of making leadership decisions in VHA and that Congress will take our information and make decisions useful to run the organization.

Mr. WALZ. Well, I can tell you from my perspective, I do that. I do see the OIG as being an integral part of that. I hope it is being seen that way. My concern is, and I share this with you, and I think you are stuck in a bit of a rock and a hard place on this one. At least in my opinion, I think many on this panel agree, that the OIG has been an area that has been severely under resourced in recent years. And I have deep concern over that. And I did hear your testimony, as you said, you have to make judgments. All of us do on the use of our resources. You have to prioritize.

My next question to you is, do you think if you would have had more resources, more personnel, and more ability, would your response time and the way that you handled the situation at Salisbury have changed? Would it have improved?

Dr. DAIGH. I think it would have. I am sure that it would have. The other ambiguity here is anonymous complaints are sometimes difficult to ferret out what the exact facts are, and what resources are required. So if a complainant lets us know who they are and we can quickly assess what the risk is to people on the ground, we respond as quickly as we can. So, yes, with more resources, I would be able to respond more quickly and more aggressively.

Mr. WALZ. Do you feel any pressure to try and justify the budgets that are given to you from VA management? Do you feel the need to try and say, we have sat in this Committee and had pointed questions from people sitting up here ask the VA that they had the resources, and not a month ago they told us yes, they had all they needed. Now I am hearing from you that you think that the quality of care would have increased. I think it is a logical conclusion to say possibly if you had more resources we may have fewer deaths. That is a pretty important and profound statement. My question to you is, do you feel pressure inside the VA system to justify the budgets that are given to you and to not come to us? To not come outside and give us suggestions and say, "Hey, we are overwhelmed here, help us."

Dr. DAIGH. No, sir. In the budgeting process I put down the proposals that I think would allow my office to deal with the issues that should be dealt with. I put that down in terms of manpower, usually, which is equatable into dollars, that goes forward. I do not have any direct discussion with the decision makers on what the VA IG appropriation is. But I feel no pressure to do other than tell people what we need.

Mr. WALZ. If you feel you are short, is there a process and what is the process inside the VA that you can go and talk to your superiors on where things that you think could be increased? How does that process work? Is it an open door policy? Is it a formal policy? Or how do you say, "Hey, my resources are not enough?"

Dr. DAIGH. I would have to get back to you in writing, sir. That would be handled by the management group of the IG's office. I run

the healthcare inspection group. And so the actual formulation and requesting of a budget is done by a different part of the IG's office.

[The information was provided in a followup letter from Dr. Daigh, which appears on page 66.]

Mr. WALZ. Do you think that might be a problem? Or are you comfortable with it? You are the implementer. And if they are the appropriators and there is not a lot of communication I worry about that.

Dr. DAIGH. Yes, sir. I understand what you are saying.

Mr. WALZ. Okay. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you. Mr. Bilbray?

Mr. BILBRAY. Thank you, Mr. Chairman. Let me first clarify that I think those of us in government cop out too often that the answer to every problem is to throw more money at it. That has created major problems and a break down in the credibility of those of us in government to provide cost effective, reasonable services. And frankly, let me just tell you something. I am more impressed with the fact that rather than screaming you did not have enough money and finding excuses not to address the issue, that when you found out that this crisis, or this review needed to be done and you basically did not have the capability in-house, you went and looked to find somebody to get the job done rather than screaming that you just could not get it done.

My concern is back to the procedural issue here. Were you aware of the 2005 report? You personally?

Dr. DAIGH. Yes, sir.

Mr. BILBRAY. Were the people doing their review that came out in 2006, were they aware of the 2005 report?

Dr. DAIGH. No, sir.

Mr. BILBRAY. Why were they not?

Dr. DAIGH. Because I did not tell them. The OMI publishes about, five, six, seven reports a year. We have an elaborate system so that when individuals go out on a CAP inspection they can see all of the IG activities, that would be the auditors, the healthcare activities, the hotlines, so that they are aware of those issues. We did not have an adequate system to let people know when they go out on a CAP of OMI reports. We have subsequently placed all of the OMI reports and current drafts on a share drive so everyone in OIG can see the OMI reports as they conduct their business.

Mr. BILBRAY. But you do not have a tickler system so that if somebody is going into a certain facility or a certain field, that they are automatically tickled that the fact that there are these outstanding reports that they can use as a base?

Dr. DAIGH. Well sir, it is standard practice to query the database for the site that you want to go to.

Mr. BILBRAY. Yeah?

Dr. DAIGH. Then you get a list of all the opened and closed issues at that site. So there is a way to look at IG work. The OMI work is listed in very simple format that is easy for one to look at. When you know you are going to go on a project you go look at the share drive, see the reports——

Mr. BILBRAY. So the share drive, was this available for them, the share drive?

Dr. DAIGH. It was not available then. It is available now and has been set up now.

Mr. BILBRAY. Now?

Dr. DAIGH. Yes, sir.

Mr. BILBRAY. Okay, this is the kind of testimony that we need.

Dr. DAIGH. Yes, sir.

Mr. BILBRAY. Was it oversight on your part of notifying them, "Hey, by the way guys, you are going in there and we have got this report that came out and you ought to take a review of that?"

Dr. DAIGH. That is correct, sir. That is correct, it is my oversight.

Mr. BILBRAY. Okay. Now, you have now got a system that basically if they are going in the facility, there is a tickler to let them know that there are these outstanding reports that are already on file?

Dr. DAIGH. That is correct. There is a very simple way for them to see what OMI's current work is and what the OIG's current work is.

Mr. BILBRAY. So you are here telling us now that you made a mistake. The system was not working properly. But since then, you have been able to backfill and correct the procedural mistake that occurred in this instance?

Dr. DAIGH. I am saying that I made a mistake, and that we have corrected the problem.

Mr. BILBRAY. Hang on, when you said you corrected the problem, let us clarify. You corrected the procedural problem?

Dr. DAIGH. Yes, sir.

Mr. BILBRAY. Okay, go ahead.

Dr. DAIGH. I am saying that I have made OMI's work available to my staff so that we should not have the disconnect that you are concerned with here again. That should be corrected.

Mr. BILBRAY. Because Doctor, you admit, that when anybody goes into a facility the first thing they should be looking at is the previous reports on that facility to have a base of knowledge to move forward from, rather than having to reinvent the wheel.

Dr. DAIGH. I agree, both the previous and the ongoing issues at that facility.

Mr. BILBRAY. Now at this facility we have, you know, we are talking this facility. But this is now procedure for your entire review process? To where whatever facility they are going into they now have the ability to automatically have a tickler that will refer them the reports that have predated their investigation?

Dr. DAIGH. For years, my staff have had the ability to see all of the IG reports on any site. They now have the ability, as of very recently, the ability to see OMI's work at those sites.

Mr. BILBRAY. Thank you very much. I appreciate it.

Dr. DAIGH. Yes, sir.

Mr. BILBRAY. Mr. Chairman, I yield back.

Mr. MITCHELL. Thank you. Mr. Rodriguez?

Mr. RODRIGUEZ. Thank you very much Mr. Chairman, once again. And let me thank you for taking responsibility in terms of correcting that, and that is refreshing to hear. You mentioned earlier that in reference to the manpower that is needed that you submitted your budget. And I wanted to ask you if what you requested was what you received?

Dr. DAIGH. Sir, if you are talking about the actual budget submission, I would have to refer you to the management group at the IG's office who actually constructs the budget and moves forward. I do not really know exactly what the documents are that move forward with respect to the IG's budget as whole.

Mr. RODRIGUEZ. Because you did indicate that you needed more manpower, you needed more assistance, is that correct?

Dr. DAIGH. I indicate to my boss where I think we should allocate resources to more effectively allow me to do my job, yes sir.

Mr. RODRIGUEZ. And do you feel comfortable that you received what you needed?

Dr. DAIGH. I have received in the last several years an increase in manpower of two offices, which would be 12 people, plus 2 additional physicians since the 2004 timeframe. So I have received additional assets. I feel people have been generous in providing me assets. There is, however, more significant hotlines work than I can do. I have to triage what I do based on the demands on my staff's time.

Mr. RODRIGUEZ. Now, based on the work that you have already accomplished and those areas of corrective action that have been outlined, what are some of those areas and what still needs to occur in order for those corrective actions to take place, if they have not taken place?

Dr. DAIGH. Do you mean at Salisbury, sir?

Mr. RODRIGUEZ. Yes, sir. On the report there was some indication in terms of some corrective actions that were put out there. Have those corrective actions taken place?

Dr. DAIGH. It is my understanding from Ms. Coates and her team's report to me that the CAP issues that we identified a year or so ago, the corrective actions have been taken for those issues. It is also my understanding that corrective actions have been taken with respect to OMI's report on the surgery service. So I believe that actions have been taken on both of those reports.

Mr. RODRIGUEZ. Okay. So then are there any recommendations that have not been taken care of that you know of? Or that you need to still go back and reassess?

Dr. DAIGH. On our last visit we identified a couple of issues that we have asked the facility to address. One, in tunnels that connect buildings, there are telephones under lock or under key. So we have asked that one consider that patients will not have those keys, and so that needs to be addressed so that if there is an emergency in the tunnel that can be dealt with. Secondly, we found some sprinkler heads that were dirty in the kitchen and needed to be fixed. And thirdly, we identified that in the locked psychiatric ward there were exposed pipes from the wall to the toilet, and those are also a problem that needs to be addressed. So those three items, when Ms. Coates' team was there last week were made known to the facility to address, and we will follow up as we always do to make sure that those corrections occur.

Mr. RODRIGUEZ. Are there any other things that you feel that you could be doing that might help improve the situation there now?

Dr. DAIGH. Well sir, I believe that the facility has made some changes in leadership both within their surgery group and within the senior management of the hospital. I believe we have pointed

out what recommendations we have and they have agreed to do them. So I think they need to have a chance to address the issues that we have just identified to you and we will follow up on those issues.

Mr. RODRIGUEZ. And once again, you are not aware if anybody has lost a job as a result of what has occurred, or anything to that nature?

Dr. DAIGH. In general, sir, once we identify the issue and the facility takes the correct action to deal with it, then I do not follow up on whether—we occasionally do but usually do not follow up on exactly what personnel action was taken, as long as we are assured that some appropriate personnel action was taken.

Mr. RODRIGUEZ. Okay. Thank you very much. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you. Mr. Space?

Mr. SPACE. Thank you, Mr. Chairman. I do not really have a question, but a request. And this is following my colleague's question regarding personnel actions that may have been taken. And the request I have is that you provide this Committee with a written response concerning those personnel actions that have been taken, or are being undertaken as we speak. And the concern I have is that given what appears to be a callous disregard by a collective bureaucracy for some very fundamental points involving human life, I feel very compelled to request that we follow through and find that these responsible parties are not simply being shuffled from one part of that bureaucracy to another. So I am requesting, if you would, to provide us with a written response concerning those personnel actions that have been taken.

Dr. DAIGH. At Salisbury, I will, I would be happy to, sir.

Mr. SPACE. All right. Thank you.

[The information was provided in the response to Question 2, directed to Dr. Pierce, in the Questions for the Record from the VA, which appears on page 66.]

Mr. MITCHELL. Thank you. Mr. Hayes? Oh, excuse me.

Ms. BROWN-WAITE. Mr. Chairman?

Mr. MITCHELL. Yes?

Ms. BROWN-WAITE. If, actually what I was going to ask was, I was going to ask Mr. Space if he would yield some time to me for a follow up on what he was requesting?

Mr. SPACE. Sure.

Ms. BROWN-WAITE. I appreciate the gentleman yielding. I would also ask if you could provide this Committee with a list of the people who were involved in this issue at the hospital in North Carolina, and the bonuses that they received over this period of time where obviously there was questionable quality of care that was rendered. The hospital administrator, the individuals who were involved, I think it would be very revealing to also know what kind of bonuses they received while this inferior quality of care was going on.

Dr. DAIGH. Yes, ma'am.

Ms. BROWN-WAITE. And Mr. Chairman, if you do not object to that addition?

Mr. MITCHELL. Absolutely not, so ordered.

Ms. BROWN-WAITE. Well, I think that the Inspector General certainly can provide that information also, am I correct, sir?

Dr. DAIGH. Yes, ma'am, I believe we can. I will get that for you.

Ms. BROWN-WAITE. Okay. Thank you very much.

[The information was provided in the response to Question 1, directed to Dr. Steinberg, in the Questions for the Record to the VA, which appears on page 62.]

Mr. MITCHELL. Thank you. Mr. Hayes?

Mr. HAYES. Thank you, Mr. Chairman. Dr. Daigh, thank you very much for your candor. We have covered a lot of important ground this morning but I want to focus in specifically on the nurse issue. I have written a letter on March 15 to the VISN 6 Director and only received response yesterday, which was the 18th. And again, to go back to the issue in realizing that there is separation between inspection, which is your purview, and management and care, which is the purview of others. But this person again reported a patient in stable condition 12 days after the patient had passed away. And she also, I am not sure whether it is a she, this nurse had patients under her charge who were not visited in over 2 years. Now, in my response I am told, which is entirely unacceptable, that it was decided to enter into a last chance agreement with that employee. Again, sticking to your role as Inspector General, does your department get into recommending whether this was an offense that the person should have been terminated? Or is this a question that I should ask of management coming later?

Dr. DAIGH. I generally do not get into that issue. I would ask you to ask management coming later. There are clearly cases where significant action needs to be taken, and my office is essentially composed of healthcare professionals. And when we move into the issue of disciplinary action and hiring and firing actions, we are simply not the experts on that, and do not usually get into the legal issues involved in that.

Mr. HAYES. Well, interestingly, as time passes, and it has been pointed out a lot of times past, then if corrective, proper actions are not taken then you are brought back in next year. Well, we have investigated and this person was not terminated, so do you have an opinion based on the facts if this individual should have been terminated? I think obviously they should.

Ms. COATES. What we can tell you, sir, is that this particular nurse was reassigned to another area of the hospital, and that supervision was substantially increased. In the contract nursing home program, the facility has assigned a number of staff, has added a part-time nurse, and the visitation and the monitoring of the patients in the nursing homes really is at an acceptable level. We have confidence in that.

Mr. HAYES. Well, again thank you. It certainly seems like unacceptable on any level behavior. In conclusion, again, I want to focus on the fact that dollars that are spent, and regardless of who is in the majority here I think there is a very high level of sensitivity to resources. But I feel compelled to make the point that there are a limited number of dollars. And I would say to everybody in the system, and everybody is important. The person providing care, whether it be the person who is in charge of the kitchen, or nursing, or doctors, the better quality of care that is provided, that

makes it less necessary, takes less resources, for the inspection part. So I would hope that one of the results of this hearing is everybody will come away very clearly understanding that quality care, taking the dollars and putting it into care, and not further resources because they are not needed in inspection, would be a take away that I hope results and occurs from this meeting today.

Dr. DAIGH. Yes, sir.

Mr. HAYES. I would rather have you inspecting than answering our questions up here, but I am glad you are here and we are going to follow it up. Thank you Mr. Chairman, I yield back.

Mr. MITCHELL. Thank you. Mr. Watt?

Mr. WATT. Thank you, Mr. Chairman, and I want to express the appreciation of myself, Mr. Hayes, and Mr. Coble, our colleagues from North Carolina, for the expeditious manner in which the full Committee and this Subcommittee have followed up on our letter and on independent information about what was going on at the VA hospital in Salisbury, North Carolina. He, the Inspector General, pronounces it “Salisbury,” but in North Carolina we say, “Salisbury,” so. The hospital is in my congressional district, but both Mr. Coble and Mr. Hayes have had long associations with the hospital. It has been kind of in and out of various congressional districts over time, and we all have a strong bipartisan interest in protecting our veterans and making sure that they get quality are. So I want to thank you all for following up, having the hearing, and also for allowing us to be participants in the hearing as nonmembers of this Committee and of this Subcommittee.

Doctor, I want to zero in on the bottom of page three of your testimony, and get pretty precise about the things that you say there. You indicate that on August 30, 2004, the Office of Inspector General, that is your office, received an anonymous hotline alleging that there had been more than 12 surgical deaths in over 2 years on the surgical service at the Salisbury VA Hospital. On September 21, 2004, and I emphasize the next line, “due to limited Office of Inspector General resources, this hotline was referred to the Office of the Medical Inspector.” And the Office of the Medical Inspector did the follow up. And that Office of the Medical Inspector is not in the Inspector General’s Office. Whose line of command is it under?

Dr. DAIGH. The Medical Inspector is an agent of the Under Secretary for Health.

Mr. WATT. Okay. And is it in the VA system?

Dr. DAIGH. That is correct.

Mr. WATT. So in a sense, that was kind of like having the inside people investigate their own problems at some level. I am not being critical of that.

Dr. DAIGH. No, you are correct, sir.

Mr. WATT. And then the Office of the Medical Inspector, according to your information, followed up and did a review in April, in March of 2005, that was 6, 8 months after you received the allegations. And then you got a report in April of 2005. And it issues its report of the hotline allegations and surgical services after the Office of Inspector General’s review. I am emphasizing that again. So you reviewed that report after they did it.

My question to you is on two fronts. And I am going to run out of time, so you may have to give me this information. When I walked in, you were saying that your office has sufficient resources now. I presume that is a change since this occurred, because your report says that you referred this to the Office of Medical Inspector because you did not have sufficient resources at that time. Is that a change? And the second thing I want to find out, because we may have some obligation to the families of those 12 people who may have died as a result of medical misconduct, or medical negligence, is I never saw anything in the report that suggested the outcome of the 12 allegations that were made. Did you, in fact, find that there were any deaths that resulted as a result of inadequate medical care? And are you able to tell us how many of those 12 deaths that were alleged to be as a result of insufficient care, how many of them were actually due to insufficient medical care?

Dr. DAIGH. I am going to ask, sir, that you ask that question to the Medical Inspector, who wrote the report.

Mr. WATT. I would not ask it of you except that you said that this report was issued after the Office of Inspector General reviewed it.

Dr. DAIGH. That is correct.

Mr. WATT. So you all were involved in this after they did the review. Did you ever see anything that really addressed the allegations of the 12 deaths?

Dr. DAIGH. Yes, sir. The patients' care that was the subject of the report, their care was reviewed by outside physicians who were at a local university, a well-respected medical school. And they did a peer review of the care provided. Some of the peer reviews came back saying that the care provided met the standard of care. Some of them came back saying that, "We might have done something different." And some of the peer reviews came back saying, "We would disagree with the care that was provided." The hospital then is charged to take the information and act upon it through its privileging and credentials committee, and through other actions that they would take. So I am aware that the quality of care process stepped up, looked at the problem in what I think is a reasonable way, got outside reviews of that care. What I am unable to tell you, sir, specifically is for each of those cases, what the VA did in response to each of those cases. I am satisfied that people did the kinds of things that they needed to do to begin to properly assess this situation.

Mr. WATT. Mr. Chairman, I realize my time is out. I do think there is a larger problem here, obviously, of what to do going forward to improve care. But there may be some obligations that we have to these 12 individuals, and I would request that the Subcommittee obtain the actual reports on those 12 individuals and see what dispositions were made of them, if it is your pleasure to do so.

Mr. MITCHELL. Yes.

Mr. WATT. I realize I am meddling in your Subcommittee's business, but I would respectfully make that request.

Mr. MITCHELL. We will do that. Thank you.

[The reports were received by the Subcommittee staff.]

Mr. HAYES. Mr. Chairman?

Mr. MITCHELL. Yes?

Mr. HAYES. While we are meddling, I feel compelled to say that, and everyone on the Subcommittee knows overlapping hearings, but Congressman Coble is tied up in a Judiciary Committee hearing and I assume will be here as soon as he can. But thank you for your patience.

Mr. WATT. And I can verify that. I just came from the same Judiciary Committee hearing. But he is the Ranking Member of the Subcommittee that is having the hearing, so he did not have the latitude to leave quite as quickly as I did.

Mr. MITCHELL. Thank you. I appreciate you being here, and any post-hearing questions we will get back to you, we will have those in writing for you.

Dr. DAIGH. Thank you, sir.

Mr. MITCHELL. I know there are some people who have to leave for other hearings, so thank you. I welcome Panel Two to the witness table. Dr. Sidney Steinberg is the Chief of Staff at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina, and has most recently been in the position to oversee reforms at this facility. We welcome his insight and perspectives. Dr. Steinberg is accompanied by Mr. Donald Moore, the former Director of the Salisbury facility and current Director of the Carl T. Hayden VA Medical Center in Phoenix, Arizona. Mr. Eladio Cintron, the Patient Services Coordinator of Salisbury, and Ms. Linda Shapleigh, the Patient Advocate, are also with them. Thank you. And Dr. Steinberg, you have 5 minutes if you would like to make your statement.

STATEMENT OF SIDNEY R. STEINBERG, M.D., FACS, CHIEF OF STAFF, W.G. (BILL) HEFNER VETERANS AFFAIRS MEDICAL CENTER IN SALISBURY, NORTH CAROLINA, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DONALD F. MOORE, R.PH., MBA, MEDICAL CENTER DIRECTOR, CARL T. HAYDEN VETERANS MEDICAL CENTER, PHOENIX, ARIZONA, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS (FORMER DIRECTOR, JUNE 2004–OCTOBER 2006, W.G. (BILL) HEFNER VETERANS AFFAIRS MEDICAL CENTER IN SALISBURY, NORTH CAROLINA); ELADIO CINTRON, PATIENT SERVICES COORDINATOR, W.G. (BILL) HEFNER VETERANS AFFAIRS MEDICAL CENTER IN SALISBURY, NORTH CAROLINA; AND LINDA SHAPLEIGH, PATIENT ADVOCATE, W.G. (BILL) HEFNER VETERANS AFFAIRS MEDICAL CENTER IN SALISBURY, NORTH CAROLINA

Dr. STEINBERG. Thank you very much, Mr. Chairman. As a veteran and someone who served in two previous wars, it is my pleasure to address your Committee and the members here present. I would like to thank you for giving me this opportunity to address your concerns regarding the quality of healthcare provided to our veterans at the W.G. Hefner Veterans Affairs Medical Center in Salisbury, North Carolina. The focus of my remarks will be the improvements and expansion of healthcare at Salisbury.

The Medical Center in Salisbury provides quality healthcare to our veterans in our primary care clinics, including Winston-Salem,

North Carolina, and Charlotte, North Carolina, and across many specialties of medicine and surgery with our academic partner Wake Forest University School of Medicine. In recent years, Salisbury has made a concerted effort to improve the quality of our healthcare and to make access to care readily available to our veterans. We measure our improvements in these areas on a regular basis using a variety of measures, both internal and external. We track disease prevention, treatment outcomes, physician performance, educational processes, and patient satisfaction surveys. VA is committed to make the needs of our veterans, whatever it takes, absolutely positive, and Salisbury is totally committed to that process.

Several years ago with the help of our VISN, the Veterans Integrated Service Network, with their leadership and a handful of very dedicated physicians, VA sought to make improvements in Salisbury department by department. VA leadership brought together the financial and manpower resources necessary to make these changes possible. For example, the waiting list of veterans seeking primary care appointments was a challenge and as a result we now have in place a system where every veteran on the wait list is seen promptly. VA was delighted to have members of Congress join with our former Secretary and Network Director to address the challenges that we faced in 2003 and 2004 with the addition of more than 13,000 veterans to our primary care system.

To accommodate specialty care services in the past, Salisbury had to rely upon a geographic partnership with the Asheville VA Medical Center. However, the addition of such a large number of new patients made it apparent that Salisbury would need to develop its own specialty support system for our veterans. To accomplish this task, VA established a new and stronger relationship with our academic affiliate Wake Forest University. Meeting with the dean of the medical school and the faculty leaders paved the way for the beginning of a new partnership to serve our patients with state of the art healthcare in many areas of need. These efforts led to the establishment of resident physician training programs in a number of specialties. We now have 10 approved positions, including ophthalmology, urology, ENT, psychiatry, medicine, and infectious disease. The superb eye service that we provide with multi-specialty support provided care to 27,000 patients in ophthalmology during the last fiscal year.

VISN leadership continues to engage the Office of Academic Affairs on the regular basis to assist Salisbury in adding more resident positions in primary care, internal medicine, and other specialties. This year, we have added a new affiliation. This particular affiliation is very dear to our hearts and is one which we warmly welcome, with Virginia Tech University in Blacksburg, Virginia. This relationship is key to the development of expanded primary care in the future.

The real benefit of residency training programs to our veterans is that they bring with them the highly skilled faculty members who are capable of providing state of the art care to all of our veterans. The progress VA has made in Salisbury touches every veteran and every employee of the Medical Center. Our staff, our patients, our community leaders, and our medical school educators,

recognize the quality of these additions. These improvements in facility staffing and structure allowed us to provide care to more than 400,000 outpatient visits in fiscal year 2006, as well as providing support for one of our principal components, the Veterans Benefit Administration office in Winston-Salem.

The mental health needs of our veterans are important to all of us and represent a program of excellence in Salisbury. In this area of clinical expertise, we lead our VISN and have on our staff one of the world's most prestigious investigators in the area of traumatic brain injury. Through her efforts and those of her principal neuroscientist, we now have a collaboration with Massachusetts Institute of Technology, Harvard School of Medicine, and the Department of Defense, in providing care and evaluation for patients with traumatic brain injury. This team also serves as a key investigative and educational center for the Mental Illness Research, Education, and Clinical Center know as MIRECC. And this center has the focus of post-deployment mental health evaluations and treatment. Together with other VA Medical Centers in VISN 6, this program strives to advance the study, education, and treatment of all mental health conditions resulting from war.

Mr. MITCHELL. Doctor, could you please wrap it up? You are past the 5 minutes, but more importantly we have to go take a vote.

Dr. STEINBERG. Absolutely.

Mr. MITCHELL. As soon as you are through with your wrap up right now then we are going to recess for 15 minutes while we go vote and be back. But go ahead and finish, wrap up.

Dr. STEINBERG. I will skip to just a brief statement about the surgery programs since that has been a focus of your interest. We faced challenges in the quality of our surgery program in 2003. We have turned the corner and now have a much improved program. The surgery department is totally new. It is headed by a new Chief from Vanderbilt University, and strong clinical staff from other major universities in the country. We have training programs with Wake Forest in many of our specialties, and we are very proud of the progress we have made.

I will be happy to answer any questions you have, sir.

[The statement of Dr. Steinberg appears on page 50.]

Mr. MITCHELL. Thank you very much. And as soon as we get back from voting, after the recess we will come back and ask the questions.

[Recess.]

The first question I have, is the Joint Commission on Accreditation for Health Organizations (JCHO) on June 21, 2006, the report on Salisbury said that there was no documentation to indicate that staff was educated regarding the ability to report concerns of patient safety and quality of care to the Joint Commission. This includes documentation supporting facts that no disciplinary action or retaliation will be taken toward the individual. Can you tell me what that means?

Dr. STEINBERG. Well, we do have processes in place that address the importance of that issue. We have an online reporting system which allows patients, family members, members of the staff, to report incidents to the Office of Performance and Quality which we can address. And we do have within our organization a fairly

strong peer review program, which addresses a lot of these concerns. We had a brief interlude when the peer review program had to be held in abeyance because of conflicts with other governmental agencies, and that had to do with releasing confidential information outside the organizational structure. That has fortunately been relieved by the Office of the Under Secretary, and we are now in synch with a very strong and very positive peer review program that addresses all these issues. And we do take disciplinary action and that action is very firm.

Mr. MITCHELL. Two very quick follow ups on this. The report also states that there was an incident, and I just want to report these incidents, where a patient was on oxygen when admitted to a home-based program. However, there was no order for the oxygen until September 2, when the patient was admitted—excuse me. The order was for oxygen, until September 2 when the patient was admitted on March 5. So there was a real gap between when they ordered the oxygen, and when they released him with the need for oxygen. Is this problem still going on? And how do you keep this from happening?

Dr. STEINBERG. I do not know the specific answer to that question, sir, but I will assure you that I will find the answer to that and send it to your Committee.

Mr. MITCHELL. All right, I would appreciate that. And also, the Joint Commission Report stated that nursing staff were not aware of the safe storage temperature ranges for the medications administered by injection. This was their report. Do you have any written guidelines from the pharmacy on safe temperatures to ensure that the nurses are able to verify medications, and that they are stable prior to administration?

Dr. STEINBERG. Those are all part of the hospital policy, and the nurses are well educated in that regard. We have had some problems in the past with nursing leadership. Those have been addressed, and those modifications in nursing leadership have been taken care of.

Mr. MITCHELL. Would you say all these incidents that were part of this Joint Commission, that they brought up, you have corrected all of these?

Dr. STEINBERG. Yes, sir.

Mr. MITCHELL. Is there any written verification that they have been corrected?

Dr. STEINBERG. Our Office of Quality Management addresses all of these, and reports these questions back to the Joint Commission on a regular basis. I have just recently made a correspondence with the Joint Commission to address other issues, as well. We have a website that we log onto from our Office of Performance and Quality, the Joint Commission website, that gives us information about our progress, what we are doing, and how we have responded.

Mr. MITCHELL. Thank you. Mr. Bilbray?

Mr. BILBRAY. Yes. Doctor, you know there are references to the construction projects and the expansion of the facilities, and I would just like to comment, give you a chance to comment on, frankly my perception is the problem is not your space, it is the breakdown in the entire operational process. And how would you

reflect the issue of the construction and how that may be part of addressing the systemic problems that we saw on the operational?

Dr. STEINBERG. We would love to have a new hospital, but I will leave that aside. We took apart every single piece of the hospital, building by building, and restructured it. The first place we started was in the surgical department, where we got the appropriate funding to build three new major operating room suites. Those suites will open effectively on May 1 this year. State of the art facility which will provide the support that Wake Forest needs, and we need, for providing the technical capabilities of the surgery department that we want to have.

The second thing we did was to take apart all of primary care. With 60,000-plus patients in primary care, we wanted to have a consolidated building to reduce the traveling that veterans had to have from building to building across this 150-acre campus. We consolidated all of primary care into one building, so there was a single site for primary care within the facility. And part of this is in preparation for the opening of two other clinics, one in Hickory, North Carolina, and one in Charlotte. But we now have a model within Salisbury that handles all of primary care within a large building.

Mr. BILBRAY. Well doctor, my point being, though, is that as you talk about, and that is easy because there is some vision, and there is concept of building it. You can buy the most modern vehicle in the world with, you know, anti-roll and all this other stuff. But if it is a reckless driver driving the vehicle, you know, we are still going to have problems. And I do not see where space and a lot of these capital projects have to do with operational problems, like having a patient sit there for over 24 hours, or 12 hours, without having postoperative observation made by a nurse. All of these facilities will not change that. So I think that in all fairness, it is almost like a bait and switch I am focusing here. It is, again, we need more money for construction, but when we get down to the deficiencies, the deficiencies were more internal, operational issues.

Let me just sort of, and accept that as a cheap shot if you think it is a cheap shot. I appreciate that. But you have got positions with vacancies now. Specifically, some of these vacancies, how long have they been open and what are you doing to take care of them?

Dr. STEINBERG. We actually do not have very many vacancies on the clinical side of the house. We have added probably 40 or 50 new clinical positions over the last year and a half. We have gone to various medical schools around the country and recruited some of the top physicians from the Mayo Clinic.

Mr. BILBRAY. How about your Chief Nursing position?

Dr. STEINBERG. Chief Nurse is filled. We have a wonderful new Chief Nurse who has joined us. She was the former Chief Nurse for the U.S. Naval Hospital in Charleston.

Mr. BILBRAY. How long was that position vacant?

Dr. STEINBERG. That position was vacant probably about 4 or 5 months.

Mr. BILBRAY. Four or 5 months?

Dr. STEINBERG. The process of bringing on a key individual at that level is a difficult process because there are a lot of human

resource requirements in recruiting and selecting an individual for that——

Mr. BILBRAY. So you are telling this Subcommittee, under oath, that it was 4 or 5 months. Which one was it?

Dr. STEINBERG. I do not really know the exact timeline.

Mr. BILBRAY. But it was not, your testimony today, doctor, is that it was not over 5 months?

Dr. STEINBERG. The position was never vacant because in the absence of a Chief Nurse there was someone appointed temporarily to that position until the new Chief Nurse could be selected.

Mr. BILBRAY. So are you saying to this Subcommittee, under oath, that there was a temporary Chief Nurse for no more than 5 months.

Dr. STEINBERG. I am not sure of the exact timeline of her visits with us as an interim Chief Nurse, but Mr. Moore could perhaps answer that.

Mr. MOORE. I believe the current Nurse Executive was removed from his position in December and the replacement was brought in, December of 2004, and the replacement was brought in approximately June of 2005. And as Dr. Steinberg had mentioned, at that level recruitment is extended, takes an extended period of time to put an appropriate search Committee together, to interview, most of these candidates apply from around the country so the interview process is quite lengthy.

Mr. BILBRAY. So now the number kind of, that, look I was a history major not a math major. But June tells me that it might have been a little longer than 5 months if it was December to June. Right? Is that fair to say?

Mr. MOORE. Five to 6 months, yes sir.

Mr. BILBRAY. Okay. Thank you, Mr. Chairman.

Mr. MITCHELL. Over the last few years, have you had any problems with credentialing?

Dr. STEINBERG. Well, we have a very good system called VetPro, which looks at someone's pre-appointment credentials so that we know before someone is officially appointed whether they meet the appropriate professional standards to be on the staff. And this process is repeated every 2 years to be certain that there are no gaps in the system. This includes a track with the National Practitioner Data Bank and other issues, and our credentialing system is very good, very capable.

Mr. MITCHELL. Thank you. Mr. Watt?

Mr. WATT. Thank you, Mr. Chairman. And I thank you and Mr. Bilbray for allowing us to be here. I want to do something that is kind of out of the ordinary, which is somewhat spring to the defense of Dr. Steinberg. You will note that he has been in this position only since October of 2006. And Mr. Moore has been in his position longer, but I will tell you from my own personal experiences representing this area and this VA medical facility that there was a period of time when there were major, major problems throughout the whole campus. And at least part of it was due to a Director of the entire operation who really had some serious problems, management issues, over a period of time. And it took a while to kind of work through getting him out.

I can tell you based on the number of complaints that we get in our office that substantial progress is being made. And that the work that is being done by this group of managers, while it may still leave a lot to be desired in terms of accomplishing the overall mission, I can tell you from my own experience that it is light-years better than the prior management. That is not to be taken as a ringing endorsement of everything that is going on at the VA. Obviously, there are some problems in Salisbury. But I hope we will not cast all the blame on this management team, because there was a management team there before that was not as devoted to this. And I think a lot of the problems that we are addressing today are a function of that management team rather than this particular one.

Having said that, Mr. Moore and Dr. Steinberg, I want to be reassured and have the Subcommittee reassured that you all have looked at all 12 or 13 of the points that were made in the evaluation that was done by the OIG and the Medical Director, and have taken specific, concrete steps to address each one of those areas that was identified as shortcomings. Would you be able to verify that you either have taken steps or are in the process of taking steps? And with respect to the ones that you are not now satisfied that you have reached a satisfactory conclusion, would you identify those specifically either today or in writing and tell the Committee what specific steps are being taken in response, ongoing steps, are being taken in response to those?

Dr. STEINBERG. We have taken those steps and we are still taking them. Our Morbidity and Mortality Review Program is as good as any can be within the setting that we have. It is done in concert with a very superb surgical faculty. We have taken steps to improve peer review, including within our peer review system the entire Medical Center peer review, not just for physicians, but nurses, rehabilitation medicine, physical therapists. All of the peer review programs that the hospital identifies and looks at are all brought under one roof for evaluations. We have taken steps to, one of, probably the most important one, was to bring to the Medical Center a whole new post-anesthesia care unit staff, which we did not have in 2003. That was one of the critical shortfalls of the Medical Center. And we now have nine fully trained and certified critical care, or rather PACU nurses as they are called, Post Anesthesia Recovery Nurses, who run an operation which allows us to provide care 24/7 for the surgical patients in the hospital. We have done all those things and we are addressing on a continuing basis through the Office of Quality and Management all of those issues, yes sir.

Mr. WATT. Let me ask you to be, in follow up, more specific on the things that are still in process, not necessarily right now because I am out of time and I know we are up against the voting deadline. But if you could just outline, unless you have done so in your written testimony, the specific steps that you have taken that are still in process at a subsequent time.

Dr. STEINBERG. Right. One of the specific things that is still in process is to improve our educational program. And we are doing that in several ways. But one of the things that we felt was very important was to continue the ongoing educational processes that

are important for things like peer review, morbidity and mortality review, educational processes that physicians, nurses, and other staff members need to be certain that they have the tools to address these issues on a regular basis. The anonymous reporting system that we have for staff members at the hospital that allows us to have in our hands, anonymously, any issue that anyone wants to bring to our table to discuss is something we welcome, and we are expanding that program on a regular basis.

Mr. MITCHELL. Thank you. Thank you. Mr. Hayes?

Mr. HAYES. Thank you, Dr. Steinberg and Mr. Moore and others for coming today. I think fairness is important. I appreciate Congressman Watt's comments. I, too, would like to say that in our district office we have had a number of compliments for exceptional care, and that is important. And we do have an occasional complaint, and we are talking about some very serious issues. Dr. Steinberg or Mr. Moore, should the nurse that I referred to in my statement have been fired?

Mr. MOORE. Actually, I had proposed removal of that nurse. And we were planning to fire her. Then upon advice from regional counsel and human resources, they recommended that we not fire her and it was based on three issues. One, she had had no adverse, any other adverse, actions in nearly 30 years of service. While what she did was just terrible, it had no effect at all on patient care. She was not the patients' caregiver in these nursing homes. Her role was an oversight role, a vendor oversight, to see that the vendors did under contract what they were supposed to do. And third, regional counsel said it was very unlikely that any outside disciplinary appeals board would uphold the firing. That we could go through a protracted length of time, hundreds of thousands of dollars, and wind up with her back. So they had several recommendations which I felt were too light for this situation. I went with the proposed removal, and then did hold it in abeyance for 2 years.

Mr. HAYES. I appreciate the completeness and the detail of your answer. However, the facts would ask that additional oversight be provided here for someone to report that a patient was stable 12 days after they had died. And again, let me stop there and back up just a minute. We appreciate the service of veterans hospital employees and others who are tremendous civil servants. And there are requirements, and those employees have rights and deserve to be protected as well. So with the qualification, again I would like you to report back to me and Congressman Watt and others, is to, the reluctance of the oversight board, the problems of a termination here. I think we should look at that a little bit more closely because number one, you have got the 12 days after which the person had passed away, but you have also got over 2 years where this person had not visited. Something was wrong. This person had issues that were keeping them from doing their job, but let us look more deeply into that. Because the confidence of the Subcommittee, the public, and other members of the VA, it is not as important as the care of the patient, but it is very important going forward that we do not have a system that allows someone whose performance determines life or death, in some instances, of the patient, let us investigate that further and review it more.

Dr. STEINBERG. That, sir, is a very important statement. And the CAP survey did point out another very serious flaw in the system, which I would address with you, and that I think we have corrected. What we found was that we were never notified by any of the contract nursing homes when they had been placed on a Licensed Agency Watch List. In other words, they had done something which had raised a red flag about the care that they provided in these contract nursing homes. We had no way of getting that information automatically. We have had our contracting folks change the rules now, so that as part of their contract if they are notified by any agency that they are placed on the Watch List that they have to report that to us within 10 days. That is a very important change in the system, and is a reflection, I think, of the findings from the CAP survey.

Mr. HAYES. It is important. Thank you for pointing that out. Mr. Cintron, or Ms. Shapleigh, do you have anything you would like to add to that? That is what the newspaper always does when they want to trick you into saying something. Thank you very much. Mr. Chairman, I yield back.

Mr. MITCHELL. Thank you. And I would just like to tell the panel, any reports that were asked by either Mr. Watt or Mr. Hayes, if you would address those to the Subcommittee, and then we will distribute those to the members of this Subcommittee and those who ask for it. So, please give those reports to us.

Just very quickly, a couple questions to Mr. Moore. And Mr. Moore, it is good to see you. He took me on a tour of the Carl T. Hayden Medical Center in Phoenix not too long ago. Just very quickly, how are doctors and nurses screened throughout the whole VA system to ensure that they are in compliance with the VA medical guidelines?

Mr. MOORE. Well, as Dr. Steinberg had alluded to, we have an extensive credentialing and privileging process. And I really can only speak to the hospitals that were under my management, but the systems are common to all hospitals. There is a, I would venture to say our screening and prescreening process is far more stringent than any private sector. We have actually had some physicians decide maybe not to come to the VA because we went so far back in their history, getting all of the, assuring that all of the credentials were appropriate for them.

Mr. MITCHELL. So, all their verifications with their licenses and their practices, this is all done——

Mr. MOORE. Before they walk in the door, yes sir.

Mr. MITCHELL. Okay. I have one other question, Mr. Moore. I want to depart from what we have been saying here. One question that my constituents would like to know, are there any quality care issues at the Carl Hayden VA Facility in Phoenix that I should know about? Especially in light of issues that we are addressing today. I do not want to find out that there are problems at the Carl Hayden VA Hospital from the newspaper, like some of the reports that we have been finding out lately. So, are there any quality of care issues that we need to know about at the Phoenix facility? And if there are, what are they and what are we doing about it?

Mr. MOORE. Well, I certainly hope that there are not. There is always clinical issues that we are looking at. We look at different

rates of deaths in intensive care units and other areas. But there is nothing that I am aware of that should be of major concern that would put any of our veterans patients and their care in jeopardy at the Carl T. Hayden VA Medical Center.

Mr. MITCHELL. So you do not think there is going to be anything I am going to be reading about in the paper about the Carl Hayden Medical Facility in terms of quality of care?

Mr. MOORE. No, sir. There was an Office of the Inspector General CAP survey at the Carl T. Hayden VA Medical Center I believe just several weeks before I got there. And it was one of the best CAP survey reports that I have read. So I was very proud to be coming into a facility that achieved such a great survey.

Mr. MITCHELL. All right. I do not want to read about any problems with that facility. Thank you. Thank you very much. And we are going to recess this Subcommittee hearing until after the vote, which is about 15 minutes.

Mr. BILBRAY. Mr. Chairman, can I just ask quick question? Doctor?

Dr. STEINBERG. Yes, sir.

Mr. BILBRAY. The sort of the last ditch tickler that there is a major problem is usually the morbidity review. There are no minutes of a Committee reviewing the deaths in the facility. Did you have a review process or was there a review process?

Dr. STEINBERG. We review every death at the hospital. We do a lot of RCAs to look at these.

Mr. BILBRAY. Do you do it with a review Committee?

Dr. STEINBERG. We have a review Committee, we absolutely——

Mr. BILBRAY. Is there a reason why there were no minutes to the Committee?

Dr. STEINBERG. Well, I think we have minutes.

Mr. BILBRAY. Now?

Dr. STEINBERG. I do not know what the history was, you know? I was not there for that at the time, but we have good minutes now.

Mr. BILBRAY. Okay.

Dr. STEINBERG. They are well recorded, and our morbidity and mortality data ranks the VA Medical Center in Salisbury within the top eight VAs in the country. We are below the morbidity and mortality levels——

Mr. BILBRAY. But prior to your arrival?

Dr. STEINBERG. The numbers were not good. You know, part of the reason for the issues that were brought up by that anonymous call had to do with the fact that there were procedures done in the operating room which belonged in an endoscopy suite. And if you look carefully as we did at the 12 alleged deaths, many of these were in terminally ill patients who were part of the hospice unit who had feeding tubes put in for palliative reasons. And their deaths were anticipated deaths, and they were not related to a surgical procedure per se.

Mr. BILBRAY. That is not what I was concerned about. Again, I am going over the procedure. We have corrected the procedure that, the reports I had was that they did not have a functioning Committee reviewing these deaths, or at least we do not have any records of them. And that, let us face it, that is sort of the last

ditch catch all, is always reviewing every time we have a death in a facility, is to make sure that the process that led up to that death was well within the parameters of the facility.

Dr. STEINBERG. I would not minimize the problems that were there in years past, because they were significant. It is my hope and prayer that we address all of them effectively as we have in the last few years, and that we will continue to do that. But there were mistakes made and there were serious problems and we think they have been corrected.

Mr. BILBRAY. Thank you very much, Mr. Chairman.

Mr. MITCHELL. Thank you. We are going to take about a 20 minute recess. And when we come back we will see Panel Three and will continue. This meeting is recessed.

[Recess.]

Mr. MITCHELL. We will reconvene the Subcommittee on Oversight and Investigations for the Committee on Veterans' Affairs. And I would like to just mention that the Ranking Member will not be here. She is tending to one of her own bills, which is having a hearing right now. So instead I will have the Minority Counsel follow the line of questioning that would have occurred.

At this time we are welcoming Panel Three. Mr. William Feeley, the Deputy Under Secretary for Health for Operations and Management is here courtesy of the VA and I would like to welcome his thoughts. He is accompanied by Dr. James Bagian, the Chief Patient Safety Officer, Dr. Barbara Fleming, the Chief Quality and Performance Officer, and Dr. John Pierce, the Medical Inspector. Mr. Feeley, you have 5 minutes to make your comments.

STATEMENT OF WILLIAM F. FEELEY, MSW, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JAMES P. BAGIAN, M.D., CHIEF PATIENT SAFETY OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; BARBARA FLEMING, M.D., PH.D., CHIEF QUALITY AND PERFORMANCE OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JOHN R. PIERCE, M.D., MEDICAL INSPECTOR, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. FEELEY. Good afternoon Mr. Chairman and mmbers of the Subcommittee, and I want to thank you for the opportunity to be here today. I want to state that Salisbury has turned a corner and I am pleased with the positive steps they have taken to improve the quality of care provided at the VA Medical Center during the past 2 years. In my statement, I will focus on the many ways VA monitors the healthcare of our veterans and returning warriors and ensures that our VHA facilities learn from this process.

In the late eighties, VA healthcare programs came under intense scrutiny because of the perception that quality was not comparable to that found in the private sector. Since that time, VA has implemented numerous programs to ensure that quality of healthcare provided to our veterans is world class. The results of these efforts have brought national recognition to VA as consistently being rec-

ognized as one of the premier healthcare providers in the United States. VA's successes can be attributed to the leadership and contributions made by the offices of the talent sitting with me today, as well as the daily efforts of the VHA workforce.

VA's performance measuring system is a key part of the transformation of care that started in the mid-1990's. The system has over 100 performance measurements in the areas of access, satisfaction, cost, and quality. Data on these measures are collected monthly and all performance is shared and distributed in a quarterly report to the field facilities with information broken down into aggregated totals for facilities, network, and the VHA overall performance. Patient complaints are assessed by a series of questions on the inpatient and outpatient satisfaction survey asking whether each veteran has a complaint about VA care and whether the veteran was satisfied with the resolution of the complaint. Patient advocates in the National VA Patient Advocacy Office monitor these results closely to ensure that veterans' voices are being heard daily.

VA utilizes a learning system that exports and disseminates information to all segments of the VA healthcare system so that providers can learn how to deliver care that is not only safe, efficient, cost effective, but clinically measurable and evidence based. For example, the systematic ongoing assessment and review strategy, known as SOARS, is a unique internal initiative that was implemented within VHA in 2004. Our own staff are trained to conduct assessments of more than 30 major processes at facilities to identify weaknesses, best practices, and help educate staff required for functions and activities across the country. These are not people reviewing their own facilities; these are people reviewing other facilities. This innovative approach promotes a culture of continuous learning and readiness throughout the organization.

As a public system the VA undergoes intense scrutiny from a variety of accreditation agencies, both external and internal. There are approximately 45 different types of reviews that can occur at our Medical Centers during any period of time. One of the most recognized is the Joint Commission on Accreditation and Healthcare. All our VA facilities are accredited. Also, the Office of the Inspector General, the Government Accounting Office, are frequently visiting our facilities and giving us feedback on how to improve our system. Both the JCHO and OIG reviews give us ongoing opportunities to identify our strengths and weaknesses.

I appreciate the opportunity to talk with you today. The events at Salisbury have spurred us to go even farther in our monitoring process than I have described to you. I am instituting additional rigor with oversight in transporting our learning throughout the system. The more rapidly we learn, the better our patient care impacts will be. I look forward to taking any questions that you might have, and that concludes my statements. Thank you.

[The prepared statement of Mr. Feeley appears on page 52.]

Mr. MITCHELL. Thank you, Mr. Feeley. I have a couple questions for Dr. Pierce. I know the focus here is on Salisbury, but we are also trying to find out if procedures and things at Salisbury are also going on in other hospitals, because this is a concern we all have. In the June 9, 2005, report you stated that the culture of surgery service was not one of quality improvement. You stated that

there has been inadequate ongoing review of the quality of care provided by the surgery service, as their participation in performance improvement has been lacking. Firstly, I want to know, what has Salisbury done to rectify this? And is this problem solely one that is at Salisbury, or is this problem found in any other VA hospitals?

Dr. PIERCE. Good afternoon, sir. I feel like Salisbury has done a very good job to correct this. I think they have turned this program around 180 degrees. And if they were, if I were to grade them from when we first went I would have to give them probably a D minus, but I would have to give them a very strong B plus now because they have grabbed this problem by the throat and taken care of it, I think. They have new personnel, and they have a new commitment to quality management. They have a new quality management nurse that is in the surgery service, and they have grasped the requirements and they are doing a good job with that.

We have seen some, probably not quite as broad, but some similar issues at other facilities. For example, we went to a place to look at their surgical program and they were doing surgical morbidity and mortality Committee meetings but they were not doing minutes. And so we took that information back to the National Director of Surgery and on a systemwide conference call he made sure all the Chiefs of Surgery understood that not only do they have to do an M and M Committee meeting but they have to do minutes of that Committee. And that was spread throughout the whole system. So we do take the information we find and try to transport it throughout the whole system.

Mr. MITCHELL. I think you understand that our concern is that while we know that you said maybe Salisbury had a D minus, and it was very bad, and so that is why you came in. But we want to make sure that other hospitals do not ever reach that level. I think it is up to you to make sure that what you found in other hospitals is transmitted. And if you had a conference call, for example, on minutes I would hope that there are systemwide conference calls very frequently so that what you find in one place can be transmitted and everybody is aware of how to correct these.

Let me ask also, Dr. Pierce, have you gone back to Salisbury for a follow up from your initial visit in 2005?

Dr. PIERCE. Yes sir, we went back last month. You know, when we first went there, what our process is, is when we go to a site visit and we come back and write our report, we usually make a number of suggestions for them to change things to improve things. And those things, when they are agreed to by the Under Secretary for Health, the facility does an action plan addressing each and every one of those items. And I think the initial Salisbury report had 18 findings on it that they had to address. The facility did an action plan, and addressed each one of those 18 findings. We reviewed the action plan, and then we approved the action plan. And over the course of the next year, we tracked those items with input from the facility to show to us that they had corrected these things.

Mr. MITCHELL. And they have met them?

Dr. PIERCE. There is follow up on our reports. That came up before, that we follow those reports up and every finding that we have, an action plan is done and we track that with the facility,

and make sure that those things are done. And then once they are done, which sometimes it takes a year or so for everything to be accomplished to our satisfaction, we usually close the report.

Mr. MITCHELL. Have they been closed?

Dr. PIERCE. We did close the Salisbury report in August of 2006.

Mr. MITCHELL. Thank you.

Dr. PIERCE. And we did go back about a month ago to make sure, just to check everything, and we felt like that they had responded appropriately to all of the things that we had found there. We did find that, we had asked them to make sure that they informed the families about autopsy findings. And we asked them to show us their autopsy reports for the last couple years. They do not do a lot of autopsies there, and there were seven total reports. And of those seven reports they were not all done to our satisfaction. They need to improve that, and I think they are aware of that. So there was only two of those where there was documentation in the medical record that the family had been notified. There was another documentation elsewhere that letters had been sent to the family. There were a couple that apparently they could not document they had actually talked to the family about the autopsy results. So that was one of our findings that they have not completely responded to.

Mr. MITCHELL. All right, let me ask just one quick follow up. Every time you find a deficiency in these, I would hope that you would pass this finding onto other medical facilities. That you would not have to go to each facility and say, "Oh yeah, we just had this same problem in another State." That you would make sure, that if these things were not followed in Salisbury, for example, communicating with family members, I assume they probably were not being followed in other hospitals as well. I would think that every time you find a problem in one, that you have a conference call or you have something that says, "Hey, we need to make sure." If it is done in one, I suspect it is going to be done in another. Thank you. Mr. Wu?

Mr. WU. Mr. Chairman, Ms. Brown-Waite, the Ranking Member of your Subcommittee appreciates your indulgence in allowing the Minority Counsel to pursue her line of questioning, and I thank you again.

Mr. Feeley, we have read in your testimony about how the VA's National Center for Patient Safety has made great strides to have VHA understand and prevent adverse events to our veterans patients. I would like to recognize Dr. Jim Bagian, who is accompanying you, for all his efforts in spearheading these preventive, lifesaving measures. I especially appreciate his efforts in bringing the dangerous practice of incorrectly cleaning and disinfecting a special ultrasound device used for prostate biopsies. His discovery and immediate alert on this potentially extremely dangerous practice prompted this Subcommittee to bring the FDA lack of interest in issuing a national alert to the forefront, and resulted in a national alert warning to help protect all patients, not just veterans. Thank you, Dr. Bagian. Would you like to talk on your role in how we use the Patient Safety Center that you head up in recognizing these adverse events and trends so that you can prevent them on a systemic basis using Salisbury as a study?

Dr. BAGIAN. Sure. Yes, I would be glad to. Thank you. I would like to make a few remarks to start out with. Earlier the question was asked, I think, of Dr. Daigh, how collegial, the word was not collegial, but the interaction between OMI, OIG, and the VA. And I would like to say from the beginning when we set up the Patient Safety Program with the VA one of the first sets of meetings I had, and they were the predecessors of Dr. Pierce and Dr. Daigh, was to talk to them because my view, and I think the view of VHA, was that though it might not always seem that way, we are working toward the same goal, and that is to deliver the best quality of care and safest care we can to our patients. And if they would know something or discover something that we did not know, and that certainly can happen, we want to profit by that. So that is one thing I would like to get out front, and we continue to have, I think, a good ongoing relationship in that regard.

We have numerous ways that we find out about things. Some are through formal reporting systems, and we have several of those. I would point out that we look not only at adverse events that happen, some of which have been discussed today, but we also look at close calls. Close calls are those events that could have resulted in harm to the patient but did not, either due to a good catch by somebody or sometimes just good luck.

Mr. WU. Well, let me interrupt you for a second here. In your reporting system on close calls and non-attribution on reporting near misses, using your system and the way you have educated the system and tried to promulgate that, did any of the events at Salisbury ever rise to your attention based upon the system that you utilize?

Dr. BAGIAN. Absolutely yes. In fact, the one case that was talked about is the index case, the surgical case that was mentioned a little bit earlier. That case occurred, if I recall correctly, on July 14. The RCA Panel was convened and charged on July 14, and I believe on August 23 they had concluded the RCA with their recommendations and action plans were filed. So it was well within the prescribed period of time to respond and action was already being taken. I mean, that is one for example I know of in detail, off the top of my head.

Mr. WU. Well, how would you follow up, once it reaches your radar screen, and the RCA, the Root Cause Analysis is done, that you follow up, or what is the follow up mechanism of whether or not that facility and those findings are corrected or remedied?

Dr. BAGIAN. Okay. When an RCA is submitted, well, there are a couple of things in the flow. Firstly, when the incident is first discovered and is SACed, that is when they prioritize it and that is where we have a very explicit method by which we decide does this rise to the level that requires action. In the case of that surgical case, that met that mark. Even if it does not, it is filed in our data collection system so we get it right then. At that time, we will review that. If we think it is something that has global impact based on just a few sentences that were reported. We do not know all the things yet, it is just that it happened. If we think this is something, and that is what happened with the ultrasound you talked about. Before the RCA, Root Cause Analysis, was even completed we real-

ized this was much bigger than that and we in parallel did the things that you referred to.

Mr. WU. Well, how was your system used in those issues that rose to your attention out of Salisbury then?

Dr. BAGIAN. Okay. So what happens is, in this case the Salisbury incident, that first report that there had been a patient incident was not enough to say is this a generic widespread thing, as the Chairman talked about a few moments ago. It was not clear. So we waited for the results of the root cause analysis. When the root cause analysis is finished, it is submitted to the National Center for Patient Safety. They are all filed with us, and they are reviewed by our analysts there. And there are a number of criteria. But then they feed back to the institution if there are things that appear to be lacking, for instance specificity of causation statements or weaknesses of corrective actions, and that is fed back in a short period of time.

At that point, in the forms, in the system, it also sets reminders. So, for instance, if they say——

Mr. WU. And Dr. Bagian, I see that my time is up and I do not want to outlive my welcome with Chairman Mitchell. And I will pursue this on the second line of questioning. Thank you, Chairman Mitchell.

Mr. MITCHELL. Thank you. Mr. Watt?

Mr. WATT. Thank you, Mr. Chairman. And this is likely to be my last opportunity to reinforce something I said earlier to you and the Ranking Member of this Subcommittee and to the Chairman and Ranking Member of the full Committee how much we appreciate, Congressman Hayes, Congressman Coble, and myself, the speed with which you all undertook this review and the thoroughness and attention that you have paid to it. And also, to thank you once again for allowing us, as nonmembers of the Veterans Affairs' Committee, to be active participants in today's hearing. So I know I have said that three times now, so three times is the charm and I will try not to say it again.

Mr. Pierce, I think I want to follow up with you because the Inspector General kind of threw a ball to you. And I want to break this down as concretely as I can. This original investigation was started by an anonymous phone call that alleged that twelve veterans had died as a result of improper medical care. And I am putting myself in the position of the family members of those 12 people. And I would like to know, obviously what Mr. Feeley has said, that attention has been given to correcting the problems and that the VA Hospital at Salisbury has a B plus report. We hope it gets up to an A at some point going forward, and that quality medical care is provided to all veterans going forward. But the other side of this is that the question I raised this morning, is our responsibility to those 12 families. An investigation was done by your office, and an evaluation was made individually, I assume, of those 12 cases. Is that correct?

Dr. PIERCE. Sir, our office did not look at all 12 of those cases. Those 12 cases, in fact, let me back up a little bit. The anonymous information we had had no names of patients.

Mr. WATT. Yes.

Dr. PIERCE. It mentioned one patient, the gentleman that was the surgical index case in our report of 2005. The other, we did not have any names for.

Mr. WATT. Well, at Salisbury VA Hospital, how many deaths would you have on average in a 1 or 2 year period before this anonymous tip came?

Dr. PIERCE. The information that I have looked at from the facility, their reports, including the nursing home and the psychiatric units, they have about 50 deaths every 6 months. So it is about 100 deaths a year.

Mr. WATT. So you would have had to go back individually and review all 100 of those cases for the prior year?

Dr. PIERCE. Well, the assumption was that these were from the surgical service because of the way the letter was——

Mr. WATT. Okay, how many would you have in the surgical service?

Dr. PIERCE. Well, I think these 12 deaths, what they did is they went back 2 years and it equated to about 12 deaths, and they had all 12 deaths reviewed by their affiliate medical school.

Mr. WATT. Now——

Dr. PIERCE. We looked at those, and we looked at those reviews that the medical school did, and thought they had done an acceptable job in reviewing those.

Mr. WATT. Okay.

Dr. PIERCE. We pulled out the case that became the index case for us because we thought that was particularly problematic, and went to the facility to specifically look at that case and the care that that gentleman got.

Mr. WATT. Okay, well let us look at the other 11 cases first. You are saying that your determination in the other 11 cases was that there was no lower than expected quality of care?

Dr. PIERCE. In those 11 cases, 5 of them were rated as they received care that every other doctor would give.

Mr. WATT. Okay.

Dr. PIERCE. Five were rated that we might have done some things a little different, and two were rated we would have done it differently.

Mr. WATT. Okay. Let us look at the seven, then, that we have narrowed this down to, and what I am trying to get to is what is our obligation then, what then happens with the families of those seven people? There is a possibility that less than adequate medical care has been provided to their loved one. There is a possibility that their loved one may have died as a result of that lower quality medical care. What is our responsibility? What is our follow up? What do we do with a family in that situation?

Dr. PIERCE. We have a requirement if an adverse event has occurred, whether it results in a death or not, but just an adverse event occurs to a patient, the patient has to be told about that. And so in these seven cases or, you know, we would look at those cases——

Mr. WATT. Well, we know an adverse event occurred. They died. So that was an adverse event. Who would have the responsibility of going out and communicating with the family of that patient and looking them in the eye? And what would you say about the quality

of care? Would you just say your loved one died and it is unfortunate? Or how much information would we give the family about the circumstances of that investigation?

Dr. PIERCE. I think full disclosure is what we would like to see. That if we have done something incorrect medically, the family should be told about that and should be offered the opportunity to file a claim about that.

Mr. WATT. Okay. All right. I know I am out of time. I am sorry.

Mr. MITCHELL. Thank you. We can come back. Mr. Coble?

Mr. COBLE. Thank you, Mr. Chairman. I want to reiterate what Congressman Watt said. Thank you for extending the courtesy to him, Congressman Hayes, and me for this. And I want to thank Congressman Watt also for explaining my absence earlier. I was tied up in a Judiciary Committee hearing and simply could not get over here.

Congressman Watt, Congressman Hayes, and I are involved. The facility is located in Congressman Watt's district. He and I share the county in which it is located, and Congressman Hayes represents the adjoining county. So that explains why we are the triumvirate in this matter. We received responses from our joint letter from Salisbury and it appears they are responding favorably to criticisms that were leveled earlier. I guess one thing that prompted a lot of attention, not only to Salisbury but elsewhere, when the problems at Walter Reed surfaced, I think many folks said, "My gosh, if it is this bad at Walter Reed, what is it like in the hinterland?" And I think that may have triggered a lot of the attention.

As an aside, Dr. Pierce, this has nothing to do, well, this has something to do with Salisbury as a matter of fact. Most of the complaints that we received down home, Mr. Chairman, in my district, do not involve the delivery of quality healthcare. Most of my veterans are not unhappy with that. That is not to say we do not get complaints, we do. But for the most part, the complaints zero in on the delay that the veterans incur before claims are approved, as an example. And that is just for your information. I want to throw that out.

And Mr. Chairman, let me ask you a question if I may. Does the Committee on Veterans' Affairs plan to follow up on the Salisbury matter?

Mr. MITCHELL. Yes, Mr. Coble. In fact, in earlier panels there were some reports that were asked for by Mr. Hayes and Mr. Watt.

Mr. COBLE. Okay.

Mr. MITCHELL. And when we get those report back we will communicate them.

Mr. COBLE. And I think that is important, and that pretty much exhausts my line of questioning because I haven't been here earlier. And I again apologize for my delay, but thank you for having the hearing. Thank you all for being here.

Mr. MITCHELL. Thank you. Mr. Wu, do you have any followup?

Mr. WU. After you, sir.

Mr. MITCHELL. I do not have any. I am fine.

Mr. WU. Thank you, Chairman Mitchell. Question for Mr. Feeley. In your testimony you stated that by issuing a multitude of important directives to improve patient safety, "VA has acquired the ability as the largest integrated healthcare system to affect change

and impact millions of patients." I think this is very important, and you can stack those directives from the floor to the ceiling, but can you explain how you can ensure implementation? And what is the process to go back and check for the continuing compliance?

Mr. FEELEY. I think we are really operating with a trust and verify design. We have numerous ways that we get information out: emails, teleconferences, directives. But we also have a training that employees get and we have numerous systems in place where we go out and review. And one of those systems is the SOARS process. There are 42 different checklists that we have got in the SOARS process, not dissimilar to the same type of checklist that a flight crew would use before it takes off. So you want to make sure everything is in place and working. That goes on at a national level, it goes on at a network level, and it also goes on at a facility level via our quality management department and utilization review programs. So the more rapidly we transport learning, the better we are going to perform. But also, we are out there verifying that actions are being taken.

Mr. BILBRAY. Mr. Feeley, I have a question for you. Your SOARS Program has been in place for how long?

Mr. FEELEY. Since 2004.

Mr. BILBRAY. So what happened at Salisbury that this was not detected, then?

Mr. FEELEY. SOARS visits sites on a schedule, and we I think visit 47 sites per year. I do not know whether a SOARS visit has occurred at Salisbury, but would like to defer to Dr. Steinberg.

Dr. STEINBERG. I am right here. We had a SOARS visit this past year. I am not aware of a previous one.

Mr. WU. Mr. Feeley, could we have the results of that SOARS report for Salisbury? The other question I have, and I am trying to make efficient time for my 5 minutes here for the minority. Dr. Pierce, it is my understanding that you have issued six OMI reports in the recent past. Is that not correct? Two part question. Is a follow up to those OMI reports any more expeditious and thorough than what has been done on the Salisbury 2005 OMI report? And two, to the best of my recollection as the staff director of this Subcommittee for the minority side, we have asked for all OMI reports on a timely basis upon release, and unless our mail system has failed us abjectly I do not believe that we are in possession of the majority of those OMI reports. And I know that those are, I would not say close hold, but is there a reason why we have not received those, this Subcommittee?

Dr. PIERCE. Sir, I do not know if there is. We have forwarded your request several times, that these reports be sent up to you once they are approved by the Secretary.

Mr. WU. Do you think it is the Subcommittee? Me? That we are not receiving these?

Dr. PIERCE. I will look into it, sir. I cannot answer that.

Mr. WU. All right.

Dr. PIERCE. The first part of that is, the follow up of our reports depend upon the things that have to be done. Some of the things that the facility has to do are relatively minor and can be done fairly quickly. Others take longer. With this report we had 18 things the facility needed to do and so that took longer to accomplish.

Mr. WU. All right. If it would not be unreasonable to request all outstanding OMI reports for the past 2 years. If we could have them by close of business tomorrow, if that is not too adverse and laborious an issue. We would like to see that. I understand that there is also an OMI report on Asheville?

Dr. PIERCE. Yes, sir.

Mr. WU. Okay. Mr. Chairman, if we could get those delivered to us.

[The Subcommittee received the OMI reports from VA.]

I do have one other question, here. Dr. Fleming I hate to have you come up here without being able to say anything and we are bringing you up here. I know that you would rather not say anything. But as the Chief of Quality and Performance, how would you rate the 100 performance measures in the areas of access, satisfaction, and quality at Salisbury right now?

Dr. FLEMING. We checked all of our numbers. We have audited their credentialing, we have looked at their performance from 2002 when there were really problems, we have looked at our Joint Commission reports, we have looked at the OIG reports, we have looked at the OMI reports. Salisbury is really a success story. It is, in my view, a phenomenal story. They are now ranked I believe 35 in terms of quality, access, and satisfaction aggregate score of our facilities.

Mr. WU. Out of the 152 facilities?

Dr. FLEMING. We have enough data actually to rank I think 140 of those. So they have just done a phenomenal job. The measures that we have looked at that they have had problems with, they have really turned around. They have processes in place that we actually have also replicated on a national level. That team at that facility took their problems to heart and really did some fixes. So I would be pleased to get care, personally, there, and I think our veterans should feel very comfortable at that facility at this point in time.

Mr. WU. All right, Dr. Fleming, I know the red light is on, Mr. Chairman, Mr. Feeley, and Dr. Pierce, how would you rate Salisbury today? If you were the teacher, what would the report card be? You can all three confer and come up with an average.

Mr. FEELEY. I am going to stick with Dr. Pierce's rating of B plus. Having said that, though, the goal here is to get an A, because I think veterans deserve that and we had better be constantly looking to improve in every one of our locations.

Dr. FLEMING. And I just would like to add that they are actually a model for the kinds of improvement and the kinds of commitment to improvement with this team that is currently there.

Mr. WU. Thank you very much. One last comment I would like to make is I am retired from the military, and I see your Chief of Staff at Salisbury, Dr. Sid Steinberg, used to be the Commander at the Fort Belvoir Hospital, and he had such a reputation of being such a hard charging guy that I made every effort that I did not have to work for him. But I am sure that you are in good stead with him.

Dr. STEINBERG. Nothing has changed.

[Laughter.]

Mr. WU. Thank you very much, Mr. Chairman.

Mr. MITCHELL. Thank you. And just add one thing to what Mr. Coble said, I think that every Congressman and every Senator here would say the same thing. When they get complaints, the biggest complaint is time and waiting in line. And something really needs to be done with that, because that is a universal complaint that I think we all hear. Mr. Watt.

Mr. WATT. Thank you, Mr. Chairman, once again. And I will not prolong this, but with two questions, one of which I hope you will follow up with the Committee to provide the answers to. A full report of whatever exists on the contacts that were made with the families of those seven individuals that we have narrowed this down to now, because it may have some implication, may not, for how we deal with families and what kind of rules of the road may be important going forward. And second, on the one that we really zeroed in on at the end of the day, tell us, if you can, what the remedies are in the current legal framework that we have set up for veterans. If somebody were in the private sector, there would be some possibility of pursuing a cause of action for medical negligence. What is the counterpart to that in the VA system? I mean, what is the remedy?

Mr. FEELEY. I would like to comment that Dr. Pierce described the policy and the policy is when there is a clear mistake we have made, we have a responsibility to sit down with the patient. And if the patient is deceased with the family members and explain what has happened. That is usually done by the Quality Management Department Head and the Chief of Staff, the Director might become involved, and at that point in time usually some sort of investigation has occurred and findings have occurred, and we are going to discuss with them what has happened. We are then going to advise and give them counsel on how to file a tort claim, which is how they seek compensation from the Federal Government for any error that——

Mr. WATT. So it is under the Federal Tort Claims Act?

Mr. FEELEY. Correct.

Mr. WATT. Okay. All right.

Mr. FEELEY. And I would say to you that this is the way it is supposed to be, and I think we have many, many people operating that way. Healthcare providers come to work to do a good job, but they also know the only way we are going to learn is unfortunately from errors that we make and get better.

Mr. WATT. And when you sit down with the family, once that is done is there a report rendered on that meeting? I mean, can the Subcommittee expect at the end of each one of these seven processes that there will be a report of a meeting with a family?

Mr. FEELEY. What I would indicate to you is I described the way the process would happen in any case, across the country. As it relates to the seven cases, I did not pick up, Mr. Watt, what Dr. Pierce said, whether there was a negligence issue in these cases. I may have misunderstood him.

Dr. PIERCE. Well, two of the seven were level three findings. And the other five were level two findings. And so there may not have been any negligence, and a level two finding is that some people might have done this differently but some people would have done it the way you did it. And so there——

Mr. WATT. What would you say to a family under those circumstances? I guess what I am trying to figure out is what would be the protocol when there is even a question raised insofar as dealing with the family member or members.

Dr. PIERCE. I think that different physicians would handle that differently. I doubt if they would have a meeting with the Chief of Staff in a situation where the finding was that some people would have done this the same way, and so there was no malpractice there.

Mr. WATT. No, in those seven, as I understand it, there was a determination that some people would have done it a different way. The five you eliminated because some people, would all people who reviewed it said they would have done it the same way. The seven, that is the reason I zeroed in on the, what I am trying to find out is what is the protocol when that question is raised. There might be a protocol for those, and then there might be a separate protocol for those where you actually make a determination, "Yes, somebody did something wrong." But there should be a protocol for both and I think it is our responsibility to the families to know what the protocol is and if requires adjustment, have the Committee make an evaluation of it. That is the only question I am raising. I am not saying anybody did anything improper. I just, this is information that is being generated retrospectively just as the Council is trying to get information about information going forward. So that is the request I would make.

Mr. MITCHELL. Mr. Coble, anything? I think that exhausts our questions, but I do have a concern. I know this was a case study on Salisbury. But how many medical centers did you say we have throughout the Nation?

Mr. FEELEY. One fifty-four.

Mr. MITCHELL. One fifty-four?

Mr. FEELEY. Be aware, too, Mr. Chairman that we have about 850 clinics.

Mr. MITCHELL. Right.

Mr. FEELEY. So we take it very seriously in monitoring the quality in those clinics as well.

Mr. MITCHELL. Well, my concern is that because of the spotlight that has been on Salisbury, things everybody has said, even panel members here, or members of the Subcommittee, that things have improved a great deal and are super. But my concern is, that is because the spotlight is on here, what are you doing with all these others? You know, I understand there are reports out there from Asheville, Phoenix just had a report that has not been released yet. But I am concerned, what I would like to see is the same kind of oversight, the same type of concern that you put on Salisbury on every one of these medical centers. And I am not so sure that has happened. How are we going to know that what, the findings you have made at Salisbury are also going to be implemented and carried out in all the other medical centers?

Mr. FEELEY. There are multiple mechanisms through which that occurs. As the SOARS process which was developed in 2004, I have been in this position about 13 months. We have added additional resources to that group, and we are cross working all findings from what the SOARS group finds, and the IG finds, and JCHO finds,

or any outside review group, so we see recurrent themes, shows us where we need to do training, we take these issues up on national conference calls with our quality managers and our chief medical officers at a network level. Again, our goal is to transport that learning rapidly across the system. I think the Committee has a legitimate concern, that a sense of urgency exists when we do this. And now we see Dr. Pierce going out on an issue within 24 hours. That has happened probably four times in the last month, where we have had a concern and we wanted to look at something. When we go out and look, we had a wrong site surgery occur, we are going to transport that across the system.

Mr. MITCHELL. I heard you say that Salisbury is now maybe about a 35 out of 140. I would like all those below that, the other 100——

Dr. FLEMING. Correct.

Mr. MITCHELL [continuing]. To be at the same level, all above average.

Dr. FLEMING. I wanted to comment on a couple of things. I do not think there is another medical system that measures itself as intensively and comprehensively as this one does. Every month facilities get reports on how they are doing that month. Every quarter we roll that data up so that facilities see how they are doing, their network director also sees for the network. As a system of care, every quarter we look across those measures and we say, "Do we have a systems issue? Do we have 1 facility that is really doing poorly in 1 area, or do we have 10 facilities?" When we do that, then there are a variety of things that we do, including making sure that our leadership gets that report, or picking up the telephone and calling the Chief Medical Officer and saying, "You know, you have got one extra case this month we need you to review. Can you go back and do a case review and let us know what you find?" So there is a tremendous amount of feedback that occurs, and a tremendous effort to ask, "Have we got a systems issue?" So hopefully we do that.

One thing I think is important to know, when the VA is benchmarked against the private sector we do very well. For the outpatient measures we consistently have trumped the private sector for all of the 15 commonly measured and reported outpatient measures. For the inpatient measures we have a little bit more of a challenge, but we still consistently do the same as or better than the private sector for most of the measures that we measure. When it comes to patient satisfaction there is only one nationally standardized survey, it is the American Customer Satisfaction Index. And the VA consistently does five points better than the rest of the world. Do we have things we want to work on? Absolutely. Are we doing that? Absolutely. But overall, I think our quality, the quality of care that our veterans receive is excellent and there is tremendous commitment to that. And we are working very hard every day to make sure that that quality gets better and better.

Mr. MITCHELL. Well, I would hope that if it is, if what you need is resources, that that request is made. And I would hope that we have no more case studies before this Committee on particular health centers. The last question is Mr. Wu.

Mr. WU. Thank you, Chairman Mitchell. Mr. Hayes is asking for his letter that was responded to him by the VISN Director, Dan Hoffman of VISN 6 dated April 18, 2007, addressing his concerns that were in the Charlotte Observer be entered into the record.

Mr. MITCHELL. So be it.

[The referenced letter to Congressman Hayes from VA appears on page 55.]

If there are no other comments?

Mr. WU. Well, just one other comment, sir. Dr. Fleming, great benchmarks against the private sector. I think great kudos to the VA healthcare delivery system. Is there any possibility in talking with Mr. Feeley said about all your cross walk and measuring performance in the SOARS report, the IG report, the OMI reports, that you rank order these facilities in some public forum? Is that not a good idea?

Dr. FLEMING. We do rank order the facilities and we do rank order the networks. Now at the network level there is hardly, I mean, the networks are clustered very tightly. And the facility ranks, there is probably maybe a 10-point difference in our aggregate rankings. But I would also tell you that when we look at our worst facilities, and we just actually ran these numbers, our worst facilities based on VA standards compare to private sector averages are still better than the private sector averages. So——

Mr. WU. I appreciate that. But I am talking about within, we are concerned about veterans.

Dr. FLEMING. I am sorry, I guess I missed——

Mr. WU. Do we rank, not bench marking against private sector, but just an internal benchmark?

Dr. FLEMING. We do internal bench marking on a quarterly basis.

Mr. WU. And is that in a public forum? Or how is that displayed?

Dr. FLEMING. It is displayed, it is sent out to the field. It is sent up in the VA. So everyone within the VA knows it. As you know, there was an executive order August of 2006 that has mandated all Federal entities will do public reporting at the provider level.

Mr. WU. Correct.

Dr. FLEMING. So we are on a, in fact we are ahead of our 2009 timeline to do that. So our other Federal agencies will be with us in doing that. So at that point, the veteran, or the Medicare beneficiary, or whomever, will have access to the provider data.

Mr. WU. Thank you, Dr. Fleming. Dr. Bagian, Mr. Feeley, Dr. Fleming, Dr. Pierce, I think there was a lot that was discussed today and brought out and echoing Chairman Mitchell about we now understand Salisbury, but how are we dealing with this on a systemic basis? I would hope that when issues that rise to this level, as Salisbury did indicate in 2005, that this Committee and this Subcommittee and members that are affected in facilities are notified on a timely basis by the VA and not by the Charlotte Observer, the St. Pete Times, or the New York Times. Thank you very much, Mr. Chairman.

Mr. MITCHELL. Thank you. And with that, this meeting is adjourned.

[Whereupon, at 1:32 p.m., the Subcommittee was adjourned.]

APPENDIX

Prepared Statement of Hon. Harry E. Mitchell Chairman, Subcommittee on Oversight and Investigations

This hearing will come to order.

I want to thank our colleagues from North Carolina for joining us today. I know they have been very active on this issue, and I know the people of their great state appreciate their hard work on behalf of veterans in North Carolina.

Of course, we are here today to explore the quality of care available to our Nation's veterans. We know there have been significant problems at the Salisbury VA Medical Center in North Carolina and we'll be using Salisbury as a case study so we can better learn if the problems there are indicative of quality of care throughout the VA medical system.

We will explore management accountability and leadership issues within the VA medical system.

Today's hearing will revolve primarily around three issues:

Firstly, how does the VA ensure access to the medical system is timely and is delivering proper quality of care?

Secondly, what is the process the VA uses in determining whether the quality of care is proper?

And, thirdly, are the problems that occurred in Salisbury indicative of a larger set of issues that affect other VA medical facilities as well?

More than 2 years ago—in March 2005—an anonymous allegation that improper or inadequate medical treatment led to the death of veterans at Salisbury prompted the VA office of Medical Inspector to conduct a review of care delivered to both medical and surgical patients.

The OMI report—issued 3 months later—found significant problems with the quality of care that patients were receiving in the Surgery Service of the Salisbury facility.

Unfortunately, we learned that Salisbury leadership had already been notified of many of the shortcomings in Surgery Service through an earlier Root Cause Analysis.

I know that all of us on the Subcommittee are particularly troubled to hear about the story of a North Carolina veteran who sought treatment at Salisbury and died. . . . He went in for a toe nail injury, and even though doctors knew he had an enlarged heart, he wasn't treated . . . it was ignored . . . and the morning after he had surgery on his toe, he died from heart failure the next morning.

According to media reports, this veteran received excessive intravenous fluids in the OR and post-operatively as well; the medical officer of the day wrote orders for the patient without examining him; and the patient did not receive proper assessment and care by the nursing staff.

More recently, we also learned through the media of another incident—a wrong site surgery at another VA medical facility on the west coast. . . . The list goes on and on. . . .

We hope to hear today how the VA is working to ensure that these types of incidents *do not* happen at other facilities around the country and how the VA is working to deliver the best quality of care throughout the VA system.

We also hope to hear from the VA how its leaders reacted to these problems, worked to solve these problems, and what lessons it learned to make sure this never happens again.

Prepared Statement of Hon. Ginny Brown-Waite Ranking Republican Member

Thank you for yielding me time, Mr. Chairman.

Mr. Chairman, on March 28 through March 31, 2005, at the request of the VA's IG in September 2004, the Office of the Medical Inspector conducted a site visit to

the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina, focusing on the facility's delivery of surgical services. This report presented some serious inadequacies of care at this facility. On March 21, 2007, three members of the North Carolina delegation, my colleagues, the Honorable Howard Coble, the Honorable Mel Watt, and the Honorable Robin Hayes, *[who are present at this hearing,]* wrote to our Committee expressing concern about this report, requesting additional oversight into patient safety at the VA.

I am looking forward to hearing from our witnesses today to learn how these inadequacies have been addressed. I am particularly looking forward to Dr. Daigh's (DAY's) testimony providing the results of the facility's 2006 OIG Combined Assessment Program (CAP) Review of the VA Medical Center in Salisbury, North Carolina, and the results of the OIG's inspection last week of the facility. I also look forward to hearing from Dr. Steinberg, the current Chief of Staff and the former Interim Director on how the facility is continuing to work to address these issues, and how the lessons learned at Salisbury can be used to implement safer delivery of healthcare to our veterans.

It is my contention that this hearing is not to single out one facility, but to take lessons learned as a case study in patient care, and implement better patient safety across the entire VA. I plan to continue to work with you, Chairman Mitchell to continue this oversight of Patient Safety at VA facilities across the Nation. Quality of care everywhere is my goal.

Again, thank you Mr. Chairman, and I yield back my time.

Statement of John D. Daigh, Jr., M.D.
Assistant Inspector General for Healthcare Inspections
Office of the Inspector General, U.S. Department of Veterans Affairs

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify today on patient quality of care issues at Department of Veterans Affairs (VA) medical facilities. Today I will present the results of the Office of Inspector General (OIG) *Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2006; the OIG Evaluation of Quality Management in Veterans Health Administration Facilities Fiscal Year 2004 and 2005; and the OIG Combined Assessment Program (CAP) Review of the W.G. (Bill) Hefner VA Medical Center Salisbury, North Carolina*, published on September 25, 2006. I will also present the facts surrounding the OIG hotline call that resulted in the Office of the Medical Inspector (OMI) report of June 9, 2005, *Review of the Delivery of Surgical Services Veterans Integrated Service Network 6 W.G. (Bill) Hefner VA Medical Center Salisbury, N.C.*, and the results of our followup inspection at the Hefner VA Medical Center (VAMC) conducted during the week of April 9–13, 2007. I am accompanied by Ms. Victoria Coates, Director of the Atlanta Office of Healthcare Inspections.

Since the early 1970's VA has required its healthcare facilities to operate comprehensive quality management (QM) programs to monitor the quality of care provided to patients and to ensure compliance with VA directives and accreditation standards. Public Laws 99–166 and 100–322 require the VA OIG to oversee VA QM programs at every level. QM review has been a constant focus during the OIG Combined Assessment Program (CAP) reviews since 1999. The CAP review is an OIG initiative that involves an inspection and publication of the inspection's findings for approximately one-third of VA's medical centers each year.

A comprehensive VA QM program should include the following program areas: quality management and performance improvement Committees, peer review activities, patient safety activities (healthcare failure mode and effects analysis, aggregated root cause analyses, and national patient safety goals), disclosure of adverse events protocols, utilization management programs, patient complaint management programs, medication management programs, medical record documentation reviews, blood and blood products usage reviews, operative and other invasive procedures reviews, patient outcomes of resuscitation efforts reviews, restraint and seclusion usage reviews, and staffing effectiveness reviews.

OIG Summary Reports

The OIG published a summary of the CAP findings regarding VA medical center QM findings for fiscal year 2006 in March of 2007 and for fiscal years 2004 and 2005 in December of 2006. The report of FY 2006 QM findings identified three QM activities that required systemwide improvements: peer review activities, adverse

event disclosure procedures, and utilization management programs. For FY 2006, OIG reported peer review activities were established in 46 of 47 inspected medical centers. Only 40 of 46 peer review committees complied with Veterans Health Administration (VHA) policy to met quarterly and only 49 percent of the Committees completed their reviews within the required 120 days. VHA facilities have an obligation to disclose adverse events to patients who have been harmed in the course of their care. In FY 2006, 39 of the 47 inspected facilities documented that patients had experienced serious adverse outcomes. Of these, 29 documented that the clinical discussions occurred with the veteran or family member, and 22 documented that the discussion informed the patient of the right to file tort claims or claims for increased benefits. Utilization management is the process of evaluating and determining the appropriateness of medical care services across the patient healthcare continuum to ensure the proper use of resources. In FY 2006, our review found that when resource utilization exceeded standards, referral was not made to physician advisors 16 percent of the time, thus bypassing appropriate review of resource utilization. Recommendations regarding peer review, adverse event reporting, and utilization review were made and accepted by the Acting Under Secretary of Health.

In the OIG report on FYs 2004 and 2005, VA medical center QM programs indicated that 2 of 93 facilities did not have comprehensive programs in place. These programs were identified to VA in CAP reports. Recent CAP reports indicate that one of the two facilities made significant improvements in their QM program, while the other has been less successful at improving the components of its QM program. There are ongoing personnel changes at this facility and OIG will closely monitor this facility's QM program. The FYs 2004 and 2005 QM review made recommendations to improve the analysis of patient resuscitation episodes, better consider the alternatives and document the use of restraints, and adjust current directives regarding re-privileging activities to ensure effective implementation of the continuous professional practice evaluation process.

W.G. (Bill) Hefner Medical Center in Salisbury, North Carolina

The OIG maintains a hotline call center to permit stakeholders to notify the OIG of problems. On August 30, 2004, OIG received an anonymous hotline alleging that there had been more that 12 surgical deaths in over 2 years on the surgical service at the Hefner VAMC. On September 21, 2004, due to limited OIG resources, this hotline was referred to the OMI. The OMI was onsite at Salisbury from March 28–31, 2005. The VHA Director of Surgery conducted a review from April 5–6, 2005. OMI issued its report of the hotline allegations and surgical services, after an OIG review, on June 9, 2005. It contained 18 recommendations that were accepted by the Under Secretary of Health. A regularly scheduled CAP inspection was conducted June 19–23, 2006. An OMI followup inspection of the Hefner VAMC occurred between March 26–27, 2007, and an OIG followup inspection occurred April 9–13, 2007.

OIG CAP Review—June 2006

During the week of June 19–23, 2006, the OIG CAP team evaluated clinical care and patient outcomes at the Hefner VAMC. The CAP team reported as an organizational strength, the fact that medical center staff had significantly improved their ability to provide timely laboratory support for the evaluation of patients who present with a possible myocardial infarction.

The OIG CAP inspection found that the clinicians properly addressed specific treatment issues related to diabetes that arise in the use of atypical antipsychotic medications. The review of breast cancer management found that clinicians at the facility met the VHA performance measure for breast cancer screening, provided timely surgical and oncology consultative and treatment services, promptly informed patients of diagnoses and treatment options, and developed coordinated interdisciplinary treatment plans. A review of the inpatient and outpatient Survey of Healthcare Experiences of Patients found that the Hefner VAMC measures were within acceptable ranges when compared to national and Veterans Integrated Service Network data. The OIG report noted the efforts taken by the VAMC leadership to respond to this patient-derived data.

The OIG inspection team found several conditions needing improvement in the Contract Nursing Home Program, the Quality Management Program, and the medical center environment of care. The Contract Nursing Home Program policy requires regular, periodic visits to veterans in nursing homes by VA nursing staff. These did not occur between October 2003 and June 2006 in the selected patient sample. In addition, OIG inspectors found that 4 of the 11 contract nursing homes were on the State nursing home "watch list," meaning that they had been found to be deficient during their last State inspection. Despite these deficiencies, program

managers continued to place veterans in these homes without taking prudent steps to ensure veterans would receive quality care at these homes. The medical center did not establish the required Contract Nursing Home Oversight Committee. The OIG inspectors made recommendations in the CAP report that were accepted by facility managers to remedy these conditions.

OIG inspectors identified deficiencies in the medical center's QM program in that peer reviews were not completed as required between July 2005 and June of 2006. Further, the Peer Review Committee had not met since November of 2005 because of actions taken by the VA's Office of Resolution Management to review information that was protected by 38 USC § 5705, Confidentiality of medical quality-assurance records. The chief of staff acknowledged the importance of peer review activities and reported that the peer review meetings would resume, but stated that he would not disclose protected information to the Office of Resolution Management. OIG did not make recommendations as the medical center leadership indicated that the peer review process would be resumed. A review of the Root Cause Analysis processes at this medical center found several defects, as did a review of the Administrative Board of Investigation process. OIG recommended and VA leadership agreed to make the changes required to bring these programs into compliance with appropriate policy.

A review of the facility environment of care identified several issues that were addressed prior to the inspection team leaving the facility. The OIG team also found that managers at the facility had not addressed environment of care issues that were previously identified to facility managers in 2005. Facility managers agreed with OIG recommendations to address this issue.

OIG CAP Review—April 2007

OIG inspectors visited the Hefner VAMC between April 9–13, 2007, in preparation for this hearing with two goals: to evaluate the surgical service programs and processes to determine if clinical care meets with community standards, and to determine if the facility had taken appropriate followup actions in response to the CAP report of 2006 and the OMI report of 2005. Our review of the facility Surgical Service Performance Improvement Program, National Surgical Quality Improvement Program data, morbidity and mortality minutes, surgical staffing, peer review, and surgery infection control data combined with discussions with hospital staff and leadership leads us to conclude that the Hefner VAMC surgery services meet or exceed community standards. Our review of the actions taken by the leadership of this facility in response to our CAP recommendations permits us to conclude that these recommendations have been appropriately addressed.

The OIG inspectors identified two new issues to facility leadership during the April 9–13, 2007, visit. On the locked mental health unit, there are exposed pipes that should be covered, going from the wall to toilet fixtures. In addition, telephones in tunnels connecting buildings on the campus were accessible by staff who had a key, but not by patients. OIG will followup to ensure these issues are addressed.

Summary

The OIG will continue to review QM in VA medical centers as part of the CAP process. With respect to the W.G. (Bill) Hefner Medical Center in Salisbury, North Carolina, we believe that VA leadership has responded appropriately to recommendations made by OMI and OIG in reports.

Mr. Chairman, thank you again for this opportunity and I would be pleased to answer any questions that you or other members of the Subcommittee may have.

Statement of Sidney R. Steinberg, M.D., FACS
Chief of Staff, W.G. (Bill) Hefner Veterans Affairs Medical Center in Salisbury, North Carolina, Veterans Health Administration U.S. Department of Veterans Affairs

Good morning Mr. Chairman and Members of the Committee. Thank you for giving me an opportunity to address your concerns regarding the quality of healthcare provided to our veterans at the W.G. Hefner Veterans Affairs Medical Center in Salisbury, North Carolina (Salisbury). The focus of my remarks will be the improvements and expansion of healthcare at Salisbury.

Overview

The Medical Center in Salisbury provides quality healthcare to our veterans in our primary care clinics including Winston Salem and Charlotte across many specialties of medicine and surgery with our academic partner, Wake Forest University.

In recent years, Salisbury has made a concerted effort to improve the quality of our healthcare and to make access to care readily available. We measure our improvements in these areas on a regular basis utilizing both internal and external tools. We track disease prevention, treatment outcomes, physician performance, educational processes and patients' satisfaction surveys. VA is committed to meet the needs of our veterans, whatever it takes. At Salisbury our commitment is total.

Improvements to Patient Care

Several years ago, with the help of our Veterans Integrated Service Network (VISN) leadership and a handful of dedicated clinicians, VA sought to make improvements at Salisbury, department by department. VA leadership brought together the financial and manpower resources necessary to make these changes possible. For example, the waiting list of veterans seeking a primary care appointment was a challenge. The VISN came through with funding for recruitment of new employees. As a result, every veteran on the wait list in 2003–2004 was enrolled in a primary care clinic, examined, and received his or her initial care needs. VA was delighted to have members of Congress join the former Secretary and our Network Director to personally thank the dedicated staff who gave so much of themselves to achieve that goal.

Academic Affiliate and Specialty Care Services

To accommodate Specialty Care Services in the past, Salisbury relied upon the geographic partnership with the Asheville VA Medical Center. However, the addition of a large number of new patients made it apparent that Salisbury would need to develop its own specialty support system for our veterans. To accomplish this task, VA established a new and stronger relationship with our Academic Affiliate, Wake Forest University School of Medicine in Winston Salem, North Carolina. Meetings with the Dean of the Medical School and faculty leaders paved the way for the beginning of a new partnership to serve our patients with state of the art healthcare in many areas of need. These efforts led to the establishment of resident physician training programs in a number of disciplines. We now have 10 approved resident positions which include ophthalmology, urology, otolaryngology, psychiatry, medicine, infectious disease and dermatology. The superb eye clinic with its multispecialty support provided care to 27,000 patient visits in fiscal year (FY) 2006. Ten major eye operations are performed weekly by Wake Forest faculty and resident physicians.

VISN leadership continues to engage the Office of Academic Affairs on a regular basis to assist Salisbury in adding more resident positions in primary care, medicine and other specialties. This year we have added a new affiliation agreement with Virginia Tech University and will work to incorporate their staff and residents in coming years to expand primary care. The real benefit of the residency program to our veterans is that they bring with them the highly skilled faculty members who are capable of providing state of the art care to our veterans. The progress VA has made at Salisbury touches every veteran and employee at the Medical Center. Our staff, our patients, our community leaders, and our medical school educators recognize the quality of these additions. These improvements in facility staffing and structure allowed us to see more than 400,000 out patients in FY 2006 as well as providing support for our Veterans Benefit Administration office in Winston Salem.

Mental Health

The Mental Health needs of our veterans are important to all of us and represent a program of excellence at Salisbury. In this area of clinical expertise, we lead our VISN and have on our staff one of the world's most prestigious investigators in the area of Traumatic Brain Injury. Through her efforts and those of her principal neuroscientist, there is collaboration with MIT, Harvard and the Department of Defense. This team also serves as a key investigative and educational center for the Mental Illness Research, Education, and Clinical Center (MIRECC). This Center has a focus on post-deployment mental health. Together with the other VA medical centers in VISN 6, this program strives to advance the study, education, and treatment of all mental health conditions resulting from war-time experience. This investigative center leads VHA nationally in these efforts. Our medical center's research programs have generated a full Association for the Accreditation of Human Research Protection Programs accreditation through the year 2010.

Women's Health Program

Our expanded Women's Health program now serves our patients as well as those from the Asheville and Fayetteville VA Medical Centers. The program is headed by a Gynecologist from the University of Virginia. The new director of our Imaging Department came to us from the M.D. Anderson Cancer Center in Houston, with addi-

tional fellowship training at the University of North Carolina. Her new colleagues in the department are from Duke University and Wake Forest, respectively. The Women's Health Program is just moving this week into newly renovated space where additional special services are now provided. A new bone densitometer, digital mammography and urodynamic devices are now available. A current NRM (Non Recurring Maintenance) project is now underway to provide more bed space for women veterans with private rooms and private baths.

Surgery Programs

We faced challenges in the quality of our program in 2003. But we have turned the corner and now have a much improved surgical program. The Salisbury Surgery Department is totally new and is headed by a chief from Vanderbilt University. A strong surgical program is essential to our veterans' health needs and must be one of impeccable quality. With the VISN's busiest emergency department and increasing demands for care dictated by our 62,000 enrolled patients, our efforts were directed to making this department a solid high quality program. The support of our affiliate, Wake Forest University, is vital to this effort. As additional surgical staff and residents from Wake Forest join this effort, it will continue to gain in strength and expertise. Our new construction project in Surgery will be completed in about 30 days and will provide the needed space and modernization required to meet the highest standards for operating room construction. Our new Chief is joined by a staff of surgeons from Johns Hopkins, the University of Maryland and the University of West Virginia. Other key members of the Surgery and Anesthesia Staff came from Emory University, Duke University, the Cleveland Clinic, the Mayo Clinic and the University of Michigan. We are recruiting for a new chief of Pathology, crucial to our post mortem evaluations and tissue studies. Our Chief of Infectious Disease and our fellowship program have brought a fresh and important look to the evaluation, prevention and treatment of infectious diseases at our medical center. Our large numbers of hepatitis and HIV patients are now receiving the care they must have to maintain their health and life.

Our approach to primary care was modified last year to provide more adequate care to our patients with more complex diseases. At the Salisbury VAMC we have made a concerted effort to ensure that every patient now has been assigned to a primary care provider. Our efforts in Primary Care were given a tremendous boost by the VISN's support of a total renovation of all primary care clinic space to assure that each primary physician had at least two examination rooms per physician. This space adjustment has made it possible to meet the demands of a higher patient volume.

Conclusion

Mr. Chairman, we acknowledge that Salisbury has faced problems with the quality of surgical processes in the past. However, that's behind us now, due to the hard work of the highly professional and dedicated staff at Salisbury. We are proud of Salisbury and the patients we serve. Through strong and meaningful leadership, our staff has turned the focus toward a future of excellence. We will continue these efforts in our commitment to our Nation's finest, our veterans.

Mr. Chairman, this concludes my statement. At this time I would be pleased to answer any questions that you may have.

Statement of William F. Feeley, MSW, FACHE
Deputy Under Secretary for Health for Operations and Management
Veterans Health Administration, U.S. Department of Veterans Affairs

Good morning, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to be here today to discuss the many positive steps the Department of Veterans Affairs (VA) utilizes to monitor the healthcare of our veterans and returning warriors. In my role as Deputy Under Secretary for Health for Operations and Management, I am responsible for the day to day activities at all of our facilities across the country. I would like to focus my attention on how the Veterans Health Administration (VHA) addresses quality improvement activities on a systemwide basis. I am accompanied by Dr. John Pierce, Medical Inspector, Dr. James Bagian, the Chief Patient Safety Officer, and Dr. Barbara Fleming, Chief Quality and Performance Officer.

OVERVIEW

In the late eighties, VA healthcare programs came under a great deal of scrutiny because of the perception that quality was not comparable to that found in the pri-

vate sector. Since that time, numerous programs have been implemented by VA to address and ensure that the quality of healthcare provided to our veterans is world class. The results of these efforts and achievements have brought national recognition to VA as consistently being recognized as one of the premier healthcare providers within the United States. For example, on January 20, 2006, the *Washington Post* published an article entitled "VA Care is Rated Superior to That in Private Hospitals," and the January/February 2005 issue of the *Washington Monthly* published an articled entitled "The Best Care Anywhere." And the August 27, 2006 issue of *Time* magazine had a feature article entitled, "How Veterans Hospitals Became the Best Health Care". While VA has transformed itself, we continue to strive to improve the quality of healthcare provided to our Nation's veterans through shared learning, research, and vigorous and stringent quality management and patient safety programs.

The results of this work can be attributed to the leadership and contributions made by the offices represented by those accompanying me today—the Office of the Medical Inspector, the National Center for Patient Safety, and the Office of Performance and Quality—as well as the efforts of our VA workforce who are directly involved in patient care.

VHA ensures the consistent quality of care that is delivered in its Veterans Integrated Service Networks through——

- Patient safety activities;
- Systems that listen, teach and detect problems early;
- Ongoing measurement of clinical processes;
- Establishment and control of quality standards for both clinical protocols (Peer Review, Evidence-Based Guidelines, Utilization Management) and for the providers of care (National Credentialing and Privileging);
- Personal and anonymous patient surveys after the care has been provided;
- Oversight by external organizations such as the Joint Commission; and
- Oversight by internal organizations such as Systematic Ongoing Assessment and Review Strategy (SOARS), Office of Medical Inspector (OMI), Office of Inspector General (OIG), Government Accountability Office (GAO), Veterans Service Organizations (VSO).

PATIENT SAFETY

The VA National Center for Patient Safety (NCPS) is guided by a mission to prevent harm to patients. The focus is to prevent inadvertent or accidental harm that may occur as a result of incidents such as patient falls, medication errors, malfunction or misuse of medical devices, and hospital-acquired infections. The NCPS works with Patient Safety Managers in all VA medical centers and Patient Safety Officers in the network offices to facilitate the implementation of an integrated patient safety improvement program throughout VHA. The primary methodology used in VHA to understand and prevent adverse events is Root Cause Analysis (RCA). The RCA teams focus on determining what happened, why it happened, and what systems changes should be made to prevent similar incidents from recurring. Information from RCAs is used to inform other VAMCs of potential problems, potential solutions, and in the development of VHA-wide policies and practices to prevent adverse events from occurring in VHA facilities.

The NCPS also issues Patient Safety Alerts (Alerts) and Advisories on specific issues relating to medical devices and products, and other potential sources of harm to patients. Several Alerts have brought problems coupled with recommended solutions to the attention of other government agencies such as the Food and Drug Administration (FDA), and organizations such as the Joint Commission. Topics of recent Alerts of special interest included one that led to the withdrawal of Benzocaine spray from our facilities due to its high potential for accidental misuse and dangerous overdoses, and another one that described the correct way to clean and disinfect a special ultrasound device used for prostate biopsies. Both Alerts were of special interest to the FDA and resulted in FDA disseminating the potential vulnerabilities brought to light by VA to hospitals in the private sector.

Another method to improve quality and patient safety is to reduce ineffective variation in practices. This is where VHA Directives (Directives) are issued to address patient safety topics. Based on information from RCAs, emerging standard practices, and other sources, VA has developed and implemented several important Directives to improve patient safety such as: *Ensuring Correct Surgery and Invasive Procedures; Prevention of Retained Surgical Items; Out-of-Operating Room Airway Management; Recall of Defective Medical Devices and Medical Products; Planning for Fire Response; Reducing the Fire Hazard of Smoking when Oxygen Treatment is Expected; and Required Hand Hygiene Practices (based on the CDC's Guideline on this*

topic). These topics vary widely but are all related to preventing harm to patients as they receive care at a VA facility. By issuing these Directives, VA has acquired the ability, as the largest integrated healthcare system, to effect change that impacts millions of patients.

PERFORMANCE MEASUREMENT

VA's performance measurement system is a key part of the transformation of care that started in the mid-nineties. The system has over 100 performance measures in the areas of access, satisfaction, cost, and quality. Data on these measures are collected monthly and all performance is shared and distributed on a quarterly basis to the field facilities with information broken out into aggregate totals for facilities, networks and VHA overall. The aggregated quarterly data is also used to produce detailed annual reports shared with senior leadership and the field.

Special reports are also produced that focus on particular measures of concern or special populations. For example, reports have been provided on minority health, women's health, the health of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) veterans, and characteristics of facilities and networks leading to high performance with Best Practices shared across the system via video conferences which are web-based and enhanced and national face to face meetings.

These data analyses lead directly to quality improvement efforts. When quality concerns are identified, working task groups have been convened to further explore these issues using collected data and working directly with the VA facilities to find and share solutions to the quality problems. VA consistently benchmarks its performance data, both internally and externally. Ongoing reports are prepared that compare VHA to other Federal and private sector healthcare organizations.

The successful use of the performance measurement system for driving quality is based upon widespread dissemination of information and feedback to individuals at all levels of the healthcare system. Also, it is important to link measures not only in performance evaluations but also incentives in a variety of local and national means, for example, through awards to facilities, and networks. Linkage of measures to performance contracts result in personal accountability. In addition, for each quarter, I conduct individual performance reviews with each Network Director to personally review performance measure results for their VISN and to discuss plans for improving performance in areas that are needed. The Network Directors are held accountable for performance improvement through performance measurements.

CREDENTIALING AND PEER REVIEW

VA also has a very sophisticated electronic credentialing program that is used system wide. We believe that careful credentialing is a cornerstone of assuring quality. The quality of privileging, which defines the practice scope of a provider, is also essential to maintaining a good clinical staff.

Peer review is another mechanism in place to assure that the highest quality of care is delivered. Peer review is intended to contribute to quality improvement efforts of the individual provider, in a non-punitive way.

UTILIZATION MANAGEMENT

Utilization Management (UM) allows the VA to determine that the right care is provided to the right patient at the right place for the right amount of time. A national Utilization Management Committee has put standards for UM in place, adopted nationally standardized criteria, conducted extensive training, and is beginning the implementation of a national data base to assure that there is facility, national, and network learning and quality improvement around the data collected.

Patient complaints are assessed by a series of questions on the inpatient and outpatient surveys asking whether the veteran had a complaint about VHA care, and whether the veteran was satisfied with the resolution of that complaint. Patient advocates and the national VHA Patient Advocacy Office monitor these results closely to ensure that veterans' and their families' voices are being heard.

SYSTEMATIC ONGOING ASSESSMENT AND REVIEW STRATEGY

The VA utilizes a learning system that exports and disseminates information to all segments of the VA healthcare system so that providers can learn how to deliver care that is not only safe, efficient, cost-effective, but clinically measurable and evidence-based. For example, the Systematic Ongoing Assessment and Review Strategy (SOARS) is an internal review initiative that was initially implemented within the VA as an internal voluntary program that facilities could use as a systematic method for on-going self-improvement and to support the culture of continuous readiness. Now, based on the success of this program, all VA facilities participate in a SOARS site visit every 3 years. As the SOARS team members interview staff, they frequently become aware of an excellent practice implemented at the surveyed site that

could improve patient care quality or efficiency or reduce costs that could easily be shared with other VA facilities. The information regarding these "Strong Practices" is kept on the SOARS VA intranet Web site that is easily accessed by all VA staff.

OFFICE OF THE MEDICAL INSPECTOR

Another internal review mechanism involves the reviews done by the Office of the Medical Inspector who evaluates quality of care concerns raised by veterans and other stakeholders and makes recommendations to enhance and improve the quality of care provided by VHA. These recommendations are directed at the facility involved in the site visit. When common issues are identified, the recommendations may result in a Directive or guidance to the entire VHA system.

EXTERNAL OVERSIGHT

As a public system, the VA undergoes intense scrutiny from a variety of accreditation agencies, both internal and external reviewers. All VA medical facilities are accredited by the Joint Commission on Accreditation for Healthcare or organizations on a triennial cycle.

The Office of the Inspector General (OIG) for the VA, and the Government Accountability Office are frequent inspectors of care provided at individual VA facilities and often address issues that cut across specific VAMCs. For each review, VHA drafts a response and action plan to respond to findings. We welcome the opportunity for external regulators to help us identify areas where improvement is needed and strives hard to make those improvements.

CONCLUSION

As a system, VA is continuously looking for opportunities to learn and improve. The components described above provide a solid foundation for identification of problem areas and challenges for the system of care that can be transported to improve our entire healthcare delivery system for individuals.

One of the advantages of being a large integrated healthcare organization is that VHA has the ability to learn and share examples of best practices from our clinicians and administrators across our entire system. I personally speak with the Veterans Integrated Service Network (VISN) Directors as well as Facility leadership on a weekly basis; best practices are identified and shared via these teleconferences. In addition, conference calls are held by my colleagues with patient safety and quality management staff. There are many examples of how VA learns from specific clinical incidents.

I appreciate the opportunity to talk with you today. The events at Salisbury have spurred us to go even farther in our monitoring process than I have described here. I have asked that the Network Chief Medical Officers and Quality Managers heighten their personal ownership of issues affecting their facilities and ensure that best practices are shared systemwide. Mr. Chairman, this concludes my statement. At this time I would be pleased to answer any questions that you may have.

U.S. Department of Veterans Affairs
Veterans Health Administration
Veterans Integrated Services Network Six
Durham, NC.
April 18, 2007

Hon. Robin Hayes
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Hayes:

Thank you for the opportunity to respond to your letter of March 15, 2007, regarding article in *The Charlotte Observer* detailing the actions of a nurse at our Salisbury VA Medical Center (VAMC) who reportedly falsified care reports on VA patients in contract nursing homes. You indicate that while what may have happened previously is of concern, you are troubled by the article's assertion that the nurse is still employed by the VA in Salisbury. You ask why, if the assertion is correct, did VA not find this behavior grounds for dismissal?

These are appropriate questions, which relate to our oversight of long-term care of our veterans and our personnel action procedures with staff. I can assure you that we have taken both matters very seriously. The VA Office of Inspector General (OIG) Review of Contract Nursing Home Oversight at our Salisbury VA Medical

Center was conducted June 19–23, 2006. The OIG report is indicative of VA's internal monitoring to promote quality of care.

I apologize for the delay in responding to you, but a second OIG review was just completed last week concerning the oversight of nursing home care for our Salisbury VAMC patients. Although we do not have the final written repot, we received an oral summary, which emphasized that oversight is underway.

At the time of the original report, from October 2003 to June 2006, Salisbury VA Medical Center had placed 17 veterans in 11 contract nursing homes. We can confirm that all these veterans had been visited at least monthly by a Salisbury VAMC Social Worker. This VA staff member met with each veteran; spoke with clinical providers; reviewed progress notes regarding each veteran's care; and made every reasonable effort assure that appropriate followup treatment was being provided. The Social Worker involved family members in the care plans for their loved ones. Neither the veterans in these contracted nursing homes nor the family members expressed any safety concerns or requested placement in another facility.

Salisbury quickly assigned another nurse to resume monthly visits to these veterans, and an Administrative Board of Investigation was convened to analyze Salisbury VA Medical Center's oversight of veterans placed in contracted nursing homes.

The former Salisbury VA Medical Center Director reviewed the recommendations with the employee and that individual's representatives. The VA Regional Counsel was consulted and it was decided to enter into a "last-chance" agreement with the employee. As a result this nurse continues to be employed at the Salisbury facility but is no longer involved with the Contract Nursing Home Program or with patient care. The North Carolina Board of Nursing is investigating the individual at this time. If a bar is placed on this individual's license, then VA will terminate this nurse's employment.

We currently have 11 veterans placed by Salisbury VAMC for long-term care in eight contracted nursing home facilities, and the program is working well to the benefits of these patients.

Recent media reports about this facility notwithstanding, I can assure that our team at Salisbury is serving our veterans effectively. With funding and other support from you and other members of Congress, we are constructing a new 65,000 square-foot VA Outpatient Clinic in Charlotte and another facility, of approximately 20,000 square feet, in Hickory. These new sites of care will extend the outreach of primary care, general mental health, eye care and other services to our veterans in these areas. Both of these facilities will be staffed and managed by the Salisbury VA Medical Center, along with our major clinic in Winston-Salem.

Our Salisbury VA Medical Center and its clinics provided care to 60,000 veterans last year. It is our leading site for care of our newest veterans returning from duty in Operations Iraqi and Enduring Freedom, caring for 4,248 of these individuals out of approximately 16,000 served since September 11, 2001, in our Network facilities.

We want to extend a cordial invitation to you and your staff to visit the Salisbury facility at your convenience. Please contact Dr. Dave Raney at 919–956–5541 and he can assist you.

Please be assured that throughout our 8 VA Medical Centers and our current 10 and soon to be 15 outpatient facilities, our mission is to provide safe, efficient, effective, and compassionate care to the more than 292,000 veterans we so proudly serve. I greatly appreciate your personal support of the development of an outpatient clinic in Hamlet and your other efforts to enhance healthcare services to our Nation's veterans.

Sincerely,

Daniel F. Hoffmann, FACHE
Network Director, VISN 6

QUESTIONS FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
May 21, 2007

Honorable George J. Opfer
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Opfer:

On Thursday, April 19, 2007, the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs held a hearing using the VA Medical Center in Salisbury, North Carolina as case study for the quality of care veterans receive across the country.

During the hearing, the Subcommittee heard testimony from Dr. John D. Daigh, the Assistant Inspector General for Healthcare Inspections. As a followup to that hearing, the Subcommittee is requesting that Dr. Daigh answer the following question for the record:

1. Your site visit indicated that 4 of the 11 contract nursing homes were on the state "watch list" meaning that they had been found deficient during their last state inspection. Is it not disturbing that Salisbury would continue to place veterans in these homes? And furthermore, the medical center did not establish the required Contract Nursing Home Oversight Committee. When was this glaring deficiency finally remedied? Would you not characterize this situation as less than proactive and a symptom of senior management malaise?
2. How and when did you realize that your budget and staffing would not allow you to address these investigations?

We request you provide responses to the Subcommittee no later than close of business, Friday, June 8, 2007.

If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Acting Staff Director, Dion S. Trahan, Esq., at (202) 225–3569 or the Subcommittee Republican Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

HARRY E. MITCHELL
Chairman

VIRGINIA BROWN-WAITE
Ranking Republican Member

U.S. Department of Veterans Affairs
Office of Inspector General
Washington, DC
June 21, 2007

Hon. Harry Mitchell Chairman
Hon. Ginny Brown-Waite
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman and Congresswoman Brown-Waite:

Enclosed are responses to followup questions from the April 19, 2007, hearing before the Subcommittee that were included in a letter from you and the Ranking Republican Member. A similar letter is being sent to the Ranking Republican Member of the Subcommittee.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

George J. Opfer
Inspector General

Enclosure

Questions from Hon. Harry E. Mitchell, Chairman and Hon. Ginny Brown-Waite, Ranking Republican Member Subcommittee on Oversight and Investigations, to Mr. Opfer, Inspector General, U.S. Department of Veterans Affairs

Question: Your site visit indicated that 4 of 11 contract nursing homes were on the state "watch list" meaning that they had been found deficient during their last state inspection. Is it not disturbing that Salisbury would continue to place veterans in these homes? And furthermore, the medical center did not establish the required Contract Nursing Home Oversight Committee. When was this glaring deficiency finally remedied? Would you not characterize this situation as less than proactive and a symptom of senior management malaise?

Answer: A nursing home may be placed on a state watch list for a variety of reasons ranging from not meeting safe food preparation and storage standards to inadequate care practices. Inclusion of a nursing home on a state watch list is not by itself disqualifying for placement of veterans. However, OIG expects that in these circumstances medical center staff review and consider watch list data to ensure that the nursing home is appropriate for the veteran's clinical condition. A patient's family should also be provided the opportunity to participate in the selection of a nursing home and be made aware of watch list and other data regarding the nursing home's performance. As reported in the results of our 2006 CAP review, we found that veterans were placed in four substandard nursing facilities that were on the state watch list without proper oversight by medical center staff. We recommended that medical center staff increase monitoring of substandard nursing facilities where veterans remain under contract care. A Contract Nursing Home Oversight Committee was established just prior to our site visit in June 2006. The lack of a VHA contract nursing home oversight Committee is not acceptable and is not consistent with VHA policy.

Question: How and when did you realize that your budget and staffing would not allow you to address these investigations?

Answer: Due to resource limitations, OIG has historically lacked the capacity to meet all demands for review of complaints about VA services and programs. OIG has adopted a system of triaging incoming work to determine which cases require independent OIG review based on the seriousness and urgency of the complaint and current workload priorities. A substantial number of cases are referred to other VA elements for fact-finding and review. In these cases, the responsible VA office reports their findings back to us for final review before a case is closed.

The OIG Hotline received allegations from an anonymous complainant that 12 patient deaths occurred on the surgical service of the W.G. (Bill) Hefner Medical Center in Salisbury, North Carolina, on August 30, 2007. The next day, the case was referred to and accepted by the OIG Office of Healthcare Inspections (OHI) based on the serious nature of the allegations. OHI staff began development of an inspection plan, staff requirements, and project schedule. During this early planning phase, however, it became apparent that the scope and significance of the project demanded more immediate attention then OHI originally anticipated. After careful assessment of OHI's workload and priorities, OHI contacted the Office of the Medical Inspector (OMI), and both offices agreed that OMI was better positioned from a resource perspective to conduct and complete the review. Shortly thereafter, on September 21, 2007, the OIG made a written referral to OMI to conduct the review and to report back its findings. Consistent with OIG policy, we reviewed the OMI report prior to its issuance. Given current resource levels and workload, OIG will continue to triage incoming work and make referrals to OMI and other VA elements when appropriate.

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
May 21, 2007

Honorable R. James Nicholson
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Nicholson:

On Thursday, April 19, 2007, the Subcommittee on Oversight and Investigations of the House Committee on Veterans' Affairs held a hearing using the VA Medical Center in Salisbury, North Carolina as case study for the quality of care veterans receive across the country.

During the hearing, the Subcommittee heard testimony from Mr. William F. Feeley, the Deputy Under Secretary for Health for Operations and Management; Dr. Sidney Steinberg, the Chief of Staff at the Salisbury VAMC; Mr. Donald Moore, the former Director of the Salisbury VAMC and current Director of the VAMC in Phoenix, Arizona; and various other officials from the VA and the Salisbury facility. As a followup to that hearing, the Subcommittee is requesting that the following questions be answered for the record:

Questions for Mr. Feeley:

1. What was the Peer Review process at Salisbury VAMC, and how has it changed to ensure better patient care and reduce the incidents of surgical and post surgical deaths? Please be specific in your response.
2. How frequently does the OMI investigate and provide oversight to a VAMC such as Salisbury when allegations are made about inadequacies of care?
3. What changes have been made to the culture of care providers, such as surgeons, nursing staff, attending physicians, and anesthesiologists at Salisbury VAMC to provide better quality of care? Has VHA taken lessons learned at Salisbury and implemented directives to the rest of VHA to provide better care throughout the VA?
4. Is it your opinion that the problems outlined during the March 2005 investigation by the OMI have been resolved, and if so, what changes occurred to implement the changes necessary to resolve these issues?
5. Please provide the results of the last SOURCE visit to Salisbury.
6. Please provide SES Bonus information for staff at the Salisbury VAMC and VISN 6 during the time period in question.

Questions for Dr. Steinberg:

1. According to your testimony, the Salisbury Surgery Department has made improvements since the March 2005 OMI report, Congress received in June of 2005. Most of these improvements deal with new construction projects. How have surgical facilities expanded, and how do you anticipate further improvements in care stemming from these expansions?
2. When do you anticipate filling the Chief of Pathology position? How long has this position been empty? What criteria are you using to evaluate candidates for this position?
3. How long had the Chief nursing position been empty prior to the OMI report, and after the issuance of the OMI report?
4. It should be noted that the Women's Health Program is moving into a newly renovated space in order to provide additional services specific to the medical needs of women. How many female veterans do you anticipate being able to serve in this new space? When will this facility be fully staffed?
5. What future plans for construction do you anticipate for the future at Salisbury in order to continue to meet the needs of the veteran community in western North Carolina?
6. What specific actions have been taken to hold personnel found at fault in the deaths of the twelve patients which initiated the original OMI investigation accountable?

Questions for Mr. Moore:

1. Now that you are in a position of greater responsibility and bigger staff, how do you insure all egregious IG and OMI findings of 22 inadequate actions

in identifying and implementing specific corrective actions do not reoccur under your leadership in Phoenix?

2. Did you receive any performance bonuses during your tenure at Salisbury?

Questions for Dr. Pierce:

1. What were the steps taken to follow up on personnel reviews, oversight, and holding individuals accountable at the Salisbury VAMC? How did your office ensure all recommendations were being complied with? Please be specific in your response.
2. Please provide written documentation of all actions taken against personnel in Salisbury, North Carolina following the misconduct/malpractice instances of the seven deaths?

We request you provide responses to the Subcommittee no later than close of business, Friday, June 8, 2007.

If you have any questions concerning these questions, please contact Subcommittee on Oversight and Investigations Acting Staff Director, Dion S. Trahan, Esq., at (202) 225–3569 or the Subcommittee Republican Staff Director, Arthur Wu, at (202) 225–3527.

Sincerely,

HARRY E. MITCHELL
Chairman

VIRGINIA BROWN-WAITE
Ranking Republican Member

Questions from Hon. Harry E. Mitchell, Chairman, and Hon. Ginny Brown-Waite, Ranking Republican Member Subcommittee on Oversight and Investigations to Hon. R. James Nicholson, Secretary U.S. Department of Veterans Affairs

Case Study on the Department of Veterans Affairs (VA) Quality of Care: W.G. Hefner VA Medical Center in Salisbury, North Carolina

Questions for Mr. Feeley:

Question 1: What was the Peer Review process at Salisbury VAMC, and how has it changed to ensure better patient care and reduce the incidents of surgical and post surgical deaths? Please be specific in your response.

Response: The peer review process at the Salisbury VA Medical Center (VAMC) included critical reviews of episodes of care performed by a peer or by a group of peers.

Inspectors from the Office of the Inspector General (OIG) identified deficiencies in the Salisbury VAMC's quality management program during a June 2006 combined assessment program (CAP) survey. They found that peer reviews were not completed as required between July 2005 and June 2006. They also found that the peer review Committee (PRC) had not met since November 2005.

The local peer review process was stopped in response to VA Office of Resolution Management's request to review information protected by 38 USC § 5705, *Confidentialityof Medical Quality-Assurance Records.* When informed that the confidentiality of documents regarding peer reviews would be compromised, the physicians refused to further participate in what is understood to be a confidential process.

During the OIG CAP survey, the chief of staff acknowledged the importance of peer review activities and reported that the peer review meetings would resume, but stated that he would not disclose protected information to the Office of Resolution Management. The OIG did not make recommendations as the medical center leadership indicated that the peer review process would be resumed. The peer review process was resumed immediately.

Question 2: How frequently does the OMI investigate and provide oversight to a VAMC such as Salisbury when allegations are made about inadequacies of care?

Response: The Office of the Medical Inspector (OMI) investigates all allegations made about inadequate quality of care provided to veterans brought to their attention—The OMI monitors, along with the Deputy Under Secretary Health for Oper-

ations and Management, the VA medical center's action plan, developed as a result of the OMI's recommendations.

Question 3: What changes have been made to the culture of care providers, such as surgeons, nursing staff, attending physicians, and anesthesiologists at Salisbury VAMC to provide better quality of care? Has VHA taken lessons learned at Salisbury and implemented directives to the rest of VHA to provide better care throughout the VA?

Response: A total change in surgical, anesthesia and nursing leadership was effected. Dr. Charles Graham was appointed as chief of surgery with concurrence of Dr. Ralph DePalma, national director of surgery. With his guidance, new policies and procedures were implemented directed at improving and maintaining the highest quality of surgical care. A new chief of anesthesia was appointed, Dr. Robert Slok, from Ohio University with an assistant chief, Dr. John Murphy from Duke University. Ms. Judith Pennington, RN, was selected as the new chief operating room nurse from a major medical center in Denver, Colorado.

With this leadership team in place, all aspects of surgical care are being addressed, including fundamental education of staff, addition of critical support staff and establishment of key management tools to assure highest quality and adherence to all performance measures. Input from existing staff was readily sought and team building was begun in a new and dynamic fashion.

Everyone involved in surgical care was brought to the table to learn, address and execute a comprehensive plan for "their" surgical program. The result has been a dramatic improvement in all aspects of surgical care, surpassing all national quality standards for morbidity and mortality.

The Veterans Health Administration (VHA) has published several handbooks and directives regarding provision of quality, safe patient care. In addition, a weekly national conference call is held which includes the presentation of lessons learned and best practices in the delivery of patient care. In January 2007, the VA national surgical quality improvement program (NSQIP) sent out a newsletter to the field that provided information, data and updates on the program.

Question 4: Is it your opinion that the problems outlined during the March 2005 investigation by the OMI have been resolved, and if so, what changes occurred to implement the changes necessary to resolve these issues?

Response: Yes. To begin the process of correcting problems identified by the OMI, removal of some staff was required. The existing chief of surgery was removed and his surgical privileges terminated. The physician in charge of the medical management issues was terminated and no longer practices medicine. The anesthesia chief was terminated.

Conferences and training programs are now in place to assure adequate continuing education for all staff. Preoperative and postoperative care issues are continually reviewed to assure quality of care at every step, A new medical center director and the chief of staff provide day to day oversight. All issues reported in the OMI report have been addressed and resolved.

Question 5: Please provide the results of the last SOURCE visit to Salisbury.

Response: A system wide ongoing assessment and review strategy (SOARS) site visit was conducted at the Salisbury VA medical center (VAMC) December 6–9, 2005. Written reports were not required during this period, a verbal out-briefing of findings and recommendations were provided to facility leadership and staff at the conclusion of the visit. The visit found many areas of compliance with standards, and others that appeared to be improving. Areas identified as needing attention and improvement included:

- Medication and controlled substance management. Comprised of several issues around medication storage.
- Information security. Specifically related to ensuring that access to computer systems are terminated immediately when employees, volunteers, and contractors *leave* VA service.
- Patient transportation. Ensuring that all drivers meet standards for training, physical screening, and license checks.
- General safety concerns related to fire extinguishers and exit doors.
- Process improvements needed to enhance medical care cost recovery insurance identification and billing.

The discrepancies identified during the SOARS site visit have been addressed.

Questions for Dr. Steinberg:

Question 1: Please provide SES Bonus information for staff at the Salisbury VAMC and VISN 6 during the time period in question.

Response: The following individual received bonuses at that time:

Timothy May—Director Salisbury VAMC
2000—no VISN records of any awards or bonuses
2001—no VISN records of any awards or bonuses
2002—no VISN records of any awards or bonuses
2003—no VISN bonuses—retired

Stephen Lemons—Director Salisbury VAMC—11/1/03–6/12/04
2003—$20,000

Donald Moore—Director Salisbury VAMC—6/13/2004–11/11/2006
2004—0
2005—$12,000
2006—$9,000

James L. Robinson III Associate Director, Salisbury VAMC
August 4, 2004—$1,000
August 8, 2004—$2,000
September 15, 2004—$3,000
April 22, 2005—$5,000
November 15, 2005—$5,000
November 14, 2006—$4,000
January 18, 2007—$5,000

Sidney R. Steinberg Chief of Staff, Salisbury VAMC
September 15, 2004 $5,000
April 22, 2005—$5,000
April 22, 2005—$2,500
November 15, 2005—$5,000
January 24, 2007—$5,000

Mark Shelhorse, MD Chief Medical Officer—VISN 6
2001—$6000
2002—$15,000
2003—$15,000
2004—$24,500
2005—$25,000
2006—$19,000

Daniel F. Hoffmann Network Director—VISN 6
2000—$15,000
2001—$12,000
2002—$26,000
2003—$26,000
2004—$29,120
2005—$20,000
2006—$24,000

Question 2: According to your testimony, the Salisbury Surgery Department has made improvements since the March 2005 OMI report, Congress received in June of 2005. Most of these improvements deal with new construction projects. How have surgical facilities expanded, and how do you anticipate further improvements in care stemming from these expansions.

Response: In mid-2003, a vigorous recruiting effort was begun to attract the highest quality professional staff to the VAMC at Salisbury. Efforts were also initiated to build an academic relationship with Wake Forest University School of Medicine to gain their support in improving the professional staff at Salisbury and to develop the framework for establishing training programs for resident education in a variety of medical and surgical specialties. Contingent on developing a strong and effective surgical program was the need to improve surgical nursing capabilities, anesthesia support, an appropriate post anesthesia care unit (PACU) and improving both the equipment available and the physical plant.

Project requests were submitted to address the physical plant needs through a nonrecurring maintenance proposal. The physical plant improvements included the construction of a completely new surgical suite with adequate space and proper air

flow to improve the safety and efficiency of surgical care. Better air flow reduces the risk of airborne infection and cross contamination. The larger space allows for introduction of modern endoscopic equipment important for safer inpatient and ambulatory surgical interventions with reduced operative morbidity and mortality. This construction replaced an out-dated operating room and air handling system essential to improve quality of care. The addition of both space and staff for the PACU assures maximum post anesthesia safety for patients. The first part of this project will be completed in the summer of 2007. A second proposal to complete the physical plant modifications has been submitted. The completed projects will allow for the addition of important specialties and better support from our academic affiliate with the addition of vital resident training programs and faculty.

Nursing support was completely retooled. A new and very experienced operating room supervisor, Judith Pennington, RN, was recruited from Denver and is the nurse in charge of surgical operations. She has selected a superb staff of qualified and experienced surgical nurses in a variety of discipline specialties to support the surgical programs. A PACU staff was recruited and is now in place.

Key surgical staff members were recruited. Dr. Charles Graham, Vanderbilt University trained, was selected as the new chief of surgery. Dr. David Crist, Johns Hopkins trained, was selected to head the section of gastrointestinal surgery. Dr. Valerie Moore was recruited from the University of Maryland to provide expertise in breast surgery and laparoscopic surgery. Dr. Anthony Burke from West Virginia University joined the staff with expertise in colon and rectal surgery. The women's surgical unit was expanded to provide expert gynecological surgery with the addition of Dr. Helen Malone from the University of Virginia.

Key anesthesia staff were recruited and added to the staff. Drs Block, Murphy and Breton, all highly qualified anesthesiologists have added great expertise in anesthesia and pain management at the medical center.

Expanded training programs in ophthalmology, and otolaryngology were established with Wake Forest University with both resident and faculty support from the University. A new program in urologic surgery supported by Wake Forest is set to begin the summer of 2007. A new chief of urology has been selected, Dr. Hector Henry, an adjunct clinical Professor from Duke University.

All quality measures including morbidity and mortality data exceed national standards. Effective monitoring is in place to ensure continued high quality performance and excellent patient care outcomes. Additional residency program commitments from Wake Forest and the Office of Academic Affairs are being sought to further the professional expertise at Salisbury.

Additional support in other related disciplines has been added. These include critical care specialists, infectious disease specialists, and others.

Question 3: When do you anticipate filling the Chief of Pathology position? How long has this position been empty? What criteria are you using to evaluate candidates for this position?

Response: The position is posted and a team of highly regarded pathologists has been appointed to serve on the selection Committee. Several excellent candidates have been identified and a selection is anticipated by September 2007. The current pathologist will remain in place until a new chief is selected and has had adequate time to be oriented to the department.

Question 4: How long had the Chief nursing position been empty prior to the OMI report, and after the issuance of the OM I report?

Response: The chief nurse on staff during the OMI site visit was removed on December 30, 2004. A new executive nurse was selected and joined the staff on June 10, 2005.

Question 5: It should be noted that the Women's Health Program is moving into a newly renovated space in order to provide additional services specific to the medical needs of women. How many female veterans do you anticipate being able to serve in this new space? When will this facility be fully staffed?

Response: The new women's health clinic space was completed in May 2007 and is now occupied. A complete staff is in place and includes a gynecologist, physician assistant, two nurses, a clinic clerk, an administrative officer and a dedicated primary care physician. Plans to add an additional staff gynecologist are in place and recruitment will be completed in the fall of 2007. The new space will allow for important additions to the women's health program, Primary care physicians will be added to the clinic in order to provide comprehensive care to our female patients.

This is particularly important for those women with a history of military sexual trauma. Additionally, for completeness in our comprehensive approach to women's health, the new space will include a new digital mammography unit for prompt breast cancer screening for all patients.

Capacity will be doubled, thus allowing the center to increase the number of female veterans seen and referred for complex gynecologic issues from Fayetteville and Asheville VAMCs along with the anticipated surge from Charlotte's new facility scheduled to open in early 2008. Currently the number of women veterans represents nearly 3000 veterans. With expansion into Charlotte and Hickory, numbers should exceed 5000 by the end of 2008.

Question 6: What future plans for construction do you anticipate for the future at Salisbury in order to continue to meet the needs of the veteran community in western North Carolina?

Response: Two minor projects have been funded and are currently under design for construction in 2008 and 2009. These projects will add 9,000 square feet to the existing medical surgical building and will provide space for radiology, pharmacy, dental service, a post anesthesia care unit (PACU) and special clinic space for urology and oncology.

There is a renovation project currently underway to add additional patient rooms with private baths to accommodate the needs of female patients and an expanded medicine service. A new eight bed intensive care unit is included in the project. Additional renovations are planned for the surgical care unit. A major project has been submitted to add additional needed space for specialty clinics and rehabilitation. This project is essential to meet the demand for additional services at Salisbury and is particularly important with the future addition of major clinics in our service area at Charlotte and Hickory. Major renovations have also been completed in mental health and existing primary care units.

Question 7: What specific actions have been taken to hold personnel found at fault in the deaths of the 12 patients which initiated the original OMI investigation accountable?

Response: There were three specific actions taken that affected hospital personnel.

- The chief of surgery was removed from his position. His surgical privileges were withdrawn permanently. After consultation with VA authorities, he was allowed to remain on the staff in a non-surgical capacity with the provision that he obtain additional training and meet the requirements for and obtain re-certification in his specialty. He will, however, not be allowed to operate independently again.
- The second index case was a non-surgical case and involved poor care on the part of an internal medicine physician. He was removed from the staff, his license to practice medicine in North Carolina was terminated and he moved from the State. To our knowledge he no longer practices medicine in any venue.
- The nursing issue that led to the failure to notify the appropriate on call physician in the index surgical case resulted in changing nursing leadership at the medical center and on the care unit involved.

The allegation of 12 suspicious deaths was not substantiated by the OMl or the national surgical director. After a review of all deaths at the medical center for a period of 1 year, there were two index cases, where death was related to substandard care. One surgical index case as noted, and one medical index, as noted. The personnel actions taken were related to those cases.

Questions for Mr. Moore:

Question 1: Now that you are in a position of greater responsibility and bigger staff, how do you insure all egregious IG and OMI findings of 22 inadequate actions in identifying and implementing specific corrective actions do not reoccur under your leadership in Phoenix?

Response: The Carl T. Hayden VAMC has multiple systems/structures in place to anticipate or prevent adverse events. These include the following:

- **Chief of Staff Oversight**—The chief of staff provides oversight of clinical programs, is involved in medical staff activities and leaders are held accountable for performance.

- **Performance Improvement Program**—The program has active participants from both clinical and administrative staff. There is an executive performance improvement council which meets monthly to review performance and other key indicators in the medical center.
- **Peer Review Committee**—The Committee meets quarterly and provides oversight for the peer review program. The peer review program meets standards required by VHA Directive 2004–054, *Peer Review for Quality Management* and is chaired by the chief of staff.
- **Risk Management Program**—The program includes anticipation of risk, staff education and prevention of adverse events. It also includes disclosure of adverse events to patients and review of 100 percent of patient deaths and adverse events.
- **Surgical Risk Assessment Program**—This facility participates in the national surgical quality improvement program (NSQIP). Surgical cases are reviewed and compared with all VA facilities nationally for mortality and morbidity. Outliers are immediately identified and actions taken to address any concerns.
- **Patient Safety Program**—This active program promotes a strong safety culture. Both clinical and administrative staff are involved with ongoing patient safety activities.
- **Infection Control Program**—The comprehensive infection control program focuses on prevention and monitoring of infections. The infection control committee works with providers offering feedback to clinicians about infection and related issues in the medical center. Infection control also serves as liaison with local and State health departments for reporting and followup activities related to infections that are public health concerns.
- **Medical Staff Monitoring & Active Medical Staff Committees**—The external peer review program (EPRP) is in place. There are several active medical staff Committees which monitor and improve patient care. These include the invasive procedures Committee, transfusion Committee, pharmacy and therapeutics Committee, medical records Committee.
- **Review by External Agencies**—We are reviewed by Joint Commission and had successful surveys. The next survey is expected during 2008.
- **Review by Internal VA Agencies**—We are reviewed by the Office of the Inspector General, Office of Research, etc. Our most recent OIG/ CAP review was completed in November 2006 and was successful resulting in only one recommendation.
- **Credentialing and Privileging**—This program provides oversight for a credentialing and privileging system of medical staff. VetPro (VHA's electronic system) used for credentialing all providers, assures appropriate documentation, credentialing, privilege delineation and service review and adheres to VA's regulations.

Question 2: Did you receive any performance bonuses during your tenure at Salisbury?

Response: Yes. $12,000 in 2005, $9,000 in 2006

Questions for Dr. Pierce:

Question 1: What were the steps taken to follow up on personnel reviews, oversight, and holding individuals accountable at the Salisbury VAMC? How did your office ensure all recommendations were being complied with? Please be specific in your response.

Response: Personnel issues are outside the purview of the OMI; however, as part of the closure of the case resulting in the report, *Review of the Delivery of Surgical Services, Salisbury VAMC*, of June 9, 2005, we noted that the following actions were taken by the VHA leadership "the physician involved in the surgical case has had his privileges removed and the physician in the medical case resigned after having a summary suspension of his privileges" as part of the medical center's fulfillment of its corrective action plan.

Medical centers are routinely required to submit a corrective action plan responding to all OMI recommendations within 2 weeks of their receiving the final report approved by the Under Secretary for Health. The OMI makes a judgment to accept the corrective action plan based on the medical center's timely, positive, and enthusiastic response; whether the proposed actions will suitably address the rec-

ommendations; and after reviewing evidence of proposed corrections. Some actions, e.g., clear VAMC policy on a particular issue, may be judged complete on the documentation; other actions, e.g., suitable nursing coverage, may require more intense follow up, such as conference calls and additional documentation. In some cases, the OMI conducts follow up site visits to be certain the corrective actions are all in place and effective.

In this case, the corrective action plan was accepted by the OMI, monitored, and the investigation closed when the intent of the recommendations were met. However, due to publicity surrounding this report and Congressional interest, the OMI conducted a follow up visit March 26–27, 2007 to assure all parties that the recommended corrective actions had been completed.

Question 2: Please provide written documentation of all actions taken against personnel in Salisbury, North Carolina following the misconduct/malpractice instances of the seven deaths.

Response: Personnel issues are outside the purview of the OMI. With regard to the seven deaths, these cases were reviewed under VHA's peer review program which is governed by title 38 United States Code 5705 *Confidentiality of Medical Quality Assurance Records* and found to be Level two on a scale of one to three. This means, "Most experienced, competent practitioners might have managed the case differently in one or more aspects." However, this difference in practice does not equate to misconduct/malpractice.

U.S. Department of Veterans Affairs
Office of Inspector General
Washington, DC.
December 18, 2007

Hon. Harry E. Mitchell
Chairman, Subcommittee on
Oversight and Investigations
Committee on Veterans Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

During the Subcommittee hearing on April 19, 2007, on *Case Study on U.S. Department of Veterans Affairs (VA) Quality of Care: W.G. (Bill) Hefner Veterans Affairs Medical Center in Salisbury, North Carolina*, Congressman Walz inquired about the process for requesting additional resources within the Office of Inspector General (OIG). We indicated that we would provide additional information for the record.

The OIG is an independent entity within the VA and has a separate line item in the VA appropriations bill. During the year, the funds available to the OIG are limited to this specific budget authority. The VA may not reprogram funds to augment the OIG's funding nor can VA take funding away from the OIG. The only way to ensure the OIG has sufficient resources to meet its mandated oversight responsibilities is though the annual internal VA budget formulation process and subsequent congressional appropriation actions.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

John D. Daigh, Jr., M.D.
Assistant Inspector General for Healthcare Inspections