

**AN ASSESSMENT OF LEADERSHIP FAILURES AT
THE MANCHESTER, NH VA MEDICAL CENTER**

FIELD HEARING

BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS**

OF THE

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

MONDAY, SEPTEMBER 18, 2017

**FIELD HEARING HELD IN PEMBROKE,
NEW HAMPSHIRE**

Serial No. 115-30

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: <http://www.govinfo.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

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AT THE MANCHESTER, NH VA MEDICAL
CENTER**

Monday September 18, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON DISABILITY ASSISTANCE
AND MEMORIAL AFFAIRS,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:35 a.m., at the New Hampshire National Guard Edward Cross Training Complex, 772 Riverwood Drive, Pembroke, NH, Hon. Jack Bergman presiding.

Present: Representatives Bergman and Kuster.

Also present: Senators Shaheen and Hassan.

OPENING STATEMENT OF JACK BERGMAN, CHAIRMAN

Mr. BERGMAN. This hearing will come to order.

Welcome to all who came out this morning to this beautiful new Guard building that we have an opportunity to have this hearing in. As you know, around the country our National Guard steps up every day in many different forms to do what needs to be done, and to be able to work out of facilities like this makes the job, I think, quite a bit probably more productive.

Thank you to all of my colleagues here at the table and those of you in the audience who take the time and effort to make projects like this become reality.

Thank you to all of you who have joined us in the audience.

Today we will discuss issues with the five witnesses at the table but will not be able to field questions from the audience. If you would like to write questions, any questions that you have down, we will be happy to take them back and we will answer them through the office later.

Prior to getting started, I would like to ask unanimous consent that Senators Hassan and Shaheen from the State of New Hampshire be allowed to participate in today's hearing.

Without objection, so ordered.

And, by the way, thank you for joining us. I know that you all have to go back into session here this afternoon, and you potentially have flights to catch. So depending on how long the hearing goes, if you see somebody leave, it is because they have to go back to Washington, D.C.

We are here today to address failures of facility and VISN leadership to identify and resolve problems at the Manchester, New Hampshire VA Medical Center. Many of these problems involve the same issues that arise in VA medical centers around the country. At least 12 whistleblowers have come forward to report a series of problems occurring at the Manchester VA Medical Center. Some have provided statements for the record, and I would like to also ask unanimous consent that these statements be entered into the hearing record.

Without objection, so ordered.

Mr. BERGMAN. These whistleblowers tried to go through proper channels and find solutions to these problems. But as we have seen happen over and over again in VHA, complaints were either ignored or went unaddressed. In Manchester, an operating room was abandoned due to a fly infestation, surgeries were canceled after discovering what appeared to be rust or blood on instruments that were supposed to be sterile, and thousands of patients struggled to get care because the system for getting non-VA care was severely broken.

Notably, in 2016, VA gave the Manchester Medical Center a four-star rating out of a possible five. It has been ranked above average for overall patient experience and near the top for minimizing the amount of time patients had to wait to see providers.

However, a Korean War veteran is reportedly suffering the effects of a large tumor on his spinal cord that was apparently missed by VA physicians for more than 20 years. Another veteran waited more than four weeks to be seen by an oncologist following a diagnosis of lung cancer.

I have to question a rating system that gives out such a high score while these and many other issues we will discuss today were occurring during the same period of time.

To be clear, I wholeheartedly believe that the frontline and clinical employees at the Manchester VA Medical Center demonstrate hard work and dedication every day and deliver excellent service to veterans. However, it is also clear that serious, immediate leadership changes are needed at this facility to right the ship and to ensure that these employees are in a position to provide the best possible care that they can.

After reading VA's written testimony, I am encouraged by the actions they are taking to attempt to remediate the problems at the Manchester VA Medical Center. However, I look forward to hearing from all the witnesses on our panel to discuss what more must be done to ensure that progress translates into actual results.

I now yield to Ranking Member Kuster for her opening remarks. And, by the way, thank you, Ranking Member Kuster, for spearheading this and getting us all up here, because of all the Committees that we have in the 115th Congress, the Veterans' Affairs Committee is far and away the one where we work—there are no party lines here. This is all about the veterans, and I am proud and honored to have Representative Kuster up here as my partner. So, I yield to you.

OPENING STATEMENT OF ANN KUSTER, RANKING MEMBER

Ms. KUSTER. Thank you, and thank you, Chairman Bergman, for coming to New Hampshire and making the trip. A month ago I had a great trip out to Chairman Bergman's district, and we had a good hearing in Traverse City, Michigan, and I am delighted to have you here on behalf of our Oversight Committee at the House Veterans' Affairs Committee. Welcome to our beautiful state.

I am also pleased that both Senator Shaheen and Senator Hassan can be with us today. I want to thank them for taking the time out of their busy schedules.

And I want to thank our witnesses, especially Dr. Kois, a whistleblower that has come forward, and Dr. Levenson and other whistleblowers that are with us in the audience today.

I want to welcome Commander Kenney and thank you for stepping up into a leadership role as co-chair of the task force. Commander Kenney is the chair of our State Veterans Advisory Committee, and he has been nominated by Secretary Shulkin to co-chair the task force that will review health care services provided to our New Hampshire veterans. I appreciate your extra effort.

Like many, I was appalled to hear about the breakdown in care, in coordination, in quality of care, and particularly in patient safety and very serious infrastructure issues that arose at the Manchester VA Hospital. It took brave whistleblowers, several investigations, the work of several congressional offices and agencies, as well as the media to uncover the serious problems at the Manchester VA Hospital.

In 2015, we started to see symptoms of the problem after Michael Farley, a New Hampshire veteran, was left permanently disabled because Manchester's Urgent Care Center failed to transfer him to a hospital just two miles away. At that time I asked the Inspector General to investigate Manchester's procedures for treating stroke patients. The IG's report found Manchester failed to follow its own procedures because of the facility's culture. Employees thought they could administer care when the hospital did not have the specialists and capability to provide acute care for stroke patients.

It is clear now to everyone that the Manchester VA Hospital needs a top-to-bottom or bottom-to-top transformation, and that is why we are here today, to look at what must be done to ensure that our New Hampshire veterans are receiving the highest quality of care at Manchester VAMC from the community providers and from the hospital itself.

VA can start by holding all of its employees accountable, from the hospital and network leadership to the administrative and frontline staff. Secretary Shulkin made the right decision to remove the hospital director, the chief of staff, and the head of nursing services, and I know that efforts are underway at recruitment for these important positions as we speak.

VA leadership who knew about the reports of substandard care and failed to act should be held accountable. Supervisors who retaliate against whistleblowers should not be employed at the Manchester VA Hospital. The culture at the Manchester VA Medical Center must change so that our providers follow procedures and

clinical guidelines, and so that providers and veterans are supported and unafraid to report problems when they arise.

New Hampshire is the only state in the continental U.S. without a full-service VA medical facility. Manchester should be a model for delivering quality care both in the hospital and in the community. It should be the model for solving administrative challenges so our veterans can easily access care. But instead, Manchester is a glaring example of the same challenges that VA hospitals and networks face throughout the country to meet patient demand and coordinate care under the current Choice program. Our facility here in Manchester needs serious repairs. Patients wait too long to receive care at the hospital and through the Choice program. Providers at both the hospital and in the community have difficulty coordinating care because of the administrative burden. This must change.

I want to know how the \$30 million will be spent and if it will truly address the infrastructure and care coordination problems in Manchester, or if more funding will be needed to ensure that the VA has the resources in New Hampshire to meet the needs of our veterans. The task force is charged with making recommendations for the health care needs of our veterans, and I hope they will thoughtfully examine how we can improve care coordination, including the model that is very successful now in the North Country here in New Hampshire, and how we can coordinate care with our community providers.

We rely on our community providers to provide acute care and inpatient care, and that is something that should continue. We need to determine what is the best course forward. I am eager to see what the task force recommends, and as we move forward to improve care for New Hampshire veterans, the patients, the veteran service organizations, VA providers and community providers should all have a stake in the decisions that are made.

I hope we can use what we learn here today as a starting point to work together to develop commonsense solutions to VA's challenges and to ensure that what has happened in Manchester will not be repeated. Veterans must be able to trust that the VA will provide them with the best quality of care.

This will take some time, but I believe we can work together to bring New Hampshire veterans the highest quality of care that they deserve, and I yield back my time.

Mr. BERGMAN. Thank you, Ranking Member Kuster.

Our Committee custom is generally to ask other Members to waive opening remarks. But seeing it is just the four of us up here today, I would like to allow Senators Shaheen and Hassan the opportunity to provide some brief opening remarks as well.

Senator Shaheen?

OPENING STATEMENT OF SENATOR JEANNE SHAHEEN

Senator SHAHEEN. Thank you very much, Chairman Bergman and Ranking Member Kuster, for convening this field hearing and for shining a spotlight on the efforts to correct problems at the Manchester VA Medical Center. I very much appreciate your willingness to give me and Senator Hassan the opportunity to join you and to say a few words.

I believe very strongly that the Federal Government has a contract with those who have served in uniform. We have a duty to provide our veterans with the quality health care that they have earned and that they deserve.

We in Congress also, as well as leaders at the VA, have a responsibility to identify any problems where they exist, to hold people accountable, and to make things right. In the case of the Manchester VA Medical Center, I am grateful to the whistleblowers, represented today by Dr. Ed Kois, for coming forward and for your persistence in raising serious concerns about the treatment of patients at the Manchester VA. I also respect that you and the other whistleblowers continue to be determined not only to raise questions but to be part of the solution. So, thank you for that.

I know all of us appreciate Secretary David Shulkin's hands-on approach to the challenges here in Manchester, including his decisive action to remove top management at the center and to order a range of reviews, improvements, and new hires. During his visit last month, I was heartened by his decision to name a task force to come up with a plan by January for offering full services to New Hampshire veterans, and he put on that list the prospect of a full-service veteran's hospital. As Congresswoman Kuster has said, New Hampshire is the only state in the lower 48 that does not have a full-service VA hospital. We have been waiting for this for a very long time.

In the meantime, I hope that task force will take steps to ensure that care in the community programs, in particular the Veterans Choice program, is working effectively for New Hampshire veterans. And as Congress considers reauthorization of the Choice program, we need to look very closely at how we can make that program work better.

I am grateful to Acting Medical Director Al Montoya and Acting Chief of Staff Dr. Brett Rusch for stepping into a very difficult situation and jump-starting necessary changes and reforms.

And in addition, I want to salute the health care providers and support personnel, the frontline folks at the Manchester VA, who despite the recent difficulties have stayed focused on providing high-quality care to the people they serve.

As we go forward, I know that we all share the same goals, to correct deficiencies that have been identified at the center, to restore trust in the center's leadership, as well as accountability at all levels, and to ensure that our New Hampshire veterans receive the excellent health care they deserve.

Thank you very much, Mr. Chairman, and I look forward to hearing from our witnesses and appreciate their being here today.

Mr. BERGMAN. Thank you, Senator Shaheen.

Senator Hassan?

OPENING STATEMENT OF SENATOR MAGGIE HASSAN

Senator HASSAN. Well, thank you very much, Chairman Bergman and Congresswoman Kuster, Ranking Member, for convening this hearing. Senator Shaheen, it is always good to be in the same hearing with you. And to all of our witnesses, thank you so much for being part of today's hearing. Dr. Kois, I thank you and all the whistleblowers as well for your persistence and diligence in

standing up for the men and women, the veterans treated at our Manchester VA.

Veterans across New Hampshire and the United States of America have demonstrated a selfless commitment to keeping our Nation safe, secure, and free, and we have to ensure that every single one of our veterans receives the care that they need and, to Senator Shaheen's point, and to all of the legislators' points here that they have earned.

All of us here today are outraged by the poor conditions and quality of care that were alleged by whistleblowers, and I thank Dr. Kois and his fellow whistleblowers for help bringing this to our attention.

I appreciated very much that last month Dr. Shulkin visited the Manchester facility to learn about these concerns, but his visit has to be just the first step of many to address the problems raised by whistleblowers. We have to continue to work together to get to the bottom of these issues and to make sure that our veterans get the high-quality care that they deserve, and field hearings such as this one will help us do that.

I believe that we need a thorough, independent review process which includes interviews with clinicians and patients in order to address these concerns and prevent future failures in care for our veterans.

I also continue to support a full-service VA hospital in New Hampshire, and I believe that we need to improve coordination and communication at the VA and more broadly, because the unfortunate reality is that health care is far too siloed. I am going to continue to work with everyone here and partners at the state and Federal level to ensure that we are fully honoring the commitments we have made to our veterans.

I also join all of my colleagues here in thanking the hard-working health care providers at the Manchester VA. We have heard time and time again, since the whistleblower report came forward, from individual veterans who are very, very grateful to the health care providers who work with them at the VA, and I want us to support those providers and move forward again so that every veteran in New Hampshire knows that they are getting the highest possible quality care in a setting and in a timely way that makes sense for them.

Thank you.

Mr. BERGMAN. Thank you, Senator Hassan.

With that, I now welcome the panel that is seated at the witness table. On the panel we have Dr. Carolyn Clancy, Deputy Under Secretary for Health for Organizational Excellence at the Department of Veterans Affairs. She is accompanied by Dr. Michael Mayo-Smith, Network Director for VISN 1, and Mr. Al Montoya, Jr., Acting Director of the Manchester VA Medical Center. Also on the panel we have Mr. David Kenney, Chairman of the New Hampshire State Veterans Advisory Committee. And finally we will hear from Dr. Ed Kois, a Pain Management Specialist at the Manchester VA Medical Center, who has brought many of the issues we will discuss here today to light.

Dr. Clancy, you are now recognized for 5 minutes.

STATEMENT OF CAROLYN CLANCY, M.D.

Dr. CLANCY. Good morning, Chairman Bergman, Ranking Member Kuster, Senators Shaheen and Hassan. Thank you for the opportunity to participate in this hearing to discuss VA's response to the concerns raised at the Manchester VA Medical Center. As you mentioned, I am accompanied by Dr. Michael Mayo-Smith and Mr. Montoya.

I want to specifically mention our appreciation for Mr. Montoya's stepping into a tough situation and handling it admirably.

First let me say that VA appreciates the actions taken by whistleblowers when it comes to safeguarding care for our veterans. I thanked Dr. Kois when we met for the first time this morning. We are committed to always protecting those whistleblowers from retaliation. VA has and will continue to take immediate action when responding to whistleblower concerns at any VA facility across the country. The Office of the Medical Inspector and the Office of Accountability and Whistleblower Protection were sent to conduct a top-to-bottom review of the Manchester VA, and the Secretary rapidly recognized the need for a new leadership team. We look forward to this opportunity to build trust between VA and our veterans and to keep Congress up to date on our progress.

Our focus in Manchester now is on the way forward and ensuring that high-quality, timely access to care is the default in all aspects of medical center operations. Currently, the medical center is executing a plan that focuses on five key areas: rebuilding leadership; restoring trust; improving care; fixing the Veterans Choice program's local operations; and designing the future.

To address the lack of consistent leadership at the VA, we are recruiting nationally for the medical center Director, Chief of Staff, Nurse Executive, Chief of Medicine, Chief of Surgery, Chief of Primary Care, Director of Urgent Care, and a physician leader for the newly-created Office of Community Care.

Second, we are also working on restoring the trust of our veteran staff and community stakeholders. Medical center leadership has taken swift action to ensure that all members of the medical center, including clinical staff, are included in key decisions. As noted, VA immediately responded to the whistleblower allegations with thorough reviews from several offices, and we have an external non-VA review being done by an organization called Lumetra of our myelopathy cases and the cases that we have reviewed internally. These will be Board-certified physicians in the appropriate specialties who are bringing fresh eyes to the clinical evidence at hand.

Finally, there has been consistent structured public reporting and listening sessions with veterans, staff, and community stakeholders to discuss progress at the Manchester VA.

To improve timely access to care, we have committed over \$5 million to hiring additional staff. This includes several key positions on the cardiology staff and two new patient-aligned care teams for primary care. We have accelerated community and academic partnerships to support the medical center and are looking to open an accredited rehabilitation program for chronic pain and purchase needed equipment for surgery.

We have also restarted nuclear medical testing at the VA, Manchester, with the goal of adding stress tests by October. We have

successfully hired two suicide prevention coordinators, a women's health medical director, and a women veterans program manager, and working very hard to ensure all areas affected by the flood are open and operational by December 2017.

On July 26 of 2017, we created a new Office of Community Care in Manchester that consists of over 30 staff, including 17 new physicians dedicated to ensuring our veterans have assistance in navigating all aspects of care in the community. This office processed and cleared a backlog of approximately 3,300 pending consults. With a change in process, 95 percent of all pending consults are being taken care of within two business days.

Additionally, we have taken a proactive approach with our community providers and assisted in ensuring that bills from our providers within the Veterans Choice program network and our community care providers are being processed in a timely manner. We have established routine calls with our Veterans Choice program network's field operations staff, embedded a network representative, and fostered a relationship of collaboration.

We are positioning the Manchester VA Office of Community Care to be able to handle any changes to the Veterans Choice program in the future as we continue to work with the Congress to improve that program.

Finally, Secretary Shulkin will be creating a Subcommittee of VA, a Special Medical Advisory Group—this is one of our big Federal advisory committees—to make recommendations on the future of the VA care delivery model for New Hampshire veterans. The Subcommittee membership will consist of strong representation from New Hampshire veterans, VA Medical Center staff, including representation from the whistleblowers, regional and national subject-matter experts, and leaders of the New Hampshire hospital and provider communities.

Under the direction of the advisory group, the Subcommittee will undertake a careful review of data and develop innovative solutions for improvement. The Subcommittee will take the grave infrastructure issues at the Manchester VA into account when developing its recommendations. The advisory group will, in turn, make recommendations to the Secretary through the Under Secretary of Health by the end of January 2018.

We look forward to this opportunity for our new leadership to restore the trust of our veterans and continue to improve access to care inside and outside VA. Our objective is to give our Nation's veterans the top-quality care they have earned and deserve. We appreciate this Subcommittee's support and encouragement in identifying and resolving challenges as we find new ways to care for veterans.

My colleagues and I are prepared to respond to any questions you have.

[THE PREPARED STATEMENT OF DR. CLANCY APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Dr. Clancy.

Dr. Kois, you are now recognized for 5 minutes.

STATEMENT OF WILLIAM E. KOIS, M.D.

Dr. KOIS. Thank you. I want to thank the Committee here. Bringing light onto this subject is a wonderful thing. I would also like to thank the whistleblowers. I may just be the pretty face that is sitting at the desk, but they are the substance behind me, and I want to make sure that everybody reads their statements because they are worthwhile to look at and they have different perspectives. It is just not my perspective.

I would like to thank the press. I think without the free press, we probably wouldn't be sitting here.

And finally, I want to thank the veterans of our state. They are what has driven this whole process, and we hope to continue to work for them. None of the whistleblowers have quit and are looking for settlements. We are looking to make the situation better for our veterans, and we hope to work with everybody, with Congress and with the Administration and with veterans and veteran organizations, and with community leaders and providers to really come together.

New Hampshire is a unique state. It is like a little village. If you have lived here any length of time, you start to know people. That is good and that is bad. You can't make too many people angry at you. But on the other hand, you can bring in resources in an amazing way, and that is what I hope to have happen with what is going on here, is that we come together and call our resources from a variety of different institutions and make something better.

My name is Ed Kois, and I am a VA physician at the Manchester Medical Center. I have worked there since 2012. I have a variety of different hats. I have worked in the spinal cord clinic, the pain clinic, the amputation clinic, the traumatic brain injury clinic, and the physical medicine clinic. During that period of time, I have grown to love the veteran population.

Prior to that, in '86, I started working in New Hampshire and had a traditional private practice until 2012, and I have to say the veteran population is completely unique. When I hear people say let's just privatize things, I don't think they understand the uniqueness of our vets and the uniqueness of their needs. And I think that we have to really think long and hard about that.

I receive a paycheck from the VA, but I consider myself an employee of the veterans of the state, and that is who I work for, and that is why I started to talk to other physicians when concerns about patient care started to raise its head.

After almost two years of utilizing all avenues available to me and not receiving satisfactory solutions, I eventually started to talk to Dr. Levenson, Dr. Funk, and some of the other physicians that initially were on my floor, and then we started to talk to other physicians throughout the building and found that they had similar complaints.

At that point we had all sort of been isolated. No one really talked to each other, but it was great because we were able to say, hey, are you having this type of experience? And we realized we all were. And so for that reason we eventually formed the whistleblowers, but I can tell you we represent a large number of physicians and nurses in our facility who had similar problems.

The Boston Globe article on July 16th really broke this story right open, but the groundwork had been laid by Senator Shaheen and by Representative Kuster. We met with them earlier, discussed our concerns, and they were able to direct us to the Office of Special Counsel. The Office of Special Counsel was wonderful in dealing with them.

I am going to level my first complaint. My first complaint is that the Office of Medical Investigation that was initially done at the request of the Office of Special Counsel was a sham, and I feel it was not representative of good work. Later, if you people want to ask me about it, I would be glad to talk about that.

But that, I think, is troubling, because they are supposed to be the front line to prevent catastrophe from happening, and it didn't happen.

The problems, however, in the Manchester VA that had been well exposed by the Boston Globe are not unique to our VA. I believe if you read the Globe's article yesterday, they talked about many other facilities. There was a recent facility in Memphis, there have been throughout the country, and I think unless we get a handle on really what is happening in the VA system, this is going to continue.

In a nutshell, we have really dedicated people who work in the system, but we have a bureaucracy that is so top-heavy and so slow to react that it is problematic. I liken it to a 900-foot ship or a barge that is going down a river. It can't make the quick turns that are needed in today's changing medical care, and we need nimbleness.

One of the things that really delighted me in meeting Dr. Shulkin is he gets it. He gets the fact that we have to be nimble and that we have to react and do the right thing, and we can't let our cumbersome rules get in the way.

The publication in the Globe resulted in the meeting with David Shulkin. On August 4th he met with eight whistleblowers, and the other thing that impressed me was he listened to us. He didn't tell us what we needed to do. He listened to us, and then he took quick action. He removed the three individuals at the top, but those aren't the only three. If you read some of the other reports from the whistleblowers, there are other people within our system that we need to continue to evaluate.

The other thing, and I hate to bring unpleasant stuff, but our VISN didn't support us. Now, maybe it is because we are in the North Woods or we are in the hinterlands, but we complained to the VISN incessantly on this. Dr. Levenson complained, I complained, and we did not see the support at the VISN level to make these actions. In fact, we felt ignored, and that is troublesome when you are sitting in front of a patient like I was seeing some of them have disastrous results and not being able to get the resources that were appropriate for them.

Now, Dr. Shulkin named Acting Director Montoya and Dr. Rusch, and I have to say they are both nice guys, and I think they are trying very hard, and I am glad to have them on the team and glad to work with them. They have tried to already start to institute things, but this is a process that is going to take months and months, or years, to really complete and turn around. We still have

tremendous problems in the operations of our ORs. We have a situation right now that I have talked to Al about, and we have a whole group of practitioners who are ready to walk out, and I don't think people realize the seriousness of it, and that has to be addressed.

I also have to comment that Al and Brett have tried to include us. I am going to be part of the new search committee for the chief of staff, and other physicians are going to be involved with that.

Finally, I think that what has happened in the VA—we can talk about this for the rest of this morning, but I think it is emblematic of other issues throughout the VA system, and I would hope that what we learn in Manchester and what we do in Manchester can be used in a nationwide change of the VA system. I hope that we are able to get a full-service hospital here. I hope that we get a new facility, and I hope that we are able to community partner.

Thank you.

[THE PREPARED STATEMENT OF DR. KOIS APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you very much, Dr. Kois.

Mr. Kenney, you are now recognized for 5 minutes.

STATEMENT OF DAVID J. KENNEY

Mr. KENNEY. Thank you, Mr. Chairman, Ranking Member Kuster, Senator Shaheen, Senator Hassan, and distinguished Committee Members. It is an honor to submit this testimony as the current Chairman of the State Veterans Advisory Committee. Our Committee is comprised of 19 veteran service organizations, as well as advisors from a number of state agencies in New Hampshire that provide services to veterans and their families. I should also state for the record that I am a 40-year Navy veteran and currently do not obtain care at the Manchester VA.

As part of the New Hampshire veteran leadership, I have heard various individual complaints with the VA over time. However, the revelations by the Boston Globe article were appalling. The article alleged alarming levels of systemic breakdown at the VA Manchester and an apparent lack of commitment to fixing the issues.

Since the Boston Globe article was published, I personally participated and/or observed a number of meetings related to the VA and Manchester, including the public meeting held by the whistleblowers to air their concerns. I am pleased that these deficiencies have been uncovered and believe that the exposure offers a great opportunity to not only fix the issues at VA Manchester but to potentially develop some valuable best practices which could be deployed to other VA facilities around the country.

It is, however, unfortunate that we are here today once again providing testimony that cites problems and deficiencies with the VA medical system. In fact, the need for whistleblowers or a protection system for them implies an underlying lack of genuine accountability.

One could surmise that if the system worked as it should, there would be no need for whistleblowers, reactive repairs, and veterans would get the best care that they deserve. Today there are thousands of veterans in VA facilities across the country. Most are

there because our Nation put them there. When our Nation issued the call to war, these men and women answered because they took the oath to do so, but they did not die on the battlefield. They came home and in many cases later suffered the manifestations of disease caused by chemicals we employed in the jungles of Vietnam, from the oil fields and burn pits in the Middle East, from the atomic waste at the atolls and the Marshall Islands and, sadly, poisoned by the water on their own U.S. bases.

In today's conflicts, body armor protects the core but not the limbs. We now have more amputee survivors than we have ever had before. And there are the hidden wounds of TBI and PTSD, which cannot be repaired by a quick pill or by some one-stop therapy.

This is the reality of the VA's responsibility. It is the reality of our responsibility.

If you think about it, great medical care transcends the VA. When we go to our doctor, do we not expect to be treated properly? It is reasonable to expect that when a doctor orders a test or some follow-on procedures that we expected those to be done professionally and in a timely manner. So why would we continue to stymie the kind of care for our Nation's heroes? Why do we continue to mire them in a system of complex bureaucracy, having to navigate and fight and make hundreds of phone calls just to get basic services?

The answer is simple: If we are truly serious about providing excellent care to our veterans, then we need to change our culture of bureaucratic blockage and budgetary excuses for not providing what is needed. The culture change must also embrace the notion that doctors and medical staff know what is needed, and it is the Administration's job to figure out how to best get that done in a timely manner. Do that, and we can truly say that we have made progress?

Thankfully, not all is bad news. Director Montoya has advanced a number of significant improvements to solving many of the problems and deficiencies discovered since he arrived in July of 2017, and the VA Manchester has been lauded by many veterans for the superb quality care that they receive there.

But challenges remain, including access to care, ensuring the best technologies are available, improved access to primary care physicians and, when needed, a properly functioning, fully funded Choice program. It is imperative that the new leadership will create an environment of trust for both the staff and the patients alike. Accountability and a pursuit of excellence should be a daily routine. When a patient's safety is at stake, there can be no compromise.

I have been asked to serve as a co-chair on Secretary Shulkin's task force Subcommittee to review and make recommendations for improvements at Manchester VA. Part of our charter is to ensure that we think creatively and entertain all reasonable options that would be most prudent to implement and send to the Secretary for his consideration. It is my sincere hope that our recommendations will get the full support of the VA Secretary and the Congress' financial backing.

Our process will be closely monitored by the veterans here in the State of New Hampshire and around the country. We cannot fail them any longer. Their lives depend on it.

In closing, General Washington wrote a letter in 1781 to Governor Trumbull in Connecticut, and what he said was this: "Permit me, sir, to add that the policy alone in our present circumstances seemed to demand that every satisfaction which can reasonably be requested should be given to those veteran troops who, through almost every distress, have been so long and so faithfully serving our states."

General Washington strongly believed in the importance of supporting veterans in all aspects. We need to keep that visionary wisdom in the forefront of everything that we do for veterans.

Thank you for your consideration of my testimony, and I remain at your service to answer any questions.

[THE PREPARED STATEMENT OF MR. KENNEY APPEARS IN THE APPENDIX]

Mr. BERGMAN. Thank you, Mr. Kenney.

The written statements of those who have just provided oral testimony will be entered into the hearing record.

We will now proceed to questioning.

Ranking Member Kuster, you are recognized for 5 minutes.

Ms. KUSTER. Thank you, General Bergman.

And thank you to our witnesses for appearing with us today and for your excellent testimony.

I am going to take my first round of questions to focus in on that Mr. Kenney said that Manchester could provide valuable best practices that could be shared across the country, and I believe, Dr. Kois, you were taking a similar approach.

I just want to ask Mr. Montoya if we could focus in on this issue of the Choice Act and community care. What are the steps that you are taking to bring better practices? And then Mr. Kenney had a very important point, a properly functioning and fully funded Choice program, if you could walk us through that. And then I have one other question for Dr. Kois.

Mr. MONTOYA. So, thank you so much for the question and for the opportunity to be here today.

I think as a veteran myself who gets 100 percent of my health care within the VA, this mission has been a very personal one for me. It has been very long days, but I know that at the end of those days the veterans are getting the care that they deserve.

So the best practice as far as the Office of Community Care, the first week that I was at the Manchester VA I recognized the need to really transform the delivery model for Choice for the veterans within the State of New Hampshire. So I essentially enlisted the help of some subject-matter experts who have helped us throughout the network and standing up traditional offices of community care. These are models that are based very much on the models that you are familiar with up in the North Country where there are case-managed models with a nurse case manager, as well as MSAs or medical support assistants that help those case managers.

So we essentially took that model and scaled that to one that would be successful here in Manchester. I will tell you that imme-

diately there were 3,200 pending consults, so we had a lot of work that we had to do in order to be able to make sure that veterans were getting the best access to care.

The processes that we have put into place now require there to be six different nurse case management teams, which are all supported by a nurse manager, as well as a physician leader who reports directly to the chief of staff of the organization. Because of that approach and the processes that we have put in place, I am very happy to report that there are no pending consults greater than three days. The National Directive states that that requirement is seven days. So clearly, we are a best practice within the country.

I will tell you that additionally last week, we received our Joint Commission for-cause survey, and during the out-brief we were verbally recognized as that practice, the consult management practice, as being a best practice for others to emulate.

Ms. KUSTER. Thank you.

I want to turn to Dr. Kois. There is so much to discuss, and our time is brief, so I want to make sure to focus in on your role and your fellow whistleblowers to make sure that you have not experienced retaliation. I think Mr. Kenney made a really good point. If we had the appropriate processes in place, we shouldn't be so reliant on whistleblowers. But I had an amendment to our VA accountability bill that we just passed in June that would provide better training and protections for whistleblowers.

But could you just comment on your experience with that and anything more that we could be doing to protect whistleblowers?

Dr. KOIS. Sure. You know, the unfortunate situation was that we did experience retaliation. We deal with retaliation different ways. The way that I deal with it is I am sitting here talking to you, and I am happy, and I am trying to treat my patients and trying to move forward. The retaliation, the people who did it, they don't have jobs at the Manchester VA anymore. So in my heart, I am satisfied with my direction.

I know that Stewart Levenson received retaliation, and I know that we have another whistleblower who is our financial person who really had significant retaliation against him, and they will have to deal with it in their ways.

Because of seeing other people retaliated against—I remember Russ Pulinski and Harry Morse were retaliated against—it put the fear in a lot of people when we first started to bring these groups together, and in many ways it was almost like a secret society because we were concerned that if it got out we would be fired or canned or moved. They tried to move me out of the spinal cord clinic even though I have 30 years' experience in it, and they tried to replace me with someone who had none. But that didn't work, and we will just have to keep going.

But one of the things I have to tell you, the first thing that Dr. Shulkin said was along the retaliation issue, and he assured us that he would not tolerate that, and Dr. Clancy here said that in her statement, and I believe them. I think they are making a real hard attempt not to have us feel uncomfortable now, but the reality is that we were retaliated against.

Ms. KUSTER. Thank you. Thank you very much.

I yield back.

Mr. BERGMAN. Thank you.

Senator Shaheen, you are recognized for 5 minutes.

Senator SHAHEEN. Thank you, Mr. Chairman.

I want to go back to your comments, Dr. Kois, about the Office of Medical Investigation. You suggested that you were disappointed with how they operated. Can you be more specific about your particular concerns?

Dr. KOIS. Certainly. I would be glad to.

The Office of Special Counsel has a process where they divvy up the tasks of investigation to the Office of Medical Investigations. That investigatory board brings a report back to them. It is then forwarded to the whistleblower. We get a chance to rebut it. It then goes back to the OSC, and then they ultimately adjudicate that in some fashion and issue a final report.

Well, the Office of Special Medical Investigations, it wasn't a real investigation. I sat there for my—initially I wasn't on the list to be asked questions. I am the guy that brought the 96 patients, and they excluded me. And I finally stopped them in the hallway and said, "Don't you want to talk to me?" And they said, "Who are you?" And I said, "I am the guy that got the list of the 96 patients. You may want to talk to me." So they did, but they scheduled 45 minutes, spent 15 minutes introducing themselves. It came down to 18.75 seconds per patient I was allowed to discuss, okay? What kind of investigation is that?

Then the feedback in the report that there was no patient harm done. But of the 96 patients, they only did two patients. They only issued a written synopsis on two patients. They said if you want, you can look at another 30, and everybody else is fine. Well, if you read the Boston Globe article, they included the 20-year vet who had the tumor and who had never been reached as one of those who were fine. They listed the guy who had the screw going through the nerve as fine. They listed the guy who said he ate Chiclets for seven years because no one did an MRI as fine.

My question is how many of those 94 patients in which they provided no data did they really look at? So I asked the OSC to ask for time stamps on when they went into those patients' charts and for how long they were in those patients' charts, and you know what? We don't have those yet. They asked for another continuance on that.

I will tell you, if it comes out that they didn't look in those other 94 charts, you are not going to have me quiet about that. And if they didn't look for a meaningful time, they also didn't ask Dr. Ohaegbulam about his letter, which is in your files about the care.

Senator SHAHEEN. Pardon me for interrupting, as my time is running. I just want to—so your concern was that there wasn't a real independent investigation and that they didn't really extensively review the cases that you brought before them.

Dr. KOIS. Exactly. When they looked at Dr. Huq, who fabricated notes for 10 years, they said they only looked at three years, but based on those three years they don't think any patient harm occurred.

Senator SHAHEEN. Thank you.

Dr. Mayo-Smith, Dr. Kois also suggested that he was concerned that VISN 1 didn't really respond to the issues that were raised by whistleblowers. Can you talk about what your process is and whether that is a process that is designed by the VA itself or by VISN 1 to address whistleblower concerns when they are brought before you?

Dr. MAYO-SMITH. First, let me open it up by expressing my appreciation as well for the whistleblowers bringing forth these concerns. It is very important for us to hear any concerns, and we appreciate the fact that they spoke up and that they had concerns about patient care and brought them forward in the way they did.

My responsibility as a network director is to listen and respond immediately to concerns. There is a steady flow of issues that are brought into my office from patients, families, physicians, congressionals, et cetera. And I think that it is one of the things we learned, that whatever system we have now, it isn't good enough.

We did look back—I did look back, of course, and look at whatever communication that happened, and I did see that I responded. And, in fact, I reviewed those responses with the Deputy Under Secretary for Operations and Management in Central Office to get his input on whether the response was appropriate. But still, there is more to be done, I think.

That is why, on our way forward, the way forward, we are looking at rebuilding leadership and restoring trust. As was mentioned, this is actually a problem nationally in the VA.

Senator SHAHEEN. It is, and I was going to ask Dr. Clancy if there is nationally a protocol for how leadership is supposed to respond to whistleblower concerns. Is there a requirement for how they should be handled?

Dr. CLANCY. There is a very clear protocol, particularly with respect to any retaliation. I also need to just say that any health care system, VA or private sector, whatever, actually relies on the vigilance of employees who are dealing with patients directly or dealing with the services that affect patient care directly to raise their hands and say we have a problem here, you have drugs that look alike and could be confused, or whatever the problem is. In fact, we have a National Center for Patient Safety which fields those concerns all the time.

All employees have an idea, and clearly we need to be communicating this more and more vigorously, about the multiple avenues available to them, either up through their supervisory chain to the National Center for Patient Safety or others. I can attest quite personally that the National Center for Patient Safety folks, because they work for me, take that very, very seriously, and in some instances have been able to uncover problems where we didn't have the good fortune to have whistleblowers making a lot of noise and so forth, so we were able to catch that early.

It is an ongoing challenge for all health care systems, and that human surveillance or vigilance is absolutely vital. So the part of the story here that I find most disturbing is Dr. Kois saying for two years he tried but wasn't effective, and that is the piece that we need to get to.

Senator SHAHEEN. Thank you.

Mr. BERGMAN. Thank you, Senator.

Senator HASSAN, you are recognized for 5 minutes.

Senator HASSAN. Thank you very much, Mr. Chair.

Dr. Mayo-Smith, I want to ask a bit about the task force you are heading up, the task force on how to deliver full services to veterans in New Hampshire.

When Secretary Shulkin was here last month, he said—and this is his quote—“This organization is not a full-service organization, and that’s what New Hampshire needs. So I have charged Dr. Mayo-Smith to form a task force that will report back to us on how we can deliver full services to our veterans here in New Hampshire.” Those were really welcome words from Secretary Shulkin, but it is not the first time that we have heard a proposal for improved services in New Hampshire, and so I have some concerns about follow-through.

I will be paying close attention to the work of this task force to ensure that it is not just another idea that doesn’t go anywhere. I know that Senator Shaheen and Representative Kuster will be doing the same thing.

I also want to express concern at the fact that in what we have seen since Secretary Shulkin’s visit, the VA is already seeming to move away from the strong full-services language that Secretary Shulkin used. I have long felt that what we need in New Hampshire is a full-service VA hospital. Secretary Shulkin was clear that he wasn’t prejudging whether we needed a full-service hospital, but he was equally clear that the task force would create a plan to deliver “full services.”

So, Dr. Mayo-Smith, can you explain to me why Secretary Shulkin’s language about full services has been excluded from most of what we have seen from the VA so far about the task force? And can you recommit to us that the purpose of the task force is what Secretary Shulkin laid out in his quote, which is how we can deliver full services to our veterans here in New Hampshire?

Dr. MAYO-SMITH. As he stated I think in the charge letter, we were to design services that meet the needs of the veterans in New Hampshire. And as you state, for many years the veterans in New Hampshire have felt that they have to travel out of state to get services that veterans in other states can get within their own state. And we are determined, and our goal in this task force is to have everything on the table in terms of what the options are, and our goal is to bring back a set of recommendations that would allow veterans to receive here within the state a full set of services.

Senator HASSAN. Thank you for that clarification. You just moved in your answer from talking about “best meet the needs” to “full services,” and a lot of us do see a distinction in that language, and the charter of the task force says “best meets the needs” and doesn’t mention the term “full services.” So what you are hearing from me and what I hear from a lot of veterans is that we believe the only way you can best meet the needs of the veterans in New Hampshire is to have full services for them here in the state, as veterans in all the other lower 48 do. Thank you.

Dr. Clancy, my office has heard from a number of veterans and providers about concerns with Veterans’ Choice, from appointments that never get scheduled to prior authorizations that are canceled

at the very last moment. We also heard concerns raised that the results of appointments made through Veterans' Choice don't get communicated back to the patient's primary care provider at the VA. These are all serious issues, and if we are going to address improving services for veterans in New Hampshire, then the VA must fix Veterans' Choice.

But some of the lack of coordination and communication issues are not unique to the VA. Unfortunately, I think we find throughout our health care system in the United States that health care is far too siloed. In particular, we see artificial divides between primary care and behavioral health care. We know that behavioral health issues can have real impacts on physical health, and vice versa.

So as you look, Dr. Clancy, at rebuilding the VA's service capacity, how can you create a truly integrated, full-service environment?

Dr. CLANCY. Thank you so much for that question. You are right that throughout health care what my mother used to describe as the left hand not knowing what the right hand was doing is a daily, hourly occurrence, and it leaves patients and families in the middle, veterans or otherwise.

I was very, very appreciative of your comment about primary care and behavioral mental health. Throughout our system, many of our primary care teams have had a mental health specialist embedded or on-site with them. I can't tell you—I am a primary care doc. It makes a huge difference if you are recommending to an individual that they would benefit from that kind of assistance that you know the person and can say I work with this person all the time. It is even better if they are right down the hall. We are now expanding that throughout the entire system because it is a mind-body connection. The Chairman and others referred to the invisible wounds of war, Mr. Kenney and so forth, and I think that is really one of the strongest assets that we have.

Senator HASSAN. Thank you.

And thank you, Mr. Chair.

Mr. BERGMAN. Thank you, Senator Hassan.

I claim 5 minutes for myself.

Dr. Mayo-Smith, how many years have you been working for the VA, and when were you appointed as the Network Director for VISN 1?

Dr. MAYO-SMITH. I have been working for the VA for 32 years, and I was started as a staff position at the Manchester VA and practiced here in New Hampshire for almost 20 years. I spent some time in Central Office and was appointed as Network Director nine years ago.

Mr. BERGMAN. And, Dr. Mayo-Smith, whistleblowers in Manchester have stated that their concerns were sent to the Office of Special Counsel after trying to resolve them internally over a year ago. When were you made aware of the issues in Manchester, and what did you do to improve operations prior to the Boston Globe article? Essentially, why did it take a press report to get these issues at Manchester on the skyline to get resolved?

Dr. MAYO-SMITH. Well, I think that they did bring—there were a large number of issues raised in the Boston Globe report, and

some of them I was aware of before, and others I had not been aware of until they were brought up by the Boston Globe. Again, as I said, we appreciate what the whistleblowers brought up, and we have a rather extensive and rigorous way of interacting with the local medical centers to ensure that problems that they bring up are addressed between the service line leads, between site visits, between regular calls with the medical centers.

For example, let me give one example, would be the flies in the OR that was brought up. This was a well-known issue that flies had been seen in the operating room. This is not a unique problem to New Hampshire, and the medical center director there and the medical center leadership undertook multiple efforts to address this. They had a contract with a pest control officer, a pest control company. They implemented the recommendations. When that didn't work, they got another contract. Again, they implemented the recommendations. We had an infrastructure repair project to address this issue because of the way the flies were entering our whole building in the walls—

Mr. BERGMAN. Before we use up all my time here, Dr. Kois, how would you respond to Dr. Mayo-Smith's response?

Dr. KOIS. Not real happy with it. I think that—let's talk about the flies. You talked to the Boston Globe. They got testimony from someone that a contractor had been in the walls next to the OR and came across a pipe full of maggots, and they were told to close the wall back up.

Now, this you can talk to the Globe about, but this is something I have heard. I know for a fact that Stewart Levenson sacrificed his career feeding negative stuff back to the VISN, only to be treated like he was some village idiot. It disturbs me. I also know for a fact that Stewart asked to be on the commission and was told that he couldn't be on the commission because he was no longer a VA employee— this was the week after he left—only to find out that there are four or five other people on the commission that are not VA employees. Now—

Mr. BERGMAN. Let me ask—that is okay, because of the time. Dr. Kois, in your testimony you state that the former chief of staff, who was removed from the facility after you brought these problems to light, has applied for a position as the community care director at the Manchester VA Medical Center, and has even appeared before a screening committee to hire for that position. Is that correct?

Dr. KOIS. Yes.

Mr. BERGMAN. Okay.

Dr. Mayo-Smith, is the VISN seriously considering hiring him in this position despite the fact that the facility only recently cleared up a Choice consult backlog, and he was only removed two months ago due to the ongoing investigation?

Dr. MAYO-SMITH. Perhaps I should ask Mr. Montoya to answer that question.

Mr. MONTROYA. Sure. Thank you for that question. I think as part of the recruitment process, we cast the net very early on to try and get a physician leader. In that initial recruitment we had five applicants. Three of them we actually interviewed. None of those candidates were acceptable to me, which is why that position is now reposted and we are searching for another candidate.

Mr. BERGMAN. Okay, thank you. My time is getting close to expiring here, so rather than go over, I kind of set the standard as the Committee chair.

Ranking Member Kuster, we are going to go to a second round here. So, Ranking Member Kuster, you are recognized for 5 minutes.

Ms. KUSTER. Thank you, Mr. Chairman, and I will be timely.

I am torn between going back and going forward, so I am going to ask a couple of questions going back and a couple of questions going forward.

This one is for Dr. Clancy. When did the VA Central Office first learn about the standard of care issues at the Manchester VA? And do you know the steps that were taken by the Deputy Under Secretary for Health Management, a Mr. Steve Young?

Dr. CLANCY. Yes. So, we knew about a number of issues going back to about January of this year. In fact, the initial Office of Medical Inspector team went in, I believe, in February, and started working on those issues. This was related specifically to some of the clinical issues that Dr. Kois and his colleagues raised.

Ms. KUSTER. And what steps were taken?

Dr. CLANCY. That report was sent to the Office of Special Counsel in June, and there was also a request at that point in time to get an additional, more in-depth review of some of the spinal cord cases, not all. There were a couple of other issues there as well. The Deputy Under Secretary—

Ms. KUSTER. Were there meetings with the whistleblowers? Did anyone from Washington come to meet with the whistleblowers and hear their concerns?

Dr. CLANCY. Not at that point in time, no. In fact, we were not originally told by the Office of Special Counsel who the whistleblowers were. From what I gathered this morning, Dr. Kois introduced himself. So, thank you. But they couldn't have known to be looking for him because sometimes we are told up-front that the whistleblower says you can use their name, and other times we are told that this individual or individuals want to remain anonymous.

Ms. KUSTER. To protect their confidentiality.

Dr. CLANCY. Yes, yes.

Ms. KUSTER. To make sure there is no retaliation or any action taken toward them? Is that typically what the confidentiality is about?

Dr. CLANCY. Yes, and that is the saddest aspect of all, that we didn't hear it sooner and we had to get to that point in time. But that is the purpose of that confidentiality.

Ms. KUSTER. Have meetings been held with the whistleblowers since this time?

Dr. CLANCY. Yes. Some senior members of my team I know have met with Dr. Kois. I am thinking of Dr. Cox and some of his team. There have been—I think Mr. Young met with you. I could be wrong, Dr. Kois? No.

Obviously, Dr. Shulkin was here in early August, and we have routinely asked—I think we speak with leadership at the Manchester facility in the VISN two or three times a week about what is going on, and we have heard from Dr.—

Ms. KUSTER. If he is still in his role, I think it might be useful for Mr. Young to meet with the team and just get as much information and suggestions, because I can certainly say from my meetings with them that they have many strong recommendations, and they are very close to it.

Dr. CLANCY. I will bring that back for sure.

Ms. KUSTER. Thank you.

Just turning to quality of care issues, one of the issues that most concerned me was the issue about transfers from the Urgent Care Center, particularly with regard to stroke, so I am going to address this to Mr. Montoya. What is the current situation for patients transferred for stroke? What are the protocols that are being used? Where are those transfers going? And has there been sufficient training at the UCC for providers to ensure that they are following those transfer protocols?

Mr. MONTOYA. Yes. Thank you for that question, ma'am. I will tell you that out of the three recommendations that were identified in the OIG report, there is only one now that is open and actually will be closed, sent for closure within the next couple of weeks, and that one is in particular the 100 percent review of all veterans who have come into the Urgent Care who may present with stroke-like symptoms.

I am happy to report that as of last week, 100 percent of those veterans during those reviews did follow that protocol and were going to the—

Ms. KUSTER. And just to ensure the safety of our veterans going forward, what is that protocol if a veteran presents at the Manchester VA for stroke?

Mr. MONTOYA. Yes, ma'am. So, if a veteran does present with stroke-like symptoms, they immediately call 911 and transfer those veterans to the nearest hospital to be able to get the appropriate level of care.

Ms. KUSTER. My time is very limited. We probably won't get to it. I will probably have to take this for the record or the next round, but I would like to get into the collaboration, where things stand with Dartmouth and with the medical school and with other providers, CMC and others. So I will yield back and we will come back to that in the next round.

Mr. MONTOYA. Thank you.

Ms. KUSTER. Thank you.

Mr. BERGMAN. Thank you, Ranking Member Kuster.

Senator Shaheen, you are recognized for 5 minutes.

Senator SHAHEEN. Thank you, Mr. Chairman.

Dr. Clancy, in your testimony you talked about positioning the Office of Community Care to handle any changes to the Choice program. As Senator Hassan and Congresswoman Kuster have both pointed out, our office has also heard from multiple veterans and providers who are very unhappy with the way the Choice program is being administered. There is a separate insurance company, Health Net, that administers that program in New Hampshire, and we have tried to work very closely with them, but we still see providers who go months without being paid, we see veterans who have multiple appointments who have been scheduled who can't see the person that they are being directed to.

So can you talk about what you mean when you say positioning the office? And as we look at reauthorization of the Choice program in Washington, what does the VA think should be done to make that better?

Dr. CLANCY. Thank you very much for that question. I bet I hear from Secretary Shulkin about this, oh, two or three times a day. I mean, it is very, very high on his agenda.

Three years ago when the law was passed, it was, I will say, off to a bumpy start. Over that time period we have, I think, worked with the Congress to make 70 different amendments to the law to touch on some of the issues all of us have heard from veterans and providers and don't want to be there.

So we are very, very excited. You probably know that there are seven or eight different paths for us to purchase care for veterans in the community. You wouldn't design this from scratch. So we have been most appreciative of the support from committees as we work with them to come up with improved legislation that integrates that, that has one budget for that care, that actually uses eligibility that is determined clinically rather than these sort of arbitrary cut points of 30 days or 40 miles, obviously a little bit different for New Hampshire, that actually takes the clinical situation into account, including how well is the facility providing that care in contrast to the community, and we are looking everywhere and have been working with experts from around the country to try to bring in contemporary payment practices so that we can get providers paid timely.

It clearly won't work if we don't have partners in the community who are willing to share in this. It can work beautifully, but you have to have those partners, and they have to get paid, for sure. So those are really the high points, but we are very excited about this and, again, deeply appreciative of the support that we have been getting from Congress.

Senator SHAHEEN. Thank you.

Mr. Kenney, as we are looking at reauthorization, and as the VA is thinking about the Choice program going forward, what do you think veterans want to see?

Mr. KENNEY. Well, Senator, you know, we have heard a lot of the discussion about full-service hospital and everything else, and I like to drop the word "hospital" and just go right to full service. I think it is what the veterans expect, and it is what they deserve.

I think as far as the Choice program, if I could borrow an old moniker that was a wine that was served way before its time. It wasn't ready yet. The Choice program came out on a rocky start. It does have a lot of flaws. It does need to be fixed.

As you know, Senator, we were at the symposium over a year ago and we were hearing these same issues from veterans at that time who were complaining about not being able to get appointments from doctors, and then I believe from Mr. Anon from the Hospital Association said the hospitals weren't getting paid. So clearly, there are some serious flaws there, and we would like to see those fixed, obviously.

But more importantly, the care model that Al Montoya brings up is very important, because what it does is it puts people in place that help veterans navigate through that Choice quagmire. I guess

the bottom line of it really is that we really need to streamline it. We need to make it easier to use, and more importantly we need to make it more accessible for those clinicians here in the State of New Hampshire who stepped forward and want to help veterans but they are afraid because they are afraid that they are not going to get paid.

Senator SHAHEEN. Right.

Mr. KENNEY. And I have heard that complaint many, many times.

So there are a number of things that do need to be fixed, Senator, and I am heartened, and I hope that part of the result of this will be just that, to fix the Choice program.

Senator SHAHEEN. Me too, and I am certainly going to do everything I can in Washington, as I know my colleagues are, to try and make that happen.

I am also running out of time, but let me go back because, Dr. Clancy, you, I know, in talking to Mr. Montoya, have talked about the recruitment efforts to bring in the people that we need here in Manchester and at the VA. How are those going, maybe in just one word, and then I will get back to that on the next round?

Mr. MONTOKYA. I would say that the recruitment efforts are exciting. Certainly, with the nurse executive position, there were a phenomenal amount of responses from the community.

Senator SHAHEEN. Good. Thank you.

Mr. BERGMAN. Thank you.

Senator HASSAN, you are recognized for 5 minutes.

Senator HASSAN. Thank you, Mr. Chair.

I just want to make one note, Dr. Clancy, concerning the Choice program. One of the most concerning things I hear from constituents is the number of people who have been scheduled for surgery and the night before the surgery they get a call saying their prior authorization has been revoked.

Dr. CLANCY. That is unacceptable.

Senator HASSAN. That is totally unacceptable, and I just hope you will continue to look into that in particular. I can't imagine going through that. Some of them choose to go forward with the surgery. Some of their providers do, too, and then we deal with the payment afterwards. But it is just incredibly nerve-racking and unfair to the veterans.

I wanted to go back to the issue of how we handle whistleblower concerns. Mr. Montoya, first of all, thank you for stepping into a very difficult situation and working as hard as you have been working. I hope that you agree that the whistleblowers have done a service to veterans in New Hampshire and across the country by coming forward with the concerns that they have raised. They have brought forward a range of concerns that obviously are troubling for all of us.

How is leadership at the Manchester VA ensuring that issues brought forward by the whistleblowers are handled appropriately and treated with the seriousness they deserve, not just this group of whistleblowers but what is in place now to ensure that leadership is ready, able, and nimble enough to respond to these concerns?

Mr. MONTOYA. Thank you for that question, ma'am. I think for me, first and foremost, I appreciate the whistleblowers coming forward. I have met with nearly all of them and heard their concerns. Additionally, my leadership team that is in place at the Manchester VA has weekly, bi-weekly clinical and administrative listening sessions. I am a very hands-on director in that I also go out and practice management by walking around to ensure that I hear from not only our veterans but our staff members as well.

I think the one thing that really warmed my heart when I came to Manchester was that there were roughly 800 very dedicated staff who want to do the right thing, who want to provide the best care for our veterans. And so it was really harnessing that to help move the organization forward.

I think our way forward plan, which is rebuilding leadership, restoring trust, improving care, and designing the future and fixing Choice, each of those metrics in there was a roadmap based on the feedback that we had heard from both the whistleblowers as well as staff from throughout the organization. I think I am using that way forward plan now as a roadmap to very publicly talk about the progress that we are making at the Manchester VA.

I think one thing that is important to note is that the organization did not get like this overnight, and certainly progress is not going to happen instantaneously overnight. It will be a long road but one that I know our employees are dedicated to making happen.

Senator HASSAN. Well, thank you.

Dr. Kois, I would like to turn to you for your perspective. You have talked about your experience as a whistleblower and your feeling that you couldn't get the attention to the concerns that you and other whistleblowers were raising. How do you think the organization is doing now, and do you think people feel that they can come forward in a whistleblower capacity, if you will?

Dr. KOIS. Since Mr. Montoya came on, for me it has been a breath of fresh air. He has tried to be receptive, he has tried to listen, he has tried to talk to us. The only time I had met with the director, the previous director, was when there was a death threat against me, and she called me into her office and told me that I could fill out a Freedom of Information Act to get my death threat. Now, how many people would say that to someone? I have to fill out a Freedom of Information Act to get my own personal death threat?

Al stops in my office. I can't play video poker anymore because he is going to open the door and say, "What's up?" I like that. I like seeing him. He has been receptive to us, and I think it is a good direction. But as he said, it took years to get this way. It is going to take a while. We are not over it. We cannot sing Kumbaya and everything is great. We have to work together.

But you know what? I am happy to work with Al. I am happy to work with Brett. And I love Shulkin. Shulkin, to me, was a breath of fresh air, and I think that we are going to have to all work together on this. Community partnering is what I am excited about, and I would like to tell you there are some great partners out there. We are working with Larry Gammon in Easter Seals. We

are working with Dean Kamen, the inventor, and we have some exciting things.

My hope is that from this catastrophe springs a new beginning and really an exciting time for our VA in Manchester.

Senator HASSAN. Thank you.

And, Mr. Chairman, my time is up.

Mr. BERGMAN. Thank you.

I will claim my second round here of 5 minutes.

Dr. Clancy, has VHA completed a review of the deficiencies at the VISN that allowed these problems to occur in Manchester?

Dr. CLANCY. We have not. Right now what we are really focused on is what happened in the clinical care processes. I would be happy to take that for the record. I know from extensive conversations with Dr. Mayo-Smith that he has looked into this, and the question is how much of that got to him and so forth.

I will also say several of you noted the insights and implications for other VAs. This is something that all of our network directors are working on right now, trying to figure out what are our vulnerabilities and, very importantly, how do we know, if people bring this up, do we hear them. And if we are not hearing anything, does that mean that there is not a problem? That, I think, is the worry that we think about a lot in our system.

Mr. BERGMAN. Thank you.

Dr. Mayo-Smith, we know that there are several reviews being conducted here at the Manchester VA. What is being done at the VISN level to improve communication and operations management?

Dr. MAYO-SMITH. We are always seeking to make improvements, and what we have done in this particular situation is, as all the reviewers from Washington have come and gone, as I have had an opportunity to speak at length with many of the whistleblowers, as had Mr. Montoya and other leaders from both the VISN and national, we are pulling together Mr. Montoya, our quality manager, and one of the other medical center directors. I have asked them to sit down and say what are the lessons learned from this incident.

We are going to have our own internal stand-down to pick the three things that really we see went wrong in terms of process at Manchester and go around the network to the other seven medical centers and really go have a stand-down, a deep dive, and make sure that we address those issues. This is going to be done. We have a face-to-face meeting with the leaders in September. We will review it at the end of this month, and then in October we have a large leadership meeting and we are going to report back after that has been done.

We have been doing this at the national level as well. This is something that I have been an advocate for, that we take lessons learned when things go wrong at one medical center or another medical center across the country and share them among the network directors so we can be a learning organization and make improvements when something goes wrong or something goes off kilter in another area.

Mr. BERGMAN. Dr. Mayo-Smith, what is the current duty status of the former director and chief of staff for Manchester?

Dr. MAYO-SMITH. The former director has been detailed to the network office, detailed to myself, and I have assigned her to work with the strategic planner. And Dr. Schlosser, the former chief of staff, has been detailed to work with the chief medical officer.

Mr. BERGMAN. For how long?

Dr. MAYO-SMITH. Until the investigations that are being undertaken by the Office of Accountability and Whistleblower Protection are complete and they have made a decision on what the findings were with regard to the performance and conduct of these two individuals.

Mr. BERGMAN. When should we expect those investigations to be completed?

Dr. MAYO-SMITH. We are hoping that they will be done very soon. We constantly check, and I have been told sometime—two to four weeks is what I have been told, but sometimes they find new things during the investigation.

Mr. BERGMAN. Dr. Clancy, in your written testimony you state that the VA plans to create a Subcommittee of VA's Special Medical Advisory Group, which would report to the VA or on the VA care delivery model for the New Hampshire veterans by January 2018. Is that the same group as the task force that was stood up last week to perform what appears to be the same function which includes Dr. Mayo-Smith and Mr. Kenney?

Dr. CLANCY. No. We have a standing advisory group for the entire department that focuses on medical issues. It includes very prominent leaders from U.S. health care, a very, very helpful function to us, giving us feedback, advice, recommendations. They meet in public, as do all Federal advisory committees.

The task force that Dr. Mayo-Smith and Mr. Kenney are leading—and thank you for that, Mr. Kenney—was initially conceived of as internal VA people from outside the network and some inside. For a variety of reasons, primarily I believe because the focus was on New Hampshire veterans, it was thought that it would make a lot more sense to have the New Hampshire Hospital Association there, to have a New Hampshire veteran, to have Mr. Kenney, and so forth. So that cast it in the light of a public advisory committee. So it is a Subcommittee of that larger group, but ultimately it comes right back to the Secretary, and he is impatient and wants to hear from them sooner than later.

Mr. BERGMAN. Okay, thank you.

I see that my time has expired, and we are going to proceed to a third round here.

So, Ranking Member Kuster?

Ms. KUSTER. I am going to yield to Senator Hassan, who has to catch a plane.

Mr. BERGMAN. Very well.

Senator HASSAN. Thank you very much, Representative Kuster. And again, Mr. Chair, thank you so much for being here in New Hampshire. We are grateful for the bipartisan work that you and your Committee and the Ranking Member have done and continue to do.

To all the witnesses, thank you again for being here and for your commitment to our veterans.

One of the things that I also want to ensure that we focus on is that we are meeting the needs of our Nation's women veterans. That is why I have joined with a bipartisan group of colleagues in introducing the Deborah Sampson Act to address gender disparities at the VA. The bill would expand peer-to-peer counseling, improve the quality of care for infant children, increase the number of gender-specific providers and coordinators at VA facilities, and improve collection and analysis of data regarding women veterans.

Dr. Clancy's testimony notes that the Manchester VA has recently hired a women's health medical director and a women's veterans' program manager. First of all, I want our women veterans out there to know that these hires have been made and that there are services accessible to them. But, Mr. Montoya, could you elaborate on the role of these new hires? What are they going to do?

Mr. MONTOYA. Sure. Thank you so much for that question. I will tell you that they will do what all other teams do in primary care, and they will make sure that our female veterans are taken care of, and the quality of care that they receive is top-notch.

I will tell you that the women's veteran clinic was actually in one of the areas that was damaged by the flood. It is one that we hope to get back open sometime around the middle of November, and then we will be able to continue that clinic there.

In the meantime, they are actually being seen down in primary care, where we do have space, by our dedicated female veteran's team.

Senator HASSAN. Well, thank you.

Dr. Clancy, I wanted to turn back to something you said, just because I am always trying to understand the VA's terminology when you talk about progress you have made, which I am appreciative of. But when we talk about patient consults and the fact that there was a backlog in Manchester and that we are now catching up, when you say that 95 percent of pending consults are being taken care of in two days, what does "taken care of" mean?

Dr. CLANCY. It means that an appointment has been made and that we will then follow through to make sure that we get the information back, because that is the all-important care coordination that you were talking about.

Senator HASSAN. Okay. Thank you for that.

And when you mentioned the independent review of the cases that Dr. Kois and others have brought forward, it is a peer medical review; correct?

Dr. CLANCY. Yes.

Senator HASSAN. Does that include interviews of patients and clinicians?

Dr. CLANCY. Initially it is going to include a very rigorous investigation of charts, including medical images and so forth, and it may be that it will include interviews of clinicians and patients, particularly for some of the longstanding cases that Dr. Kois had mentioned. But right now we are focused on getting them that initial round of information. It is about 100 cases, and some are quite old. I mean, there are a lot of records to go through, so we have been busy getting them the information to do that.

Senator HASSAN. I understand that. I would urge you to think about the fact that if part of the concerns that have been raised

is that the records themselves do not accurately reflect the care or the symptoms or the range of possible clinical diagnoses, that just doing a chart review may not be enough. I think one of the concerns that I have heard from the whistleblowers is that by stopping at the charts, the VA really couldn't see what it needed to see. And I don't want to put words in the whistleblowers mouths, but that is just a concern I have heard. So I would urge you to empower the independent review committee to really reach deep if they need to.

Thank you very much, and thank you again, Mr. Chair.

Mr. BERGMAN. Again, thank you, Senator Hassan, for being with us today, and safe travels back to D.C.

Senator HASSAN. Thank you.

Mr. BERGMAN. Senator Shaheen, you are recognized for 5 minutes.

Senator SHAHEEN. Thank you. I also have a flight. Mine is a little later than Senator Hassan's, so I appreciate the opportunity to go next.

I guess this is for you, Dr. Mayo-Smith, because as chair of this new task force that has been created, you are charged with studying the possibility of providing full services. Whether we call it a hospital or full services, as Mr. Kenney did, the idea is how do we make sure our veterans get the care they need. How do you go about studying that? What do you expect the task force to do? Can you be a little more specific in terms of what actions you expect the task force to take?

Dr. MAYO-SMITH. Certainly. So we have laid out our plan, and we are going to be approaching it from several points. One, we are doing an extensive review of workload and demographic data and projections into the future.

Second, we are looking at—we are going to be a pilot or the first wave of the Office of Community Care doing a community market survey, something they are going to do across the country. They are going to come here first. What resources are available in the community? It varies from place to place.

We are going to be looking at the infrastructure. We have already had a consulting architect come in with a team to look at this last week.

Probably the most important part is we are doing a series of clinical service line reviews which the leads, the service line experts—primary care, mental health, rehab, geriatric medicine, surgery and radiology—they are going to be working with the staff at Manchester, review the current services and what could be the options for the future services.

So an example, with mental health, what about a day hospital? What about an inpatient hospital? What about a substance abuse treatment rehab program? Those are programs that other VAs have. Would it be a good fit? Is it needed by this population? Where are the patients getting it now?

Then we are going to have a series of meetings. A lot of the other thing is stakeholder input. We have already started a whole series of focus groups with veterans, with employees, with stakeholders. We are meeting with your staff. We are meeting with the whistleblowers, et cetera, to get input, what do they want, what do they

need, and we are going to put this together with a series of meetings to come up with options and then make recommendations.

It will go to the Special Medical Advisory Group, which is excellent because they are some of the top leaders in health care, and then they will present them to the Secretary. I encourage this group to hold us accountable to getting these recommendations in and for following through.

I am a practicing clinician in the VA. I have worked at Manchester. I see patients. I want to make sure that the practitioners and the patients at Manchester—I am determined that they get excellent care and that these changes that are needed are made.

Senator SHAHEEN. Thank you.

My last point is not really a question, but as I looked at the other testimony that was submitted before today, Mr. Chairman, there were some very serious concerns raised and allegations that had to do with the dental program, with the electronic wait list, with the nuclear camera and its impacts on radiology and cardiology. So maybe for you, Mr. Montoya, as you are going forward, but certainly also for Dr. Clancy, I hope these will also be looked at very carefully and responded to.

I have also had concerns raised about pharmaceutical protocols. So I would just urge that as you are addressing those, that you also share with us and with the public some of the changes that have been made so people understand that there is an effort to respond to the issues that have been raised.

So again, Mr. Chairman and Ranking Member Kuster, thank you very much for holding this field hearing. Thank you all on the panel for testifying.

Mr. BERGMAN. Thank you, Senator, and thank you for joining us today.

Ranking Member Kuster?

Ms. KUSTER. Thank you, Senator Shaheen, and safe travels. Thank you for being with us.

Well, I am glad that Senator Shaheen brought up the other issues because, honestly, we could be here all day. We will stay in close touch with Mr. Montoya and with Dr. Clancy and Dr. Mayo-Smith. Again, I want to thank Mr. Kenney for your role in this and for being a conduit so that veterans will be heard throughout this process. Ultimately, at the end of the day, it is their experience that counts.

Two quick questions. How does a situation occur where 3,000 consults are on hold and you don't know about that? Either Mr. Mayo-Smith or Dr. Clancy, what are the metrics? Isn't there a way, isn't there a dashboard that you would be aware of the backup? Because I certainly know from repeated meetings with Danielle Ocker that there was a problem, there was a problem with the Choice program that they weren't being approved, that financially—we haven't gotten into it today, but I know one hospital in New Hampshire that is owed \$3 million. How can we ask our community hospitals to step up and care for our veterans when they are owed \$3 million? That is real money where I come from.

Could you respond on the metrics and how you weren't aware of this? How do you get a backup of 3,000 consults?

Dr. MAYO-SMITH. Well, normally the—well, the Choice program has been problematic from the beginning. We have been working hard addressing it. At the network, in our network, we have a weekly call with our business office manager in each medical center. We have numerous reports that we track this.

In Manchester, we would expect about 3,000 consults to be in process at any given point in time, and we found, as was mentioned, 3,900 that were, so there was a backup. And it was very clear that the local business office was not—I mean, it appeared—as far as we could tell, it appeared that some of these patients were being seen, but the consults were not being closed, and in other cases the consults may have been closed but the patients weren't being seen yet. So the data that we were getting did not appear to be entirely accurate.

Ms. KUSTER. Do you think that the decision that has finally been made—this is something that I have been pushing since I first went to Congress, five years? I can still remember the very first hearing about the electronic medical record. Do you think the decision to go to a new electronic medical record that is a commercial product, off the shelf, we can now communicate DoD to VA, we will be able to communicate with our community providers, and will this help this situation?

Dr. CLANCY. Yes. I can say that we are already working with our community partners to accelerate a path to electronic information now. But having one platform for all of VHA will make a huge difference. There are a lot of clunky pieces in our system. You probably hear hospitals tell you—we have EPIC, and so do they, but they don't talk to each other. Well, essentially that is what we have internally with our home-grown system. So we are very, very excited about the path forward.

Ms. KUSTER. I don't mean to cut you off. The time is short. But I do want to make the case for VA Central Office to recognize that New Hampshire is in a different situation without a full-service medical hospital. We are over-reliant on our community care, and that was not backed up in the budgetary decisions. Frankly, I think part of what was going on was triaging and bureaucratic hurdles for the veteran because the money wasn't in the budget, and that is a bigger issue that we need to tackle.

I also just want to mention that I believe, having toured the women's facility up at White River Junction, that taking that approach of a new facility with a separate entrance and a real focus on women's health for our veterans is critical. I think Manchester has fallen behind the times, frankly, and that this is an opportunity. Certainly I can tell you, you will have the strong support of the Federal delegation to back you up with that, and if it takes additional funding or whatever is necessary.

But I do want to put on the record a relatively new allegation from a whistleblower about a female veteran that was sexually assaulted, and hopefully you are aware of that. If not, our office will bring it to your attention.

This is critical, and it is way past time for our women veterans to get the care and the respect that they need.

I will continue to work with everyone. I appreciate, General Bergman, you coming to New Hampshire and making the trip. I

am proud to be working in a bipartisan way, and we will hold the Administration's feet to the fire.

Again, thank you to the whistleblowers for bringing these issues to our attention, and I yield back.

Mr. BERGMAN. Thank you, Ranking Member Kuster.

The final question before we do a little closing here. Dr. Clancy, you stated in your opening comments that two suicide prevention coordinators had been added to the staff. How long had that request for additional positions been in the system?

Dr. MAYO-SMITH. I would have to take that question for the record and give the exact date back to you.

Mr. BERGMAN. Okay, because obviously the need for suicide prevention coordinators is not something that just popped onto the screen, okay?

Dr. Kois, VA's testimony states that an independent review to be conducted by Lumetra Health Care Solutions has been requested regarding the myelopathy and OMI investigations. You and many of the other whistleblowers have been calling for an independent review for some time. So are there any specifics that you would like to see as part of the charter for this review?

Dr. KOIS. Sure. We don't think that the medical records are sufficient to have this review. Part of the issue with myelopathies is it occurred in the absence of treatment, not because of necessarily a bad treatment. So because of that, especially in light of the fact that for 10 years the medical records were fabricated, to look at medical records is just incorrect, it is just insufficient.

What we feel needs to happen, is that you actually have to go take a history and examine the patients. You have to hear from the patients, because one of the things that stood out to me is that I would ask the patient did the doctor offer surgery, and the patient would say, well, the doctor said I would die if I had surgery. I would go back to the chart and the chart would say the patient refused to have surgery. But if you are given an option that you are going to die if you have surgery, it is sort of a no-brainer that you are going to say, no, I don't want to have surgery.

So there was a big disconnect between what was showing up in the charts and what was happening. We also had Dr. Huq, who was fabricating notes for 10 years. So I think the minimum is you have to go back, call these 96 patients, get a history from them, you have to have someone examine them.

The other thing you need to do is you have to assess their level of disability. You can have spinal stenosis that develops mild symptoms of myelopathy and it is not a surgical case, but by the time they reach the point that they are in a wheelchair, they are in an electric wheelchair or they are in diapers, you have a problem.

If you look at the durable goods that were ordered for these patients, there were 20-some people who were in electric wheelchairs or manual wheelchairs. The numbers I will have to get to you. There were a number of them that were in diapers. There were a number of them that had in-dwelling catheters or cathed themselves because their bladder was not functioning. There were a number that had adaptive equipment to eat and feed themselves and to toilet themselves.

Those cases were let go too far. You shouldn't reach that point. But the only way you can come to that realization is to ask the patients, and then to get a list of the durable medical goods. If you get the list of the durable medical goods, it just pops out at you because the list was this thick in those 96 patients, and we are talking 50 or 60 items per page.

So if you just look at the chart, it is not enough. And if you just have an outside company looking at the chart, it is not enough. You really have to go back and look at the whole thing.

You also should talk to Dr. Ohaegbulam. He is the surgeon that made the statement that these cases resembled cases he saw in the third world. I would get his opinion on that. Interestingly enough, Al Montoya and Brett Rusch have just brought Dr. Ohaegbulam on board, and he is now going to be one of our consultants. He is a great doctor. People should ask his opinion of what happened.

Mr. BERGMAN. Thank you very much.

I will conclude my questions at this point, and we are going to move to our closing statement.

I truly want to thank all of our witnesses for participating in today's hearing by making the effort to come here, by making the articulate statements that you did. I believe we have brought some very, very important and highly prioritized issues to the forefront. You are now excused.

I would especially like to thank Dr. Kois for joining us today and for being one of the main focal points for the whistleblowers who brought many of these issues to light. Without the involvement of conscientious whistleblowers at the Manchester VA Medical Center, many of these problems would likely still be unknown to the New Hampshire veterans, Congress, and the rest of our country.

As the Subcommittee Chairman and a veteran, I am very concerned about leadership failures and deficiencies that have existed in Manchester and have been allowed to be compounded for too many years.

It was also very clear that there was no sense of urgency within the VISN to address these problems. Dr. Mayo-Smith, you stated, quote, "My responsibility is to listen and respond," end quote. It should not take a news report or a congressional hearing for VA leadership to respond to veterans' and employees' concerns. As VISN director, your job is to lead proactively, not reactively.

VA has pledged publicly to make great improvements in quality of care, infrastructure, and other critical areas, but these improvements must also include better oversight and management at the VISN level and within VHA.

I hope that the discussion we have had today will help instill in VA that so necessary sense of urgency that I think we all agree is needed to bring about the systemic changes still needed within the VA New England Health Care System.

I ask unanimous consent that all Members have five legislative days to revise and extend their remarks and to include extraneous material.

Without objection, so ordered.

I would like to again sincerely thank all of our witnesses and audience members for joining in today's conversation.

With that, this hearing is adjourned.

Ms. KUSTER. I just wanted to add, thank you to the National Guard for hosting us. This is a great facility and we very much appreciate it. Thank you.

Mr. BERGMAN. Thank you.

[Whereupon, at 12:20 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Dr. Carolyn Clancy

Good morning, Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee. Thank you for the opportunity to participate in this hearing to discuss VA's response to the concerns raised at the Manchester, New Hampshire VA Medical Center (VAMC). I am accompanied today by Dr. Michael Mayo-Smith, Network Director for VA New England Healthcare System (Veterans Integrated Service Network (VISN) 1), and Mr. Alfred Montoya, Jr., Acting Medical Center Director at the Manchester VAMC. I would like to specifically note the appreciation that we have for Mr. Montoya stepping forward into a tough situation and handling it admirably.

First, let me begin by saying that VA appreciates the actions taken by whistleblowers when it comes to safeguarding care for our Veterans. We are committed to always protecting those whistleblowers from retaliation. VA has and will continue to take immediate action when responding to whistleblower concerns at any VA facility across the country. The Office of the Medical Inspector (OMI) and the Office of Accountability and Whistleblower Protection (OAWP) were sent to conduct a top-to-bottom review of the Manchester VAMC. In response to the allegations, the Secretary rapidly recognized the need for a new leadership team. We look forward to this opportunity to build trust between VA and our Veterans and to keep Congress up-to-date on our progress.

Our focus in Manchester is now on the way forward and ensuring that high quality and timely access to care is the standard in all aspects of Medical Center operations. Currently, the Medical Center is executing a plan that focuses on five key areas which include the following: rebuilding leadership, restoring trust, improving care, fixing the Veterans Choice Program's local operations, and designing the future.

One focus of the whistleblower concerns was the lack of consistent leadership in key positions at the Medical Center. Currently, we are actively recruiting for the Medical Center Director, Chief of Staff, Nurse Executive, Chief of Medicine, Chief of Surgery, Chief of Primary Care, Director of Urgent Care, and a physician leader for the newly created Office of Community Care. In order to attract the highest caliber candidates to these key positions, we are recruiting nationally.

Second, we are also working on restoring the trust of our Veterans, staff, and community stakeholders. Medical Center leadership has taken swift action to ensure that all members of the Medical Center, including clinical staff, are included in key decisions. VA acted swiftly and immediately by asking OMI and OAWP to review the allegations raised in a Boston Globe article. Additionally, the Secretary directed a top-to-bottom review of all aspects of the VAMC's operations, which provided key action plans for improvement. We also requested a non-VA review, conducted by Lumentra Healthcare Solutions, a peer review network, of our myelopathy cases and the above-mentioned OMI investigations. Finally, there has been consistent, structured public reporting and listening sessions with Veterans, staff, and community stakeholders to discuss progress at the Manchester VAMC.

Our third area of focus is improving timely access to care. To do this at the Manchester VAMC, we have committed over \$5 million to hiring additional staff. This includes several key positions on the cardiology staff and two new patient-aligned care teams (PACT) for Primary Care. In addition, we have accelerated community and academic partnerships to support the Medical Center. In a first-of-its-kind collaboration with a private hospital in Manchester, we have seen dozens of Veterans for endoscopic procedures with VA providers using the hospital's space. We are well underway to securing a second arrangement for general surgery, orthopedics, interventional pain, and urology procedures. In addition, we have successfully recruited an academically affiliated cardiologist who started last week. The Acting Chief of Staff is working with Dartmouth Hitchcock to discuss physician leaders in Manchester securing Dartmouth College affiliations. We are looking to open an accred-

ited rehabilitation program for chronic pain and purchase needed equipment for surgery. We have also restarted nuclear medicine tests at the VAMC with the goal of adding stress tests by October. We have successfully hired two suicide prevention coordinators, a Women's Health Medical Director, and a Women Veterans Program Manager. We are also working hard to ensure that all areas affected by the flood at the Medical Center are open and operational by the end of December 2017.

Using VA providers and staff to perform outpatient procedures at a number of our community providers has enhanced the experience that our Veterans in New Hampshire receive. However, our Veterans, providers, and community stakeholders have made us aware of the serious work needed to improve the Veterans Choice Program, which is why our fourth focus is on enhancing the experience of all involved in this Program. On July 26, 2017 we created a new Office of Community Care in Manchester that consists of over 30 staff, including 17 new positions, dedicated to ensuring our Veterans have assistance in navigating all aspects of Care in the Community. This Office processed and cleared a backlog of approximately 3,300 pending consults. With a change in process, 95 percent of all pending consults are being taken care of within 2 business days. Additionally, we have taken a proactive approach with our community providers and assisted in ensuring that bills from our providers within the Veterans Choice Program network and our community care providers are being processed in a timely manner. We have established routine calls with our Veterans Choice Program network's field operations staff, embedded a Veterans Choice Program network representative full-time within our staff, and fostered a relationship of collaboration. We are positioning the Manchester VA Office of Community Care to be able to handle any changes to the Veterans Choice Program in the future.

Finally, Secretary Shulkin will be creating a subcommittee of VA's Special Medical Advisory Group (Advisory Group), one of VA's Federal advisory committees, to make recommendations to the Advisory Group on the future VA care delivery model for New Hampshire Veterans. The subcommittee membership will consist of strong representation from New Hampshire Veterans, VAMC staff (including representation from whistleblowers), regional and national subject matter experts, and leaders of the New Hampshire hospital and provider communities. Under the direction of the Advisory Group, the subcommittee will undertake a careful review of data and develop innovative options for improvement. Its goal will be to provide recommendations to the Advisory Group regarding the future vision of what VA must do to best meet the needs of New Hampshire Veterans. The subcommittee will take the grave infrastructure issues at the Manchester VAMC into account when developing its recommendations to the Advisory Group. The subcommittee will make recommendations to the Advisory Group, and the Advisory Group will in turn make recommendations to the Secretary, through the Under Secretary for Health, by January 2018.

We look forward to this opportunity for our new leadership to restore the trust of our Veterans and continue to improve access to care inside and outside VA. Our objective is to give our Nation's Veterans the top quality care they have earned and deserve. Mr. Chairman, we appreciate this Subcommittee's support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. My colleagues and I are prepared to respond to any questions you may have.

Prepared Statement of William Edward Kois, MD

Mr. Chairman and Members of the Committee,

My name is Ed Kois, and I am a VA physician at the Manchester Medical Center. I have worked there since 2012 in the Spinal Cord Clinic and in the Pain Clinic. Even though I receive a paycheck through the VA Agency, I consider myself an employee of the Veterans of our state. It was because of this and because of my concern over their care, which I had deemed extremely inadequate, that I spoke out, first by going through and within the VA system.

After almost two years of utilizing all avenues available to me, and receiving no satisfactory solutions, I spoke to my colleagues and discovered that many of them had similar issues with management and patient care. Because of my fear of further harm occurring to our patients, I contacted an attorney who assisted us in being heard by Senator Shaheen and Representative Kuster, and then the process began with the Office of Special Counsel. Our Whistleblowers are comprised of doctors, nurse practitioners, nurse anesthetists, as well as a Business Service Line Manager.

The Boston Globe publication on July 16, 2017, regarding the Manchester Medical Center, almost one year after filing our Whistleblower Complaints with the Office of

Special Counsel, finally brought the light of day to our serious concerns about the care and treatment of the Veterans, as well as the sub-standard facilities and equipment found in Manchester. The details are well chronicled in this article, as well as all of the Whistleblower filings on record with the Office of Special Counsel.

The problems that are seen at the Manchester VA, however, are not unique to just this facility. I believe the same issues can be seen nationally.

The publication of the Boston Globe article resulted in a meeting with Dr. David Shulkin, the Secretary of the VA, on August 4, 2017, where he met with eight (8) of the Manchester VA Whistleblowers. Dr. Shulkin listened to us, and quickly acted to remove the three (3) top administrators, who were the focus of many of our complaints. Of note, however, it was not just these three (3) individuals, but also the entire operational system in Manchester that had led to the problems elucidated by myself and the other Whistleblowers.

As our attorney alluded to in her letters to Senator Shaheen and Representative Kuster, the inverted pyramid structure of operations at the Manchester VA, wherein there are relatively few, if any, clinicians in positions of power making patient care decisions, as well as decisions regarding needed equipment and purchase of replacement equipment, caused a disconnect between the providers of the care and the bureaucrats who controlled the decisions. This disconnect was largely responsible for the substandard treatment and care of my spinal cord patients, that led us to where we are now.

Dr. Shulkin named an Acting Medical Director, Alfred Montoya, and Dr. Rush, as Acting Chief of Staff; however, this temporary situation has not changed the corporate culture from the nurse managers below Dr. Rush and Mr. Montoya. Conditions are still unacceptable in the OR and other practice areas where managers who were put in place by Carol Williams, who was removed from her position by Dr. Shulkin on August 4th. In fact, although Dr. Shulkin removed Dr. James Schlosser as Chief of Staff on July 16, 2017, he has applied to be the new Community Care Director at the Manchester VA, and appeared before a screening committee on September 7, 2017. How can this happen?

Some things have started to improve. I have recently been asked to participate in the search committee for a new Chief of Staff. It would be advisable to put other providers on the search committee for the new Medical Center Director, and the new Chief of Nursing. Apparently, these positions cannot be filled until the current Medical Director and Chief of Staff are formally removed from their positions. It has been two (2) months and they still have not been removed, and so there has been no outside advertising for those positions.

As I said above, the issues with the administration and operational matters at the Manchester VA are not unique to Manchester; that a remodeling of the Manchester VA operation system can be used as a template for other small VA Medical Centers in this country.

Problems such as the over-reliance on metrics, the incredible bureaucratic quagmire that has existed for decades need to be changed. We must move in a direction that mirrors the public sector hospitals, where clinicians are on the governing boards, and provide a balance to the bean counters when they lose sight of the true mission of the medical facility, which is to provide excellent patient care to our Veterans.

Prepared Statement of David J. Kenney

Subj: Testimony on the Manchester, NH VA Medical Center

Mr. Chairman and distinguished committee members. It is an honor to submit this testimony as current Chairman of the NH State Veterans Advisory Committee. Our committee is comprised of 19 veteran service organizations as well as advisors from a number of state agencies in New Hampshire that provide services to veterans and their families. I should also state for the record that I am a 40 year Navy veteran and currently do not obtain care through the Manchester VA.

As part of the New Hampshire veteran leadership, I have been involved in New Hampshire veteran's issues since 1992 and a member of SVAC since 2001. In the 16 years on SVAC, I've heard briefings on various isolated complaints with the VA in general and on individual challenges with access to care. However, the revelations by the Boston Globe article were appalling. The article exposed an alarming level of systemic breakdowns with areas of the VAMC facility and alleged lack of commitment by administrators to fixing the issues that were cited by the whistleblowers.

Since the Boston Globe article has come out, I have personally participated and/or observed a number of meetings related to the VA in Manchester, including the public meeting held by the whistleblowers to air their concerns, unfiltered. I am personally pleased the deficiencies have been exposed and believe this exposure offers a great opportunity to not only fix issues at the VAMC in Manchester, but potentially develop some valuable "best practices" which could be deployed in other VA medical facilities around the country.

The VA in Manchester has been lauded by many veterans for the superb quality of care they receive there. What remains a significant challenge is the access to care, ensuring the best technology is available for care, access to primary care physicians, and when needed the CHOICE program. Interim-Director Al Montoya has advanced a number of significant improvements to solving many of the deficiencies discovered since reporting to the VAMC in July 2017. Director Montoya's precise and methodical approach to discovering key areas of lag or poor function have allowed him to create a comprehensive plan to make immediate changes and improvements to the medical center. Included in that plan is rebuilding leadership and increasing staff hiring in mental health, nursing, surgery and patient services. A key element of these improvements is creating a more robust Office of Community Care modeled after the successful pilot program he created for North Country veterans. He has been instrumental in increasing staff in key areas and working quickly to hire new leadership for departments that have senior vacancies. Despite the added challenge of a water main break at the facility that affected several floors, Director Montoya has been working diligently with contractors to get services affected back on line as quickly as possible.

Access situations, like appointment requests bouncing back and forth from CHOICE to the VA are totally unacceptable. The simple fact is veteran's lives are at stake. This is not just a trite statement but one that has been borne out in facilities around the country. In addition to the VA facilities needing to be raised to superior standards, we need a full funding commitment to the CHOICE program. CHOICE offers a flexible alternative to veterans who live long distances from a VA facility. Transportation can often be a challenge for veterans, so having a local care option is crucial. In addition, streamlining the access to CHOICE care by expediting approved doctors, and timely payments from the CHOICE program to those providers who sign on in good faith to serve the veteran population.

While significant progress has been made, more needs to be done to prevent this type of calamity from reoccurring. I believe it is imperative that new leadership take the form of someone who will create an environment of trust from both staff and patients alike. Accountability and a pursuit of excellence should be a daily routine. Prevention of issues like ill-equipped clinics or operating rooms can only occur when staff can raise those concerns confident that the administration will listen and act to address those concerns honestly. When patient safety is at stake, there can be no compromise. In the final phase of this process, the culture of the VAMC needs to change. In my experience, corporate culture refers to the shared values, attitudes, standards, and beliefs that characterize members of an organization and define its nature. The right leadership will set the standard for that culture at VAMC Manchester.

I have recently been given the privilege of serving as Co-Chairman on Secretary Shulkin's Task Force to review and make recommendations for improvements at the VA Medical Center in Manchester. Part of our charter is ensure that we think creatively and entertain all reasonable options that would be most prudent to implement and send those recommendations to Secretary Shulkin for his consideration. It is my sincere hope that our recommendations will get the full support of the VA Secretary and Congress' financial backing. As we go through this process, we will be closely monitored by the veteran population here in New Hampshire and around the country. We cannot fail them any longer - their lives may depend on it.

Thank you for your consideration of this testimony. I remain at your service to answer any questions you may have.

Respectfully Submitted,
David J. Kenney
Chairman

The Veteran Advisory committee is comprised of senior leadership from American Legion, Veterans of Foreign Wars,

Disabled American Veterans, Vietnam Veterans of America, Military Order of Purple Heart, Reserve Officers Association, The Retired Enlisted Association, Military Officers Association of America, The Air Force Association of New Hampshire, Air Force Sergeants Association, The National Guard Association of New Hampshire, Marine Corps League, Combat Veterans Motorcycle Assoc., Rolling Thunder,

Catholic War Veterans, and the New Hampshire Army Retiree Council, The NH Veterans Association and Col Cross Chapter-Association of US Army

Statements For The Record

Erik J Funk MD FACC

Statement to House Committee on Veterans Affairs Regarding Deficiencies at the Manchester VA Medical Center.

Manchester VA Medical Center Manchester, NH

Mr. Chairman and members of the committee.

I appreciate the opportunity to submit this statement regarding my observations and efforts (as well as others) to maintain and improve Cardiology services at the Manchester VA Medical Center. What needs to be conveyed today is that the VA Manchester is currently an absolutely and unequivocally a broken hospital system. A system that was devoid of adequate funding, is culturally dysfunctional and lacking in qualified administrators. The question is whether our hospital can be salvaged from the dustbin? I am a believer however that the Manchester VA can and must be an accessible and quality provider. To be sure our nascent Task Force committee project demands a comprehensive plan and follow through. This newly developed master plan and eventual end product should be guided by talented directors and chiefs of services who are in turn accountable to employees, providers as well as to the veterans we serve and finally to the Secretary, Dr. David Shulkin who has thankfully endorsed this effort.

I received my medical degree 42 years ago and have practiced Cardiology in the private sector for over 30 years. I joined the VA in December 2013. Prior to my current government service work, I was in private practice involved in outpatient and inpatient invasive and non-invasive Cardiology services. I was very fortunate to have participated in the development of Cardiac services two new hospital systems including HCA in Portsmouth, New Hampshire the Portsmouth Regional Hospital in 1987 and a Catholic hospital, the Good Samaritan Hospital in southern Illinois in 2014. In both projects I worked hand in hand with hospital administrators, department heads and nursing directors. I have also had the nurturing experience to practice at a very busy tertiary care center, The Heart Hospital of New Mexico (2004–2007) in Albuquerque, NM. All these experiences were “can do” experiences. So all in all, one could say that I have been “around the block” a bit. On my arrival at VA Manchester it did not take long to appreciate how separated, disconnected and disempowered providers were here.

Physicians were completely disenfranchised regarding any input in directing the medical center programs at the VA. There were no direct educational seminars or grand rounds in which providers and physicians could commiserate as well as discuss professional issues together. Almost all provider communications are digital and rarely by phone or face to face. This was disheartening and at the same time disappointing for it was not a culture I was accustomed to in contrast to my previous hospital practices where I typically had in person contact with other physicians. It sadly remains an academically and socially sterile place here today which I believe detracts from a challenging and stimulating collegial work environment that it could be and in turn potentially translate into quality Medicare care. If only our ORs were so sterile and antiseptic.

The next jolting revelation was that the medical center was essentially run by the administrative level nursing staff (rather than physicians) who were ill equipped to manage a medical center. I have no axe to grind against nurses in fact far from it having worked in my career quite smoothly and collaboratively with nursing staff. But here I readily became aware that the most if not all hospital services including operating room, pharmacy and urgent care center were overseen by the Head of Nursing, Carol Williams, RN. She fortunately retired in August 2017 after pressure from whistle blowers and the Boston Globe article. Most of the programmatic and fiscal decisions were run through Ms. Williams and officiated by Danielle Ocker the hospital director who was also dismissed in summer 2017. This was an outrageous revelation that there was virtually no input from practicing physicians regarding management at the VA. Between 2014–2016 the nuclear camera in radiology was breaking down several times per month. This is a critical diagnostic tool used for stress testing and needed assess patients for coronary disease. It was in dire need of replacing. Chest pain work ups and pre-op patients were being rescheduled and truly inconvenienced. Administration also would not fund rental of a nuclear camera which could have ameliorated the problem. This was and remains a culture of “no

it can't be done" here. Despite administrative promises, we were informed in January of this year that funding was not available for design and construction for the CT/Nuclear camera as well. The COS, James Schlosser, MD indicated that stress test patients would have to be sent to Boston much less preferable to veterans or that they would have to rely upon a very broken VA Choice program administered by an even less timely Health Net scheduling program for Non VA referral. This was a very faulty program that was subsequently indicted for gross delays in scheduling specialty testing and thankfully scrapped. This type of delay in care is tantamount to the optic of a cardiac patient with chest pain sitting in traffic on route 95 considering popping nitroglycerin and waiting for the traffic to clear en route to their stress tests to a referral center.

My former cardiology colleague, Dr Lombardi announced his plans for enter private practice in December 2016 with his subsequent departure in late January 2017. When discussing the hiring of a full-time Cardiologist to replace him with Danielle Ocker and Carol Williams, Ms. Williams made the disturbing comment that she was distracted by the need to hire 10 housekeepers for the hospital. She had to "balance their fiscal resources". It was frankly outrageous that Ms. Ocker and Williams had hired at least 70 non-clinical staff that the hospital could neither afford nor need. We needed providers not more educators and non-clinical staff. I might add that prior to Dr. Lombardi's departure, SAC Cardiology had 3 providers. Our program was touting a 90% access rating but unfortunately this declined to 37% in the second quarter due to the staffing shortfall in Cardiology. We will be seeing an additional 0.3 FTE Cardiologist added this month.

This compilation of events and others which will be presented today brought myself, Dr. William "Ed" Kois and Dr. Stuart Levenson together and along with eight other whistle blowers to expose the gross mismanagement that has occurred during our tenure here at the Manchester VA and and bring us to propose potential solutions to provide better access to convenient high quality medical care for our veterans.

The Manchester VA and members of the Task Force have their work cut out for them. Many choices, platforms and solutions will be considered. The first choice which may be least desirable to providers and for most veterans which is complete privatization as some legislators have hinted. The second is a hybrid public-private partnership plan culling out some least accessible medical and surgical specialty services and shunting them to the private sector. I do think that services such as Cardiology, Pulmonary, Oncology and mental health services could be bolstered at the Medical Center. For example the development of a hospital based comprehensive heart failure case management program would save millions of federal dollars and reduce CHF readmission rates. The third option and most challenging is resurrecting and rebuilding a "full service" inpatient facility service here. This would be a daunting task indeed. I do believe that whatever direction or directions this ship will sail toward it most certainly requires experienced, talented and energetic administrators who are not just skilled navigators of stormy seas but also change masters who can improve a dysfunctional institutional culture we have here today. Thank you for your attention.

Stewart I Levenson MD FACR

Mr. Chairman and Members of the Committee,

Thank you for allowing me to submit this statement regarding my efforts for reform at the Manchester VA Medical Center.

As a physician I have been employed until recently at the Manchester VA Medical Center. I was initially hired to provide both primary care and rheumatology services. Within the last several years in Manchester I became the department chairman and then the New England Network Director of the Medicine Service Line. During my tenure I have been given assignments as the chief of primary care and the chief of urgent care. I have also been assigned to another medical center as the assistant to the director. As you are all aware the Manchester VA has been featured in a Boston Globe article exposing deficiencies in care. Despite efforts on the part of myself and the other so called whistleblowers no corrective action had been taken until this article was published.

These efforts began individually by concerned physicians who worked to improve care on their own through official channels. Only when frustration was voiced to each other in informal associations, was it learned that problems were endemic and were a common experience. At that point the individual physicians came together to try to address problems as a group. Regular meetings were held and discussions

were undertaken to try to sway the leadership. Not only was this effort unsuccessful but retaliation was meted out by the leadership. As the core of the group that became known as the whistleblowers grew we would meet with the medical center director and then by early 2016 meet with members of Congress. I myself became frustrated with the pace of action so I contacted the Boston Globe Spotlight Team. The Globe staff felt the issue compelling and conducted in depth interviews. This led to the publication which brought the current scrutiny to the issues of patient's receiving substandard care.

Each member of the whistleblowers is witness to individual issues but also shares the common experiences which make up the shoddy care provided our veterans. As a leader I myself became the recipient of concerns brought to me by my subordinates.

The first major issue that became a concern for our group of physicians was noted in cardiology. This issue had to do with care of a stroke patient that eventually led to the \$21M judgment against the medical center. It also led to the unfair smearing of physicians who were directly involved in trying to improve care at the medical center.

In approx. 2003 the medicine division hired a full time cardiologist for the first time. Dr. Dan Lombardi wasted no time in bringing to my attention the shortcomings of the echo tech who performed cardiac echos. It seems that this tech never had any formal industry recognized training. She had only received on the job training through the VA. She had no certifications and had no interest in gaining any expertise. Dr. Lombardi repeatedly brought his concerns to me and I forwarded them to the tech's supervisor, who was the recently removed nurse executive, Carol Williams. Ms. Williams was not only unsympathetic but showed no interest in correcting the problem even when the Boston VA Medical Center commented that the quality of the echos was so bad that no cardiologist should validate the studies. Having our complaints fall upon deaf ears our cardiology division functioned as best it could. This culminated with the echo of a patient with a question of a cardiac derived embolic stroke being referred for a trans esophageal echo. The tech was unable to perform the study, blaming the problem on a faulty probe. It was later learned that the tech did not know how to turn on the probe.

The acceptance of incompetence is a common theme. When Dr. Kois took over as the staff physician in the spinal cord clinic he expressed similar concerns with regard to spinal cord patients. Concerns were brought to upper leadership and completely ignored. If a member of upper leadership tried to intervene they too would face retaliation. Dr. Anderw J. Brueder, the long time chief of staff, tried to assist in dealing with issues, and was removed from his position on a thin pretext. Like myself he tired of fighting and retired from the VA.

The committee will receive many statements dealing with individual issues. I will instead deal with the common threads. One obvious issue is that the VA cannot police itself. Investigations done internally become nothing more than farce, and usually end with retaliation against those who instigated the complaint process. Such was the case with Dr. Brueder. This also occurred with myself. The office of Inspector General conducts incompetent investigations geared at scapegoating and then forwards its results to Administrative Review Boards. These boards then single out a scapegoat and retaliation is undertaken. This happened to myself several years ago. It is currently happening to Gary Von George the business office chief who questioned the director's management of the Choice program. Other examples continue to arise.

Leadership covers for each other and when caught is allowed to transfer to another position in the network. Tammy Krueger (formerly Follensbee), refused to deal with problems that led to the huge malpractice judgment. She also stood by while other patients were endangered in Urgent Care. As acting chief of urgent care I brought problems to her almost daily. As retaliation for doing this I was passed over for the position of chief of staff. Despite my track record of success, I was not even given a second interview. When the issues in urgent care came to light Ms. Krueger was allowed to transfer to a position at the VISN headquarters. In a move that would be comic if not so tragic, she is now being named to the task force to study problems at Manchester.

Other incompetent leaders seem to reappear as well. Even Dr. James Schlosser, the incompetent chief of staff who was recently removed is being considered for the Care in the Community Coordinator. This position is actually constructed to deal with problems that Dr. Schlosser himself created. I personally can think of no greater irony.

Incompetent failed leaders being repeatedly placed in positions of authority occurs repeatedly. Danielle Ocker the removed medical center director also fits this mold. Her own issues led to removal at White River VA and could have predicted her poor

performance at the Manchester VA. Reviewing the education alone of these leaders should have been a red flag to begin with. It is my understanding that Ms Kreuger and Ms Ocker have only on line rudimentary degrees. In Ms. Ocker's case it is from a for profit institution.

Much of the blame for the problems in Manchester I place with Dr. Michael Mayo-Smith the VISN 1 Network director. There is simply no way that Dr. Mayo-Smith could have remained unaware of the problems at Manchester or the other medical centers for any length of time. His insular style of leadership can only be compared to Nero fiddling while Rome burned. While much of his discussions about the problems at Manchester occurred behind closed doors, he would comment on the problems at various times such as the monthly video conference referred to as "Super Tuesday." I myself have informed him of problems only to be told that they are to be handled by local leadership. As of late I have been in frequent contact with Dr. Mayo-Smith and have tried to find common ground going forward. I truly believe we both want the same outcomes for our veterans. Yet when confronting him about recent issues he still falls back on the reply that the local leadership should handle this. Is it any wonder why these issues that endanger veterans continue unabated?

One of the greatest areas of incompetence is in the area of wasteful spending. This has had a huge impact upon patient care. Through hiring of non clinical personnel and other excessive spending Danielle Ocker placed the medical center in a deep financial deficit. Without regard for patient safety and with the full knowledge and cooperation of Dr. Mayo-Smith and Dr. Schlosser clinical programs were curtailed. The money for care in the community hospitalizations was most affected. Patients were no longer being admitted to a local community hospital but only to VA facilities. This led to decreased satisfaction and mistrust. It seemed that if a patient had to be admitted to a local hospital it came directly at the expense of an on site clinical program. A single hospitalization could cost the same as an entire clinical employee FTEE. Schlosser Ocker and Mayo-Smith stood by while programs were being decimated.

Even as this committee meets, millions of dollars are being wasted at Manchester. When the water pipe burst it was estimated that it would cost \$10M to bring the building back on line. This building is well past its useful life and is now being evaluated for replacement. If it is decided that the building needs to be replaced the money spent repairing it is a total loss.

This speaks to a larger issue. Manchester is not the only VA that is exposed in the news. In fact it is so commonplace to see a story describing a VA as being terrible, that these stories fail to make the national press. In the VA system there is a culture of incompetence. Meeting measurements at the expense of providing good care, following rules while ignoring common sense and experience, are deeply ingrained in the corporate culture. The VA is a failed system that fails to keep its promise to veterans. Leadership is incompetent, money is wasted and good hard-working employees are harassed and retaliated against for trying to provide excellent care. Unless the VA changes on a fundamental level, the only solution will be to shutter it and move to a system of privatization. This in my opinion would be a mistake. The VA is the largest integrated health care system in the United States. It could be a model for providing efficient healthcare to all US citizens, instead it has become a national tragedy.

Ritamarie Moscola, MD, MPH, CMD, CPE

Mr. Chairman and Members of the Committee,

On or around June 30, 2016, we placed veterans requesting home maker home health services and service in adult day health care centers on the Electronic Wait List (EWL). This was at the direction of the Medical Center Director, Danielle Ocker and the Chief of Staff, James Schlosser. Over the course of several months we attended weekly meetings during which the EWL for Geriatric and Extended Care (GEC) services was discussed. Senior Leadership was present. We requested guidance on removing veterans from the EWL. We did not receive approval to move forward.

In February, the Director responded that we needed more investigation into the process. VISN leadership was aware because the veterans triggered on the consults pending for >90 days.

On July 11, James Schlosser commented at monthly meeting with VISN that Manchester was the only facility with EWL for GEC services.

On July 17, I received an email stream stating that Manchester was not the only facility with GEC-EWL.

On July 17, I received an email stream documenting that Manchester was not the only facility with GEC-EWL. I was asked how I was going to address this. I called a meeting of the staff working on providing these services. I told them that we would review veterans with new and old consults for eligibility. We would refer all those meeting eligibility requirements to the appropriate home health agency or adult day health care facility. Later in July, Corey Wilson, the Acting Chief of Business Office, contacted the GEC nurse and gave her assignments regarding the EWL and consults. No one spoke with me about changes in job descriptions and duties even though I am the Service Line Manager.

On 8/28, at meeting with GEC staff, the Acting Chief of Staff of Business Office, I learned that the review of consults for home maker home health services was being removed from GEC and transferred to him. He asked me why I created the EWL for GEC services. I responded that I was told to do this by Senior Leadership due to the budget. He commented that there was always money in the system for GEC services.

Electronic Wait List Numbers:

- Veteran Directed: 62
- Adult Day Health Care: 34 with 5 veterans on the EWL for over one year.
- Home Maker Home Health Aide: 138

Mark Sughrue, ACNP

Thank you for allowing me to address some of my observations. I was unable to make the hearing as I have Veterans scheduled to see me in clinic and I always try to defer to my Veterans and try not to reschedule them unless absolutely necessary.

1.The nuclear camera has been due for replacement for over three years as it has been obsolete and parts have only been available by retrieving from old machines. The camera has failed on occasions causing patients to have to repeat tests getting dosed by radiation more than one time to complete testing. The National Acquisition Center has purchased a new camera to be installed apparently pending the local Medical Center paying for the installation. The Manchester VAMC initially failed to account for the installation costs delaying the install more than 3 years ago then delayed in obtaining the designs for the construction to install the camera. The camera install was delayed again until the next Fiscal year 2017 for install with the excuse of “no money left to cover the install”. Then the administration decided to delay installation of the camera as the nuclear technician decided to retire despite the assurance that construction would begin early 2017and be completed by August of 2017. The timeframe for installation of the new camera is still not known but not until at least 2018 roughly 4 years after the process started.

2.The administration at the VAMC failed to plan for the anticipated downtime that was going to be required during the installation of the camera despite multiple requests from Cardiology and Radiology to consider the downtime. The response in early 2016 was “we will utilize Veterans Choice to bridge the construction time”. When cardiology and radiology both stated the fact that VA Choice would delay care and potentially cause patients to fail testing the administration continued to plan for VA Choice to bridge the install time. When cardiology and radiology repeatedly pointed out to the administration that the cost of renting a camera to bridge the 6 month construction gap time would only cost \$26,000 approx. for 6 months and allow for quicker safer testing at the Manchester VAMC the administration still decided to pursue VA Choice as the preferred option. For example of ineffective VA Choice testing when the cardiology echo technician went out on emergency leave for medical injury VA Choice was utilized instead of hiring a temporary echo tech and keep cardiology echo at the Manchester VAMC. For 3 months cardiac echo tests were referred to VA Choice to be completed. After 3 months almost 300 echo tests were returned to the Manchester VAMC as not completed by VA Choice, both delaying care to Veterans at great risk and increasing cost as now many man hours had to be dedicated to rescheduling and triaging the echoes for priority. The typical cost of a nuclear stress test is approximately \$4000. The administration of the Manchester VA decided instead of spending \$26,000 for 6 months of nuclear stress test (roughly 150 stress tests) that cost shifting to failed VA Choice program was more beneficial. It is clear that the benefit was not for the Veteran but rather for the bottom line of the administration.

3.The administration decided not to act to maintain the nuclear department despite persistent requests from Cardiology and Radiology. There was a full time and

a part time nuclear technician until Fall 2016. The part time nuclear technician wanted to become a full time nuclear technician but the administration had declined to make her full time (despite being aware of the impending retirement of the full time nuclear technician). That nuclear technician was offered a full time position in Massachusetts outside of the VA and despite the pleading of cardiology and radiology the administration continued to decline to hire her full time so she left fall of 2016. The sole Nuclear Technician got her retirement day finalized for the end of January 2017(it had been known she was going to retire for 2 years). From fall of 2016 through January 2017 the administration would not pursue any plan to install the camera or replace the nuclear technician despite now having a firm retirement date. The administration actually allowed the nuclear camera to go unrepaired with a function called attenuation correction because it was “going to be replaced and they didn’t want to spend any further money on the camera”. Then 1 week prior to the remaining nuclear technician’s retirement there was an emergency meeting held the week of January 14th 2017. Present was Chief of Staff Dr Schlosser, Chief of Nursing Carol Williams, Associate Chief Nurse Linda Pimenta, Chief of Radiology, Chief of Medical Specialty Dr Levenson, Nursing Supervisor of Specialty and Acute Care Shauna Dalleva, Dr Funk Cardiology, myself Mark Sughrue Nurse Practitioner Cardiology, Lead Technician Radiology Doreen Mitchell, business office representative, a union representative, and a patient safety representative were present. At this meeting a plan for nuclear testing including nuclear stress tests, nuclear imaging for other departments were considered. Cardiology, Chief of Medicine, nursing supervisor of Specialty and Acute Care, radiology, business office and patient safety all expressed the concerns with choosing to send nuclear testing to VA Choice (especially in the setting of known failures with doing exactly that with echoes which was a failure as noted above and no change had occurred to improve VA Choice at that time). Manchester averaged 11 days to completion of stress tests (which included weekends and holidays when testing not completed and patient’s desires to schedule into the future for planning etc). It was known that VA Choice could routinely take up to 7 days to even make first contact with patients followed by 30 days to actually schedule the test and up to 60 days to return the results to the VA. I suggested that the nuclear department not be closed due to above factors and the known delay in care as well as some cases of VA Choice not even completing testing as a patient safety, public health and increased cost to overall VA operations. Dr Funk also stated his opposition to closing the nuclear department and sending patients to VA Choice. Business office expressed similar concerns and felt the volume of test would overwhelm current staffing in business office who were unable to follow VA Choice effectively already. The administration stated that since the nuclear technician was leaving and a cardiologist was also leaving that the “utilization of VA choice was the best course”. When cardiology requested they hire a new technician and cardiologist so that the nuclear department could be kept the leadership including Carol Williams and Dr Schlosser both stated that the Manchester VAMC didn’t have the money to hire anyone. Carol Williams stated that Manchester VAMC “can’t recruit a new cardiologist as we have to hire housekeepers, we are down 10 housekeepers”. Linda Pimenta expressed that hard decisions had to be made but there was no money to make any other choices other than VA Choice. All of the above safety and delay concerns were felt to not be enough to choose not using VA Choice according to leadership that was present including Chief of Staff, Chief of Nursing, and Associate Chief of nursing. The plan became no technician would be hired until the new camera was installed which was then planned for fiscal year 2018 and that VA Choice would be used to complete nuclear testing for at least the next 10 months.

4.The typical cost of nuclear stress testing is approx \$4000. The Manchester VAMC averaged 350 nuclear stress tests per year totaling \$1.4 million in cost shifted to VA Choice budget from the Manchester VAMC budget. The cost to complete at Manchester VAMC would include partial salary for Cardiologist and Cardiology Nurse Practitioner(who also completes other patient visits), EKG technician (who also has other duties), Nuclear technician (also completes nuclear testing for other tests), cost of the nuclear material, camera cost and other various facilities cost which definitely costs less than \$4000 per test.The utilization of VA Choice enabled the Manchester VA administration to cost shift the testing to the VA Choice budget therefore “saving the Manchester VA money” as they say it. There was no consideration from the administration regarding the proven concerns and prior failures with utilizing VA Choice for time sensitive life altering tests.

5.After the transition to utilization of VA Choice for nuclear stress testing started in January of 2017 and through July 2017 multiple tests had not be scheduled or completed in some cases greater than 3 months delay for symptomatic patients. Multiple patient safety reports were been submitted with no action taken from the

administration to change plan or change plan to hire a nuclear technician despite the old camera which at least was still partially functioning was still present, no movement in actually hiring a cardiologist (looking was approved but not hiring). The camera install was apparently submitted improperly therefore it was not clear if it will even be installed at this point and not any sooner than 2018 at the earliest despite more than 3 years of knowing this equipment needed substantial planning and redesign of the radiology department to install. Manchester VAMC continued to refer patients to VA Choice despite continued lack of scheduling and completion of the tests as of mid May 2017.

6. After the Boston Globe article was released many changes in action from the new administration to correct the errors of the prior administration proceeded. The new acting director ordered the nuclear camera restarted (cost to decommission and then the cost to recommission likely more than the yearly salary of the nuclear technician). Unfortunately, since no recruitment for a new nuclear technician was started the nuclear stress department has yet to open but the nuclear camera is being used for less complex non cardiac testing.

7. A part time cardiologist was hired to increase availability of cardiology resources, but this is still less than the number of cardiologist available prior to the old administration effectively dismantled the cardiology service line to save money.

Observations:

The connecting theme of most of the above decision points that the Manchester VAMC administration made was completely driven by increasing bureaucracy, cost shifting and was not driven by improving care for the Veterans. The thought was never how can we make the Manchester VAMC a destination for care. It was only about how do we cover the bottom line because the Manchester VAMC budget and planning were lacking. Decisions were made to hire multiple middle management but not new clinical staff to actually see the Veterans and provide care despite the clinical staff functioning at greater than capacity in nearly all departments. An example is the creation of at least 2 new executive nursing positions in the nursing hierarchy effectively creating more managers to oversee less clinical staff because there "wasn't enough money in the budget to hire clinicians". At no point along the multiple decision points did the administration consider the input from the content experts and front line personnel to make decisions for the Veterans. The decisions were made in the dark and then dropped on the clinical staff with only token "listening sessions" where input was clearly not exploited.

What have I seen since the new acting director and the visit from VA Secretary Shulkin came to the medical center. Some changes have been positive such as more involvement of medical providers in decision making for the medical center. It seems that the cardiology service line is at least partially being rebuilt though still below prior provider levels.

Unfortunately, I have also experienced "more of the same/the VA way" still occurring. Officials removed from one job and placed in other positions of power despite the many decisions made that knowingly negatively affected Veterans. The hierarchy that enabled the poor and unsafe care of our Veterans are still in place and continue to make decisions without involvement of content experts and clinical staff. An example which may seem small but can truly negatively affect patient care. Electrocardiogram (EKG) electrodes were changed after being approved by middle management, but no input was sought from cardiology or clinical engineering (responsible for all medical devices throughout the medical center) regarding the change. The result has been increased artifact on EKGs especially during stress testing as the stickers don't stick well on someone who is moving and sweaty. This could have been avoided with less middle management making decisions without the support and input of the clinical providers or at least content experts.

I truly hope that the positive changes will be sustained but concerns remain given the persistent atmosphere of entitlement from certain staff and decisions made not because it is best for the Veteran but for other reasons.

The VA should solely be motivated to be the destination of care for our Veterans. I have seen some of that culture in the VA but it is not pervasive and was not present in the prior administration and remains in Manchester in some of the previously established hierarchy.

Gary Von George

My name is Gary Von George, and I am the Business Office Manager at the Manchester VA Medical Center. I have been an employee with the Department of Veterans Affairs for 33 years. I have held positions of progressive responsibility

throughout my career serving Veterans as I have worked at three different VA Medical Centers within VISN 1 and at our VISN 1 network office. Prior to July 26, 2017 I had not received any adverse actions nor had I been counseled for any performance or misconduct issues. On July 27, 2017 I received a letter from my supervisor, Kevin Forrest, Associate Medical Center Director that informed me that I was being detailed to the office of Mental Health as an Administrative Officer, pending an investigation. This letter was signed by Alfred Montoya, Acting Medical Center Director. This letter is the result of recent communications that I have had with senior leadership and possibly other investigative teams that I met with and provided information to.

As the Business Office Manager for the Manchester VAMC, my duties included oversight of the Community Care office. The Community Care office is responsible for processing care that is referred to civilian providers, when it cannot be delivered through VA processes. The Veterans Choice Program, as it relates to New Hampshire Veterans, is encumbered under the Community Care office. The Community Care office at the Manchester VAMC has been understaffed throughout this Fiscal Year. On June 30, 2016 the community care section lost 40% of the community care case management staff as two of the nurse practitioners took other positions within the VAMC. On October 1, 2016, the Chief, Community Care became vacant as this person accepted another position within the VISN. I immediately did the expected resource request, and then the shell game of approving staff at the Quadrad level began. I repeatedly asked for these positions to be filled through both written and verbal communications to my supervisor and through written verbal communications at various meetings.

On June 7, 2017 I sent an email to Kevin Forrest, Associate Director and James Schlosser, Manchester VAMC Chief of Staff regarding processes, budget concerns and possible misuse of the of Dental care as it pertains to the non-VA Care dental process. I had identified several instances of high dollar referrals for care that did not meet the guidelines spelled out in the Community Care Dental Desk Top guide, to include mismanagement of referrals over \$1,000 which is a violation of 38 U.S.C. 1712. In addition, at a leadership meeting on June 8, 2017, I further clarified verbally to leadership that I had identified what seemed to be a large amount of dental care that was being referred to one particular dental provider and that this care was not meeting the consult review process of having a second level VA Dental opinion. On July 5, 2017 the Manchester VAMC Privacy Officer sent me a Freedom Of Information Act (FOIA) request that was received from the Boston Globe on June 12, 2017. In this request, the Boston Globe is asking for payments made to civilian dentists for a specific timeframe.

On July 21, 2017, Carol Williams, Nurse Executive sent out a communication to all clinical staff that effective Monday, July 24, 2017 the Community Care section would be stood up as a new unit separate from the Business Office and that it would be led by the Social Work Chief. This was the first communication that I received notifying me that this would be taking place and I immediately sent an email to Kevin Forrest questioning why I was not kept in the loop as the Service Line Manager. On July 22, 2017 at approximately 4:30 PM, Kevin Forrest and I had a telephone conversation regarding this process. During this conversation, I informed Mr. Forrest that I have personally witnessed Carol Williams "bully" her way around to get what she wanted. I told Mr. Forrest that VACO Office of Community Care was recommending a physician be placed in charge of this new office and that "with all that has been occurring here at the facility, Manchester does not have the juice to go against what VACO is recommending." This comment further proved to be true when VA Undersecretary for Health, Dr Poonam Alaigh came to Manchester and announced at a town hall meeting that the Community Care office would be led by a physician.

On July 19th, I was told by leadership that the OMI wanted to interview me. I presented to this interview and was asked about Veterans Choice questions. As I was not sure what they were going to ask me, and as such I was not fully prepared. It is important to note, that when I was interviewed by OMI in January 2017, I was informed by the former Quality Manager what the topic was. On July 26, I again met with OMI and this meeting was set up at my request as I felt that I had not been able to give the team a complete picture of Veterans Choice, lack of support from the VISN 1 BIM and other concerns. During this meeting, I clarified with OMI a request for information that I had received from our leadership. I then disclosed to leadership that I had met with OMI a second time and had clarification that I sought.

My case is a classic example of how this agency treats employees that try to bring issues to light and they suspect of being a whistleblower. Leadership removed me from my position and proceeded to limit my access and knowledge. I have been

blocked from program folders, have had system access removed and have been removed from pertinent mail groups that will hinder me from ever returning to my position. The “investigation” against me is now entering its eighth week and I have yet to be contacted by an investigator or be allowed to defend myself against the charges. As I had built a reputation of trust and respect amongst my peers here at the Manchester VAMC, the agency has sent a clear cut message to all other employees at the Manchester VA of what will happen to you if you challenge their norm or talk to institutions outside of their control. I had not spoken to the Boston Globe regarding the dental issue or any of my Veterans Choice concerns, as I instead preferred to work within the VA system, a healthcare system that I know and believe in, as it serves our nation’s highest heroes.

Edward Chibaro, MD

John McNemar, DNAP, CRNA

Stephen Dubois, CRNA

The surgical and anesthesia staffs represented are comprised of three providers. One surgeon and two are anesthesia providers. All three providers documented multiple areas of severe deficiency and offered suggestions and recommendations.

There has been lengthy discussion with regard to absent and outdated surgical and anesthesia equipment and instrumentation. Instruments have been repeatedly contaminated and flies were noted in operating room number two. The Chief of Surgery step-down occurred as a result of ineffective leadership, lack of productivity, unsettling day-to-day conflict and relentless opposition to develop a prestigious surgical program with Veterans as the top priority. The current acting one-day-a-week acting Chief of Surgery defers to the OR nurse manager the remainder of the week. In his absence she executes Chief of Surgery duties. Medical staff members have noted the acting chief of staff expresses no interest in Manchester and habitually dismisses concepts and ideas brought forth by permanent Manchester staff. The administrative support staff for surgery is located on different floors and is of very limited assistance to operating room ventures.

A robust culture of disrespect prevails in the OR and most of the medical center. Antagonistic interpersonal work relationships are the daily norm in the operating room. Nurses have refused to execute physician and/or provider orders, only to receive full support from nursing leadership. A concerning number of staff sign-on for employment then quickly resign from the Manchester VA.

The nurse manager bullies nursing staff, housekeepers and others. She has browbeaten and intimidated staff in the presence of nursing leadership, chief of staff and other administrators, and has not been admonished whatsoever. She has reprimanded staff in view of patients. She has lied, exhibited inferior sterile technique, encouraged the use of contaminated instruments and violated multiple Joint Commission guidelines for unprofessional behaviors. Nursing staff have complained about not receiving lunch breaks, often while the nurse manager and assistant nurse manager are sitting at their desks, in their offices. She inaccurately educated staff with respect to the World Health Organizations mandated protocol for the “time-out” procedure and encouraged staff to refrain from calling for emergency assistance in the event of a code blue. She has requested that providers fill in for OR nursing lunch breaks, an extraordinarily unorthodox request. She was noted to have not properly logged critical OR incidents, such as humidity control and contamination problems. She was unable to track cases cancelled due to contaminated equipment. Her direction of an OR remodel yielded absent emergency call intercoms or code blue buttons standardly found in operating rooms. Manchester VA administration, the Office of Medical Investigation and the Office of Whistleblower and Accountability have received numerous letters of complaint written by staff members from many disciplines, including physicians and other providers. Her supervisor is incapable of resolving everyday clinical issues and is completely unknowledgeable with regards to OR routines, primarily because her background is in primary care. Frivolous, expensive and unnecessary office renovations were approved and directed by the nurse manager. These renovations superseded recurrent pleas for essential staff, essential equipment and essential instruments required for patient care and patient safety. More extensive and serious concerns have been documented and shared with VA administration and multiple internal VA investigative agencies.

The culture in the operating room at the Manchester VA parallels the noxious culture throughout the remainder of the facility. There is a forceful refusal to collabo-

rate on vital topics and a customary atmosphere of autocratic execution and rogue decision making. Expensive and critical surgical and anesthesia supplies and equipment were independently ordered by nursing staff, without approval, collaboration or any stakeholder participation. This autocratic culture remains active today and is everyday business in the Manchester OR. Focus groups, task forces and team methodologies are all baseline concepts in any operating room, yet do not exist in the Manchester OR. Vital support staff has been repetitively requested, agreed to and confirmed, only to later be cancelled and denied. Communications are nearly non-existent. Most personnel do not respond via phone, email or otherwise.

Providers are essentially on their own, often left to flail and fail. They receive little to no support by means of staff, administration or other.

ENT surgeon Dr. James Snyder, a US Navy Captain and highly renowned surgeon in the community, was personally called and recruited to the Manchester VA last year by then Undersecretary Dr. David Shulken. In his time in Manchester, Dr. Snyder struggled to get instruments and assistance. He received no help from OR staff, leadership or administration. After being pushed to his limits when offered a miniscule workspace after the recent flood, he submitted a resignation. The administration neither appeared concerned, nor tried to troubleshoot the resignation and convince him to stay. Meanwhile, many staff members were and are in spacious offices that could have temporarily served Dr. Snyder to complete his work. Leadership is indifferent to the loss of valued staff and administration appears expressionless, despite a revolving door of employees.

Several years ago anesthesia providers had no method for drug administration. This virtually did not exist. In high-risk fashion, medications were removed outside of the OR and carried in for each patient, every case. Emergency drugs were not present and pharmacy personnel provided enormous levels of opposition and defiance when workable resolutions were suggested. Patients about to receive anesthesia get little time with anesthesia providers as providers are required to restock anesthesia supplies and clean equipment between each and every case. This highly irregular practice is necessitated as anesthesia has no support staff. After submitting countless literature sources in support of hiring this staff member to administration, anesthesia staff was repeatedly promised this position would be hired, only to be repeatedly denied. The OR pharmacist had little to no knowledge regarding anesthesia medications and ASHP (American Society of Health-System Pharmacists) and ISMP (Institute for Safe Medication Practices) protocols and guidelines. Pharmacy personnel attempted to require anesthesia providers to pick up and drop off anesthesia drugs, a practice that would be considered highly irregular. Pharmacy technicians restock medications in all operating rooms, but at the Manchester VA they are not permitted in the OR by order of the nurse manager. Pharmacy involvement is minimal as related to anesthesia, which is also highly irregular. Pharmacy personnel "lost" a large number of Propofol vials, the liquid anesthetic that killed Michael Jackson. Pharmacy personnel then accused anesthesia staff of diverting the drug, an accusation that was later rescinded in a letter of apology written by the Chief of Staff. To date, there has been no follow up with anesthesia as to the status of those missing vials. Pharmacy personnel attempted to have a standardized drug return bin removed from the exterior of the not-yet-purchased anesthesia dispensing cabinets that will be ordered. This is a violation of ISMP protocols (Institute for Safe Medication Administration) and an action that will make duties easier for pharmacy personnel, while increasing risk of incorrect medication administration to patients and increasing liability for providers and the Medical Center. This hazardous notion has more recently been supported by the interim Chief of Surgery from the White River Junction VA Medical Center, who is a surgeon and appears unacquainted with the potential safety implications of this deviance from recommended guidelines.

Providers are habitually excluded from involvement with decision making that affects their specific practice, while other uninformed staff members are incapable of completing their own duties because they are diligently working to execute duties that are not their own. This peculiar practice is unconventional, yet customary in Manchester. Providers must be integrated into their own areas of expertise and empowered to regulate their professional practice. They must also be consistently and sincerely acknowledged when conveying undisputable practice concerns. Investments into essential staff and essential equipment must be supported to provide proper care, and the use of standards of practice and recommended guidelines must be compulsory and established with an evidence-based framework. There is an imperative need to educate all Manchester VA personnel with regards to the zero tolerance policy for disruptive behavior as recommended by the Joint Commission. Rudeness, disrespect and intolerance must be replaced with optimism, kindness and basic mutual civility. This policy has to be strictly adhered to locally and all employ-

ees held accountable for their approach as the Medical Center endeavors the paradigm shift from a culture of disrespect to a culture of respect.

Questions For The Record

LETTER TO HONORABLE DAVID SHULKIN

The Honorable David J, Shulkin Secretary

U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shulkin,

Please provide written responses to the attached questions for the record regarding the Subcommittee on Oversight and Investigations field hearing entitled, “An Assessment of Leadership Failures at the Manchester” that took place on September 18, 2017. In responding to these questions for the record, please answer each question in order using single-spaced formatting. Please also restate each question in its entirety before each answer. Please provide your responses by the close of business on Friday, November 10, 2017. Answers to these questions for the record should be sent to Mrs. Tamara Bonzanto at tamara.bonzanto@mail.house.gov and Ms. Grace Rodden at grace.rodden@mail.house.gov, copying Ms. Alissa Strawcutter at alissa.strawcutter@mail.house.gov. If you have any questions, please do not hesitate to have your staff contact Mr. Jon Hodnette, Majority Staff Director, Subcommittee on Oversight and Investigations, at 202-225-3569.

Sincerely,

Nc::J—

Chairman

Subcommittee on Oversight and Investigations CJB/tb

Cc: Ann McLane Kuster, Ranking Member Attachments

“AN ASSESSMENT OF LEADERSHIP FAILURES AT THE MANCHESTER”

Questions from Chairman Jack Bergman

1. During the hearing, Dr. Mayo-Smith testified that he knew about some of the concerns raised by whistleblowers prior to the publication of the Boston Globe report, and he found out about others after the report was published. Dr. Kois stated that he and other whistleblowers raised and tried to address the myelopathy cases with Dr. Mayo-Smith for years, and the Veteran Integrated Service Network (VISN) did not take appropriate action to respond. Please inform me when Dr. Mayo-Smith was first made aware of the issues with the myelopathy cases, and what actions he and the VISN took to address those issues. Please include a timeline with the response.

2. What processes are in place at the VISN to ensure there is proper oversight of community care offices at each facility?

3. Has VHA completed a review of the deficiencies at the VISN, specifically within the business office? If yes, were there any findings?

4. What are the VISN’s plans to improve coordination of inpatient mental health services within the network?

Questions from Ranking Member Ann McLane Kuster

1. What VHA and Manchester VAMC processes exist to remedy training deficiencies in medical support staff?

2. What actions are supervisors and clinicians- required to immediately take upon discovery of training deficiencies and to ensure patient safety and quality of care in these instances?

3. What on-the-job training is provided for medical support staff?

4. What required actions do VISN Directors take when they receive patient safety and quality of care -complaints?

5. When VISN Directors receive complaints from VA employees, how do they determine whether a complaint should be addressed at the medical facility level, the Network level, or at VA Central Office?

6. What actions are being taken at the facility level, Network level, and at VA Central Office to address cultural and human resources issues that have contributed to the current workplace environment at the Manchester VAMC?

7. What actions has the Manchester VAMC and the VISN taken to protect VA whistleblowers and notify VA employees of their rights to provide information to the VA Office of Inspector General (OIG), the Office of Special Counsel (OSC), the Office of Accountability and Whistleblower Protection (QAWP) and Congress?

8. What actions will the Manchester VAMC and the Network take to hold supervisors who retaliate against VA employees accountable?

9. How will the Manchester VA incorporate physicians' input in management of the medical center's programs?

10. What provider professional educational opportunities exist at the Manchester VAMC?

11. Do forums exist for physicians and providers to raise and address issues concerning clinical operations?

12. How are staffing priorities made at the facility and VISN level?

13. Was the Manchester VA leadership incentivized to send veterans to community providers for treatment via the Choice Program instead of providing care at the Manchester VAMC as a cost-saving measure?

14. Are facility directors required to report provider vacancies and plan for new hires and attrition in the plan and budget for each fiscal year?

15. How many providers would Manchester VAMC need to hire to fully restore the cardiology service line?

16. What recruiting efforts have the Manchester VAMC taken to identify a permanent director and hire a new Chief of Staff, and when does the facility expect to have these positions filled at the facility?

VA GFR RESPONSE

Questions for the Record

"AN ASSESSMENT OF LEADERSHIP FAILURES AT THE MANCHESTER, N.H. VA MEDICAL CENTER"

Questions from Chairman Jack Bergman

Question 1. During the hearing, Dr. Mayo-Smith testified that he knew about some of the concerns raised by whistleblowers prior to the publication of the Boston Globe report, and he found out about others after the report was published. Dr. Kois stated that he and other whistleblowers raised and tried to address the myelopathy cases with Dr. Mayo-Smith for years, and the Veteran Integrated Service Network (VISN) did not take appropriate action to respond. Please inform me when Dr. Mayo-Smith was first made aware of the issues with the myelopathy cases, and what actions he and the VISN took to address those issues. Please include a timeline with the response.

VA Response: Please see the attached document.

1. In order to document communications with the whistleblowers Dr. Mayo-Smith asked OI&T to identify all emails from or to or mentioning the whistleblowers from January 2014 through July 2017. As Network Director all his emails are archived. In addition staff at the Network Office reviewed the files of written correspondence, communication to the "Ask the Network Director" option on the VISN website, the presentations by service line leads during their annual briefing to the Network Director and the minutes of the meetings of the Service Line Leads. This is of interest as Dr. Stuart Levenson was serving as the Medicine Service Line Lead for the Network and participated in these meetings.

2. There was no written correspondence to the Network Director by any of the whistleblowers during this period. There were no submissions from any of the whistleblowers to the Network Director via the “Ask the Network Director” button on the VISN website. There were no in-person or telephone meetings requested or held with any of the whistleblowers. No emails from Dr. Kois were identified by OIT in their search of the files.

3. The review of Medicine, Surgery, and Rehabilitation Service Line presentations in 2015, 2016, and 2017 did not reveal that the issues of concern were raised at these meetings. As noted Dr. Levenson was the Service Line Lead for Medicine. Dr. Chibaro also served as the Chief of Surgery and was present at the Surgery meetings. Neither the Network Director nor others present recall any of the issues of concern being raised verbally. Similarly review of the minutes and inquiry of those present established that the issues of concern were never raised during the monthly Service Line Leads meetings with the Chief Medical Officer.

4. In 2015, Dr. Mayo-Smith had the opportunity to meet with Dr. Kois. He had been mentioned by the leadership at Manchester as a new hire who was skilled in managing chronic pain patients. Dr. Mayo-Smith requested to meet him during a site visit and visited him in his clinic as management of chronic pain was a priority for VISN 1. There was no request from him to meet with the Network Director; the meeting was initiated by Dr. Mayo-Smith. Dr. Mayo-Smith believes that at this meeting Dr. Kois’ concerns regarding myelopathy management was raised. There were no concerns regarding this issue at other medical centers in the Network. There was no VISN or National Policy directing management of myelopathy. As this was a concern regarding care at Manchester, Dr. Mayo-Smith recommended to him that he bring this up with the Chief of Staff at Manchester. The VISN staff were available to assist if the Chief of Staff felt it appropriate. Subsequently a request came from Dr. Breuder, Manchester COS at the time, and Dr. Levenson, requesting Dr. Fuller, VISN Chief Medical Officer at the time, to assist in obtaining reviews 2–3 cases of patients who had undergone neurosurgery in Boston. These concerns were not brought forward to Dr. Mayo-Smith, but to Dr. Fuller. The cases were forwarded to Boston and underwent both internal and external review, without significant findings. No further concerns regarding myelopathy were brought forward to the Network Director from Dr. Kois.

5. On September 12, 2017 Dr. Mayo-Smith emailed Dr. Kois and inquired if he had copies of any correspondence, email or otherwise, with Dr. Mayo-Smith related to the myelopathy issue. Dr. Kois did not reply nor provide any evidence of communication on this issue.

6. Of interest is the letter from the whistleblowers’ lawyer to Senator Shaheen which identified their allegations. The following bullets detail the timeline regarding the sharing of the contents of the letter. They document that Dr. Mayo-Smith did not see the letter and its allegations until July 28, 2017.

- Senator Shaheen notified Ms. Ocker of this letter on September 12, 2016 but explicitly noted she was not identifying the whistleblowers or their concerns. No copy of the letter was included.
- January 2017 Office Special Counsel (OSC) requested Office of Medical Inspector (OMI) to review specific concerns. OMI did not receive a copy of the letter
- March 2017 OMI visited Manchester to conduct their investigation. In-brief and Out-brief were verbal. No copy of the letter was shared, as OMI did not have it.
- June 20, 2017 report from OMI was sent to OSC by VA COS. It referenced concerns of “a whistleblower”. No copy of the letter was included, as VA did not have it.
- July 28, 2017 a copy of the letter from the lawyer to OIG was forwarded to VISN Office. Prior to July 28, 2017 neither Dr. Mayo-Smith nor anyone else in VISN office had seen the contents of the letter.

Question 2. What processes are in place at the VISN to ensure there is proper oversight of community care offices at each facility?

VA Response: Veterans Integrated Service Network (VISN) 1 Business Office Manager conducts weekly calls with the VA Medical Center (VAMC) Business Office Managers to provide updates and problem shoot on community care issues. There are weekly and monthly data dashboards produced and distributed on community care. Community Care data are also reviewed at the monthly performance video-conferences held by VISN leadership with each medical center as well as at weekly Executive Leadership Board meetings.

VISN 1 completed a Care in the Community Stand-Down in October 2017, led by the Deputy Network Director, during which each of the other sites within the network was visited. The Stand-Down focused on five key areas within Care in the Community and provided feedback reports to all facilities for action if and where needed. In general, medical support assistants were well-trained and familiar with recommended procedures for referrals to choice. There were also identified opportunities for improvement in the management of the Veterans Choice list. Further, the VISN 1 Deputy Network Director, in consultation with the VISN 1 Business Implementation Manager, has put in place new components and controls as part of their facility site visit program.

Question 3. Has VHA completed a review of the deficiencies at the VISN, specifically within the business office? If yes, were there any findings?

VA Response: Office of Medical Inspector and the Office of Accountability and Whistleblower Protection have both completed a second round of visits to the Manchester VAMC to complete an investigation relative to Care in the Community within the Business Office; the outcome of those investigations are pending.

Question 4. What are the VISN's plans to improve coordination of inpatient mental health services within the network?

VA Response: In 2014, the VISN Mental Health Executive Council embarked on a strategic initiative to improve inter-facility transfers to ensure that Veterans requiring acute admission could be connected to available resources as soon as possible. At the outset, Manchester (which relies on external facilities for all admissions) and Boston (with Brockton campus being the largest inpatient system in the VISN) were identified as key partners to analyze and improve processes. In the first year, a work group including mental health and urgent care providers from both campuses met regularly to clarify communication processes, including revised Standard Operating Procedures and a new electronic inter-facility consult to simplify the referral process 24/7. Manchester VAMC is actively transferring patients from Manchester Urgent Care to Brockton on a 24/7/365 basis using an inter-facility transfer template. These transfers happen on a regular basis and have improved the flow of patients between those two facilities. VISN 1 Mental Health is beginning a work group to facilitate transfers between Bedford and Brockton VA using a similar template to the one used by Manchester VA and Brockton VA. These projects are both works in progress. There are also plans (with a work group forming) to develop a discharge template to aid in reconnecting patients to their home VAMC to ensure continuity of care and follow up.

Questions from Ranking Member Ann McLane Kuster

Question 1. What VHA and Manchester VAMC processes exist to remedy training deficiencies in medical support staff?

VA Response: Competence is determined through in-processing of new employees and begins during the interview process. All employees must attend new employee orientation. Once the employee is at their assigned location, supervisors are responsible for ongoing competence and identifying training needs in collaboration with employee. Many training opportunities are available in VA's online Talent Management System (TMS), in person training, in coordination with other VISN medical centers, national training, webinars, live meetings, conferences, etc.. In addition, a supervisor may assign a preceptor, sponsor or mentor. All of the decisions for training begin with the supervisor and employee identifying a training gap or need; the supervisor may consult with the education officer for resources or suggestions to meet training needs. All employees are encouraged to develop a personal development plan and to self-identify their training needs.

Question 2. What actions are supervisors and clinicians- required to immediately take upon discovery of training deficiencies and to ensure patient safety and quality of care in these instances?

VA Response: The immediate action or response is to stop the line and take a time out to avoid injury and support safety. The Medical Center has a link available on its webpage for reporting safety and patient safety issues. Training and educational needs are evaluated on all patient safety issues and Root Cause Analyses. Actions may include just-in-time training, need to develop training and or competencies, corrective counseling or discipline. The Medical Center's Educational Department, Quality Management Services, and Human Resources are available to all supervisors to assist them in resolving any training or educational deficiencies.

Question 3. What on-the-job training is provided for medical support staff?

VA Response: VA offers preceptor or sponsor assignment, Coach/Mentor, new employee orientation, TMS trainings, scheduling training, soft skills training (huge list of mandated training by groups of employees), Leadership Enhancement and Development (LEAD), EEO trainings, Excel computer classes onsite, simulations, skills training (safe patient handling equipment, safety drills, mock codes). An annual VISN-sponsored needs assessment is used to determine training/education needs for all employees.

Question 4. What required actions do VISN Directors take when they receive patient safety and quality of care complaints?

VA Response: Upon receipt of a complaint, the VISN will evaluate the nature of the complaint often utilizing input from Chief Medical Officer and other clinical subject matter experts within the network. When indicated they will consult with the medical center to ensure understanding of the complaint. Further action taken is then dependent on the nature of the issue. Oftentimes, the matter is best managed at the VAMC. In other cases, response at the VISN or National level may be needed and are pursued through the appropriate channels. When these involve complaints from patients regarding clinical care decisions frequently a recommendation is made that the Veteran submit a clinical appeal to the Network Director.

Question 5. When VISN Directors receive complaints from VA employees, how do they determine whether a complaint should be addressed at the medical facility level, the Network level, or at VA Central Office?

VA Response: It would depend on the scope of the issue. They would use their best judgement, consulting with Medical Center, VISN and National subject Matter Experts as needed, to determine if the issue can be solved locally or needs VISN or national resources.

Question 6. What actions are being taken at the facility level, Network level, and at VA Central Office to address cultural and human resources issues that have contributed to the current workplace environment at the Manchester VAMC?

VA Response:

- The Manchester Acting Chief of Staff (COS) proactively reached out to the Veterans Health Administration (VHA) National Center for Organization Development (NCOD) for support in improving the work environment in the clinical services at Manchester. NCOD consulted with the Manchester Acting COS on assessing the current situation, identifying potential challenges at the facility, and identifying possible opportunities for NCOD support.
- The Acting COS identified two specific services, Mental Health and Surgery, for our initial focus and NCOD has agreed to consult with the leadership of those two specific services and the Acting COS. Consulting calls with each of those services is ongoing.
- Manchester Acting Medical Center Director recently reached out to NCOD regarding support for the facility. A call is currently being scheduled to determine a plan for further NCOD support facility-wide.
- An organizational health survey was administered and part of the support will be assisting in reviewing the data and action planning based on identified issues.
- The Acting Medical Center Director and the Network Director have held monthly Town Hall sessions open to all employees. As part of these Town Hall agendas, employees were briefed on The Way Forward. This outlined a 5 step approach: 1. Rebuild Leadership, 2. Restore Trust, 3. Improve Care, 4. Fix Choice and 5. Design the Future. Additionally, the topics of treating each other respectfully, eliminating waste and staffing of additional positions were discussed. The Acting Medical Center Director is also working with NCOD to begin tackling cultural issues that have been inherent for many years.
- Additionally, the Acting Medical Center Director has introduced a clinical advisory board consisting of all clinical staff to have input into the decision making process at the Medical Center.
- The VISN Director has made Employee Engagement a Strategic Priority for the Network. VISN 1 has consulted with NCOD to tackle the issues of culture within the Network. VISN 1 is also hiring two organizational development specialists, one to be located at Manchester VAMC. Service Line leaders have conducted multiple listening sessions to ensure employees' voices are heard.

A VISN stand down is being led by the VISN Chief Medical Officer and facility COS to determine if similar concerns expressed by Manchester staff exist at other medical centers and to implement action plans. Nationally NCOD has undertaken

in depth analyses of Manchester All Employee Survey results and shared with VHA leadership.

Question 7. What actions has the Manchester VAMC and the VISN taken to protect VA whistleblowers and notify VA employees of their rights to provide information to the VA Office of Inspector General (JG), the Office of Special Counsel (OSC), the Office of Accountability and Whistleblower Protection (QAWP) and Congress?

VA Response: VISN 1 has had over 1,400 Supervisor and Human Resources staff complete training on whistleblower protection.

- 120 employees in VISN 1 have received “Live Lync” training from VA Chief Counsel attorneys on whistleblower protection.
- All Medical Center Directors in VISN 1 have sent out “All Employee” emails providing links to whistleblower protection information and websites to ensure visibility and promote understanding.
- All Executive Leadership Board members, including Medical Center Directors and Service Line Leads attended a 4-hour, in person Whistleblower training for Leaders led by Scott Foster, Human Resource Consultant, Workforce Management.

Question 8. What actions will the Manchester VAMC and the Network take to hold supervisors who retaliate against VA employees accountable?

VA Response: The leadership team is committed to following the guidelines for taking necessary disciplinary or corrective actions outlined in VA Directive and Handbook 5021, Employee-Management Relations and the VA Accountability and Whistleblower Protection Act of 2017. Current law regarding Whistleblower Protection has been incorporated into new supervisory training.

Question 9. How will the Manchester VA incorporate physicians’ input in management of the medical center’s programs?

VA Response: Acting Medical Center Director is conducting monthly listening session with providers and has an open door policy. Medical Center Leadership conducts monthly conversations with the Clinical Service Leadership. Service Line Managers are encouraged to hold monthly meeting with their staff to obtain physician input for those meetings. Additionally, the Acting Medical Center Director has introduced a clinical advisory board consisting of all clinical staff to have input into the decision making process at the Medical Center.

Question 10. What provider professional educational opportunities exist at the Manchester VAMC?

VA Response: Tuition & related travel support (up to \$1,000 per year) for Continuing Professional Education (CPE) for board certified physicians and dentists.

- Continuing Medical Education (CME) online courses through SWANK Healthcare.
- Onsite CME & Continuing Education Unit programs sponsored by medical center using the Employee Education System/ederal Accreditation System process.
- Remote access to Morbidity and Mortality Rounds held at WRJ.
- Schwartz Rounds.
- Patient Aligned Care Team (PACT, which is VHA version of Primary Care Medical Home) Training.
- Pharmacy training.
- Training on Electronic Medical Record.
- New Employee Orientation and other mandated training.
- Physician Assistant annual broadcast.
- Leadership Academy local, VISN, and national level programs.
- Supervisor training through Human Resources if applicable.

Question 11. Do forums exist for physicians and providers to raise and address issues concerning clinical operations?

VA Response: Acting Medical Center Director in Manchester is conducting monthly listening sessions with providers and has an open door policy. Medical Center Leadership conducts monthly conversations with the Clinical Service Leadership. Service Line Managers are encouraged to hold monthly meeting with their staff to obtain physician input for those meetings. Service Line Managers are encouraged to hold monthly meeting incorporating physician input into those meetings. Manchester VAMC is also currently in the process of setting up a clinical Advisory Board.

Question 12. How are staffing priorities made at the facility and VISN level?

VA Response: At Manchester, staffing requests with justification are made by Service Line Chiefs via an automated process through to their respective senior leaders. A Resource Committee convenes normally twice per month to review requests for new or modifications to existing positions. The Resource Committee weighs the workload need and compares it to the facility budget for affordability, then makes a recommendation to the Director. Similar processes are generally in place at other Medical Centers across VHA. VISN offices communicate key staffing priorities identified by VHA Central Office or VISN priorities and monitor success in meeting these priorities.

Question 13. Was the Manchester VA leadership incentivized to send veterans to community providers for treatment via the Choice Program instead of providing care at the Manchester VAMC as a cost-saving measure?

VA Response: Choice created a distinct and separate account of funds that were available when care was provided through the Choice program. VISNs and VAMCs received specified amounts of discretionary funds, via the VERA allocation, to provide care at the VAMC or through the traditional community care program. The new mandatory funding streamcreated a new structure with different incentives than had existed before, with the Choice Program funding existing outside of the facility's allocation.

Question 14. Are facility directors required to report provider vacancies and plan for new hires and attrition in the plan and budget for each fiscal year?

VA Response: There is no requirement to report specific vacancies from a financial perspective, but the VISNs are responsible for submitting a budget operating plan that includes estimated Budget Object Code 10 - Personnel Services obligations that should reflect annual turnover (new hires and attrition). While there is not a requirement to report vacancies in the manner that is referenced in the question, facilities are asked to report their vacancies on a monthly basis for overall position management of VA.

Question 15. How many providers would Manchester VAMC need to hire to fully restore the cardiology service line?

VA Response: The VAMC is currently in the process of conducting a full review of the Cardiology Clinic. Simply hiring additional cardiologists will not guarantee an efficiently managed clinic. The VAMC is currently engaged with the VA Office of Veteran Access to Care field service providers to assist in determining access and clinic utilization issues.

Question 16. What recruiting efforts have the Manchester VAMC taken to identify a permanent director and hire a new Chief of Staff, and when does the facility expect to have these positions filled at the facility?

VA Response: Recruitment for the Director's position is not handled by the VAMC. The Director's position was posted in October by VA Corporate Senior Executive Management Office in VA Central Office and active recruitment is underway. Since the current Chief of Staff position is still occupied pending conclusion of Office of Accountability and Whistleblower Protection investigation, the Medical Center has not yet received permission to begin the recruitment process for this position.