THE CURIOUS CASE OF THE VISN TAKEOVER: ASSESSING VA'S GOVERNANCE STRUCTURE

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THE CURIOUS CASE OF THE VISN TAKEOVER: ASSESSING VA'S GOVERNANCE STRUCTURE

Tuesday, May 22, 2018

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 10:15 a.m., in Room 334, Cannon House Office Building, Hon. David R. Roe [Chairman of the Committee] presiding.

Present: Representatives Roe, Bilirakis, Coffman, Bost, Poliquin, Dunn, Arrington, Bergman, Banks, Mast, Brownley, Kuster, Correa, Lamb, and Peters.

Also Present: Representative Moulton.

OPENING STATEMENT OF DAVID P. ROE, CHAIRMAN

The CHAIRMAN. Good morning. The Committee will come to order.

Thank you for being here today to discuss issues found at facilities in the Veterans Integrated Service Network, or VISNs, 1, 5, and 22; and, more broadly, the role of VISNs in veterans' health care.

Before we begin, I ask unanimous consent that Seth Moulton from Massachusetts be allowed to join us at the dais and participate today's hearings.

Without objection, so ordered.

On March 7th, former Secretary Shulkin held a press conference to announce a list of reforms to increase accountability, streamline operations, and remove layers of bureaucracy in VHA. He ordered plans to restructure the Central Office and to reorganize procurement and logistics functions, both due May 1st, as well as a third plan to reform VISNs by July 1st.

Additionally, Dr. Shulkin ordered a targeted VISN reorganization that gave rise to the title of this hearing. He said, quote, "Effective immediately, we are putting a new executive in charge, Dr. Bryan Gamble. Dr. Gamble is going to have direct accountability for three VISNs as we begin to redesign the role of the VISNs. Those facilities will report directly to Dr. Gamble, who will be here in Washington, and his responsibility is to oversee and to directly improve the accountability and performance, working with our facility directors to make sure that these facilities are performing up to the standards that we expect for our veterans.

"What Dr. Gamble will be doing, besides just making sure these three VISNs are operating under the correct performance standards, is that a report be given to me by July 1st of this year with

a plan to reorganize and to improve the function of our networks," end quotes.

These were forceful measures in a crucial time. Inexcusable bureaucratic failures to put veterans' health at risk in those areas of the country, particularly at the Washington, D.C.; Manchester, New Hampshire; and, Bedford, Massachusetts Medical Centers.

Dr. Shulkin was speaking from the D.C. Medical Center in the midst of its highly-publicized crisis. Not only did the medical supply chain completely break down, leading to veterans' procedures being postponed or canceled, the most basic functions of the hospital also fell into disarray. Many of us visited the facility last year and saw the situation firsthand. And, quite frankly, at that time when I went out there, I was under the impression that things were improving, were getting better.

The most worrying aspect for me is the fact that the VISN and the Central Office knew of the problems in D.C., in many cases for years, yet were unable or unwilling to solve them. I wholeheartedly agree the VISNs are due for an overhaul. They should be the failsafe mechanism when a medical center goes off course. Unfortunately, too many of them seem to be afflicted with a case of learned bureaucratic helplessness.

The VISNs were created in 1995 to decentralize budgeting, planning and oversight. There were originally 22 of them with between seven and ten employees each. Today, there are 18 VISNs with up to 61 employees each. They perform a much wider range of functions, but with some exceptions, they do so ineffectively. Only the VISN director has any real authority over the medical centers within the VISN. Many of the VISN employees view their roles as consultative or advisory.

I have had many questions about the reform measures. Obviously, May 1st has already passed, and the Central Office and procurement and logistics reorganization plans are nowhere to be found. Have these initiatives been abandoned? Secondly, what has truly changed in VISNs 1, 5, and 22 as a result of the increased scrutiny, and how will any improvements be extended to other VISNs? Thirdly, what is the vision for the nationwide VISN redesign?

I look forward to reading the plan, but July 1st is approaching fast and we have heard very little about it. If VA does not articulate a definition of success with measured outcomes, we have no guarantee that veterans will be better off under this restructuring.

I held a roundtable discussion almost a year ago with VA and over a dozen private sector health care organizations. Every one of them deals with the question of centralization versus decentralization. Most of the large hospital systems have some sort of regional organization. The Choice Act independent assessment and the Commission on Care both closely examined VHA's organization. There are many places VA can look for guidance when considering how to reshape the relationship between the Central Office, the VISNs, and the medical centers.

This Committee and the Congress as a whole are committed to VA's success. I think the MISSION Act and another budget making historic investments in veterans' health care and benefits are evidence of that. I have high expectations for these reorganization

plans. It is vital to define the goals at the beginning, engage stakeholders, and be transparent throughout. This cannot merely be a public relations exercise to get through the crisis of the moment or more glossy reports that sit on shelves.

I look forward to an open and honest conversation today about how we can ensure these particular VISNs and their medical centers live up to their purpose, and how we can strengthen VHA's governance so this sort of horrendous neglect never happens again.

The CHAIRMAN. With that, I yield to Ms. Brownley for her opening statement.

OPENING STATEMENT OF JULIA BROWNLEY, ACTING RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman, for holding today's hearing on Veteran Integrated Service Network, or VISN, governance.

The organizational structure of the Veterans Health Administration has long been an issue and I am concerned that the current VISN structure is leading to unclear roles and responsibilities at the highest levels of VA management. We are here today so we can understand how the organization and its leaders, and now lack of leaders, are contributing to the problems in facilities across the country.

VA Medical Centers in Manchester, New Hampshire; Bedford, Massachusetts; Washington, D.C.; and Phoenix, Arizona all have one thing in common: in every case, VISN and VA Central Office leaders were aware of infrastructure, care, quality, and patient safety concerns, but did not take the appropriate actions until the IG or whistleblowers uncovered these issues.

Take the D.C. VA Medical Center as the latest example. The medical center VISN and Central Office leadership ignored at least seven reports that, if considered, could have prevented nearly every issue that was identified during the IG's 2017 investigation. This is very disturbing and unacceptable.

Senior leaders must be held accountable for failing to act and we must take a hard look at the organization from top to bottom to determine what is causing this lack of accountability.

Last November, Congresswoman Kuster and I requested a GAO review of the role and responsibilities of the VISNs. Chairman Roe joined in that request, because our concern is a bipartisan one.

After whistleblower complaints, an IG and Office of Special Counsel investigations uncovered significant patient care and infrastructure issues at facilities within VISNs 1, 5, and 22, former Secretary Shulkin announced that he planned to task Dr. Bryan Gamble, here with us today, with overseeing a significant restructuring effort involving those VISNs. However, we lack an understanding of what this receivership or restructuring effort entails, and seek to understand what this announcement actually means. We would like you to clear that up for us today.

It is our understanding that Dr. Gamble will not in fact be leading a restructuring of these three VISNs, but would instead provide us a report in June, or perhaps it is July. We are tired of receiving reports, we are tired of inaction and, as I mentioned before, there were seven reports on the D.C. VA Medical Center.

Senior leaders in VISN 1 and at VA Central Office also received reports on the Manchester VA Medical Center, but did nothing until it became a national headline. If this restructuring is simply a report, then we must ask who will be responsible for leading VISNs 1, 5, and 22 now that they are leaderless, and we must ask when key senior leaders' positions will be filled at the VA Central Office.

We must also ask which leaders are contributing to what the Inspector General describes in his testimony as a culture of complacency and futility at VA Medical Centers, where dedicated and hardworking staff believe their leaders will do nothing to address problems, where leaders will not address provider concerns, and where staff must just make do with few resources and a disorganized and unaccountable organization. These leaders should be held accountable for failing to take action. These leaders should also be accountable for misleading Congress and the press. A failure to be forthcoming about patient safety, quality of care, infrastructure, and patient access concerns hurts our ability to conduct oversight, contributes to the sense of futility among providers, and creates anxiety, mistrust, and frustrations for veterans who rely on VA for their health care.

I hope today to hear more about what VA is actually doing in response to the top-to-bottom organizational failures that contributed to the most recent events in the Manchester, Bedford, and Washington, D.C. medical facilities.

Thank you, Chairman Roe, and I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

I would now like to welcome our panel seated at the witness table, if you would.

On the panel, we have Dr. Carolyn Clancy, Executive in Charge of the Veterans Health Administration. She is accompanied by Dr. Bryan Gamble, the Deputy Chief of Staff of the Orlando VA Medical Center. Welcome.

On the panel, we also have the Honorable Michael Missal, Inspector General of the Department of Veterans Affairs, and Mr. Roscoe Butler, Deputy Director for Health Care, National Veterans Affairs and Rehabilitation Division of The American Legion.

Welcome each one of you to the panel.

I ask the witnesses to stand and raise your right hand.

The CHAIRMAN. Thank you very much. Let the record reflect that all witnesses have answered in the affirmative.

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

STATEMENT OF CAROLYN CLANCY, M.D.

Dr. CLANCY. Good morning, Chairman Roe, Ranking Member Brownley, and Members of the Committee. I appreciate the opportunity to discuss the proposed redesign of the current Department of Veterans Affairs Veteran Integrated Service Network, or VISN, structure and the status of remedial action at VISNs 1, 5, and 22.

I accompanied today by Dr. Bryan Gamble, Deputy Chief of Staff at the Orlando VA Medical Center.

On March 7th, as the Chairman noted, former Secretary Shulkin announced VA would undertake a systematic review of the VISNs with a specific focus on 1, 5, and 22. These three VISNs were chal-

lenged with leadership and management issue, low-performing facilities, and culture issues.

The purpose of this review is to identify VISN strengths and weakness, and to create a plan to improve VISN oversight, accountability, performance, and strengthen lines of communication and clarify roles and responsibilities. Based on his extensive leadership with the military health system, Dr. Bryan Gamble was asked to lead this review and provide recommendations with the goal of informing that redesign process.

Our goal is to streamline processes, ensure clearly-defined roles, responsibilities, and authorities among all levels in VHA, so that we are functioning in a way that is more efficient and, most importantly, produces better results and accountability. We have also been working with our national leadership council to develop a new model of governance to shape the culture, and set expectations and requirements for improved care for veterans.

Under the VISN model, health care is provided through strategic alliances among medical centers, clinics, and other sites, contractual arrangements with private providers, sharing agreements, and other government providers. The VISN is designed to be the basic budgetary and planning unit of the VA health care system.

Since Dr. Shulkin's announcement, a team led by Dr. Gamble has visited all three VISNs. And to look at best practices, the team also visited consistently high-performing VISN 23. A resounding theme was a dedicated workforce set on providing veterans with the best possible health care, and a clear understanding and willingness from leaders and employees at all levels to improve upon deficiencies wherever found.

While these three networks are pretty dispersed geographically, the assessment team found common themes across these networks and facilities, including inconsistency of HR services and hiring; additional emphasis needed on education and training; unintended consequences of Management by Measurement; leadership challenges, including turnover, consistency, and psychological safety; and employee morale.

The findings from this review will be combined with ongoing feedback and work from the existing network directors, and our ongoing modernization effort to formulate the final plan for redesign of the VISNs.

One of the key concerns of this Committee is the progress at the Washington, D.C. VA Medical Center. While there is still a lot of work to be done, significant progress has been made.

In March of 2018, as the Chairman noted, the Inspector General released a final report finding that the D.C. VA had for many years suffered a series of systemic and programmatic failures, making it challenging for health care providers to consistently deliver timely and quality patient care.

To key on a couple of improvements made since the interim report was submitted by the IG in April of 2017, some of the improvement efforts include assuring that all patients were safe and none were harmed. VHA's National Center for Patient Safety launched a rapid-response approach with on-site visits, biweekly and weekly calls with the facility and VISN, and assured all patient-safety issues were appropriately addressed.

We awarded a contract to construct a new, 14,200-square-foot space for Sterile Processing and that will be completed in March of 2019.

Transitioned inventory to the Generic Inventory Package eliminated all pending prosthetic consults greater than 30 days from more than 9,000 to zero. In short, ordering of prosthetics is not interrupted by end-of-year financial transitions, and allocated resources and expedited hiring into logistics and Sterile Processing Service vacancies.

We know that how these networks operate is imperative. To get the type of accountability that we need at every place where veterans may seek our assistance and to ensure the best quality of care is delivered, we have to take a critical look at the processes, layers, and leaders to make sure that we don't see the failures that we didn't see at the D.C. VA.

As the VHA and the D.C. VA move forward, we are putting in place a reliable pathway for all facilities, VISNs, and business lines to escalate high-priority concerns to senior leadership for prompt action and follow-up. We encourage all employees to speak up and raise concerns to leadership, because they are an integral part of our front-line safety net and we take their concerns very seriously.

Mr. Chairman, we appreciate this Committee's continued support and encouragement in identifying and resolving challenges.

In short, there are no missing VISN directors, what we are losing is a past practice of inconsistencies in management and oversight across VISNs and all of VA health care. This enhanced consistency is imperative to our ability to achieve the best possible outcomes for veterans envisioned by the MISSION Act, which this Committee passed and subsequently the full House passed last week, as well as to assure that we get the most out of the new electronic health record implementation and that that translates into enhanced results for those who have served.

This concludes my testimony, and Dr. Gamble and I are prepared to respond to any questions that you might have.

[THE PREPARED STATEMENT OF CAROLYN CLANCY APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Clancy.

Mr. Missal, you are recognized for 5 minutes.

STATEMENT OF THE HONORABLE MICHAEL MISSAL

Mr. MISSAL. Thank you. Mr. Chairman, Ranking Member Brownley, and Members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's report, "Critical Deficiencies at the Washington, D.C. VA Medical Center." We found that serious failures in leadership and governance contributed significantly to the problems we identified.

Since becoming Inspector General 2 years ago, I have made examining leadership and governance issues at all levels of VA a priority for our work, as shortcomings in these areas affect the care and services provided to veterans, put Government assets at risk, and allow significant problems to persist for extended periods of time.

In March of 2017, we received a confidential source about the D.C. VA alleging that supply and inventory issues put patients and resources at risk. After a very quick assessment, we determined that patients were at risk as a result of the supply and inventory issues, that these problems were known at various levels at VHA, but that VHA had failed to take the necessary corrective action. As a result, we took the extraordinary step of issuing an interim report. That interim report was issued on April 12th, 2017.

We continued the inspection and issued our final report on March 7th, 2018. Significantly, while we found patients were put at unnecessary risk, we did not find any patient deaths or other adverse clinical outcomes relating to these deficiencies. This was primarily due to the efforts of a number of committed health care professionals who improvised as necessary to ensure veterans received the best possible care under the circumstances.

Our final report contained 40 recommendations addressing deficiencies in multiple core functions of the D.C. VA's operations, all of which were agreed to by VA.

The more significant findings in our final report related to patient safety include continuing supply chain and inventory management problems; unsafe storage of clean, sterile supplies; deficiencies in sterile processing service; inadequate product safety recall practices; backlogs of open and pending prosthetic consults; and staffing shortages and human resource mismanagement.

Aside from the deficiencies that resulted in risk to patients, we also found that the medical center continually mismanaged significant Government resources and did not adequately secure veterans' protected information. The D.C. VA's financial and inventory systems produced inadequate data, lacked effective management controls, and yielded no reasonable assurance that funds were appropriately expended. Accordingly, we could not estimate the loss to VA as a result of the failings identified in the final report.

It is clear that information about at least some of the failings at the D.C. VA reached responsible officials in the D.C. VA VISN 5 and VHA Central Office as early as 2013, but actions taken did not effectively remediate the conditions.

From 2013 through 2016, the D.C. VA and VISN 5 received at least seven written reports detailing significant deficiencies in logistics, sterile processing, and other services. The chronic deficiencies noted in these reports underscore the inability or unwillingness of leaders at various levels to implement and sustain lasting change within various services.

In conclusion, the critical deficiencies we found in our inspect of the D.C. VA were serious and disturbing. While the failures present significant challenges, we believe the greatest obstacle to change is a sense of futility and a culture of complacency among staff and leaders. At the core, the D.C. VA report is about the breakdown of systems and leadership at multiple levels, and an acceptance by many personnel that things will never change.

VHA has talented and committed people who could lead the turnaround at the D.C. VA. With time and concerted effort, we believe that positive change can be realized. VHA needs to recognize the urgency in making strong leadership decisions now to oversee that change. Although the findings and recommendations focus on im-

provements in the D.C. VA, the issues raised could be a checklist for other facilities, VISNs, and VA leaders.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or other Members of the Committee may have.

[THE PREPARED STATEMENT OF MICHAEL MISSAL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Missal.

Mr. Butler, you are recognized for 5 minutes.

STATEMENT OF ROSCOE G. BUTLER

Mr. BUTLER. Good morning.

In 1994, the Veterans Health Administration was structured into four regions. There was widespread consensus that the system needed a major overhaul. In that same year, President Clinton appointed Dr. Kenneth Kizer as VA Undersecretary for Health. Dr. Kizer inherited an organization famous for low-quality health care, difficult to access, and at a cost not sustainable for the American taxpayers.

Chairman Roe, Ranking Member Brownley, and distinguished Members of the Committee, on behalf of our National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime service organization for veterans, comprised of more than 2 million members and serving every man and woman who has worn the uniform for this country, we thank you for inviting us to share our position regarding the current status of remedial actions at VISNs 1, 5, and 22.

The Veterans Health Care System is the largest health care system in the United States. This national veteran-centric health care system is centrally administered, fully integrated, and is both funded and operated by the Federal Government. The purpose of creating the VISN structure was to decentralize decision-making authority regarding how to provide care and integrate the facilities to develop an interdependent system of care through the VISNs.

The VISNs' primary function was to be the basic budgetary and planning unit of the Veterans Health Care System. However, as we all know, the VISN structure has morphed into an extensive operation consuming more staff, resources, funding, and physical space.

Since the birth of Dr. Kizer's plan, VISN staff and functions have extended way beyond the original tent of Dr. Kizer's VISNs for Change. Since the creation of the VISN structures in 1995, both the veterans' demographic and geography has changed quite a bit, yet VA has not reassessed the VISN structure to determine if it still benefits veterans. However, in October 2015, VA has begun to implement a realignment of its VISN boundaries, which involves decreasing the number of VISNs from 21 to 18, and reassigning some medical centers to difficult VISNs.

A concern of The American Legion is that VA officials have stated that they do not have plans to evaluate the realignment that is currently taking place. According to GAO, VA actions are inconsistent with Federal internal control standards for monitoring and risk assessments. Without adequate monitoring, including a plan for evaluating the VISNs' realignments, VHA cannot be certain

that the changes they are currently making are effectively addressing deficiencies, nor can it ensure lessons learned can be applied to future organizational structural changes.

There is no question that VA has endured its challenges. For example, the Phoenix scandal of 2014, the 2017 VA OIG report about equipment and supply issues at the Washington, D.C. VAMC, to the January 2018 report of poor patient care at the Manchester Medical Center. I highlighted these issues not to open an old wound, but would rather use them to illustrate that these may be evidence that the VISN structures lack oversight and control, and is not living up to Dr. Kizer's original vision of a patient-centered, integrated, independent system of care.

The American Legion believes that is why former Secretary David Shulkin announced his plan to reorganize the Department VISNs network. Dr. Shulkin also discussed the appointment of a special team to work with VA's national leadership council to develop a network reorganization plan for its 23 VISNs, which is due to the Secretary by July 1st of this year.

Mr. Chairman, clearly Dr. Kizer's Vision model is no longer living up to the expectations, but rather has gone into a high-cost, ineffective operation. In 2016, our members acknowledged and voiced their concerns about this growing problem. Like most veterans do, they took action and passed a resolution discussing the effectiveness or the ineffectiveness of the current VISN structure.

American Legion Resolution 194 entitled "Department of Veterans Affairs Integrated Service Networks" urged Congress to direct the GAO and VA OIG to conduct a comprehensive study to include purpose, goals, objectives, budget, and finally an evaluation of the effectiveness of the VISN structure as a whole.

Further, The American Legion applauds former Secretary Shulkin for proposing to look into reorganizing the VISNs and the Central Office.

In conclusion, The American Legion thanks this Committee for the opportunity to elucidate the positions of the over 2 million veteran members of this organization.

Chairman Roe, Ranking Member Brownley, and distinguished Members of this critical and serving Committee, The American Legion is so very thankful for the opportunity to be here today. As Memorial Day is upon us, please allow me to also thank each of you for the incredible work this Committee does every day to help those who have already helped us.

With that, I conclude my remarks and I am happy to answer any questions this Committee may have.

[THE PREPARED STATEMENT OF ROSCOE G. BUTLER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Butler.

I will start the questioning by thanking the Committee for passing the MISSION Act. The Senate will vote on it this week. We have had seven past Secretaries and Administrator sign supporting that in both Republican and Democrat administrations. So, thank you for that.

And I voice some frustration because this Committee continues to produce legislation and this Congress, both Republican and

Democrat, continue to produce enormous amounts of money for the VA, and yet what Mr. Missal tells us is that there is a failure of leadership and governance within these VISNs that he looked at.

And I want to give a shout-out to the health care people at the hospitals who did the work around these things to help patient safety. I want them to know I appreciate that very much and I know that the veterans who are served there appreciate that very much, to know that they created as safe an environment as they possibly can even with these obstacles. So I thank them for that.

I want to just start by just telling you how my day would start and end when I was in practice. If I had a big number of cases the next day in the operating room, the operating room people, folks would show up in my office at 4:30, 5 o'clock, 5:30 when I saw my last patients, and they would say, "Dr. Roe, we have everything you need for tomorrow's surgery." Maybe you are doing a laparoscopic hysterectomy or maybe you are doing a cancer case. We have got everything you need; we have got blood available, we have got all your sutures, we have got any prostheses you need, everything you need is ready for you in the morning. There was never a question about it, I never worried about that. I worried about doing my job.

It looks like at the Washington VA the doctors and nurses had to worry about not only doing their job, but running across the street during a case to get things that they needed to take care of a patient. In one case, they put a patient to sleep and then woke him up because they didn't have the equipment to take care of him. That is absurd to do that to a patient, it is risky. Anesthesia is not as risky as it used to be, but still it is some risk to have these drugs and go to sleep.

So I want to start just very quickly. Dr. Clancy, at the VA, the Washington, D.C. VA Medical Center, which many of us have visited, and the supply shortages, and we talked about postponing and so forth, but the financial mismanagement is unbelievable to me. Somebody paid $289 for a speculum that should have cost $122, $900 for butterfly needles that should have been $251. Eight dollars for these little yellow socks, those ugly socks you wear around the hospital so you won't slip that should cost 82 cents. And all of that should have gone through the medical/surgical prime vendor and saved a lot of money.

And that is my frustration is we are providing more and more money, and yet we are seeing this. Here is a case where someone rented three hospital beds for almost $900,000 when they could have bought them for a fraction of that, just bought the thing, it would have cost that. And also somebody bought $1 million worth of copy paper. That is 60 pallets of copy paper and they didn't have anywhere to store it even. How do you do that? That would never happen in the private world. If I were a HCA, a hospital administrator or a hospital administrator at Mountain States where I worked, I would be fired, period. My job would be over if I did anything that bone-headed.

So how in the world are we to sit up here and continue to provide these resources? We have got to go back to our constituents and explain. And we want to help veterans and Mr. Butler knows that this Committee wants to do that. That is just pure waste. Think

about it, that is almost $1 million that could have been spent on health care.

So, Dr. Clancy.

Dr. CLANCY. Mr. Chairman, I would love to tell you that you got some details wrong or facts, but you are absolutely right. But I think that a lot of what you are saying underscores why we need stronger networks for that kind of financial oversight, that simply was not happening.

Now, I don't know entirely going back several years whether that is the VISN's problem or the facility's problem. People who want to hide things can sometimes be very creative. We are, as you know, getting a new financial management system, which I think will help a lot, but that is inexcusable and should not have happened, period.

The CHAIRMAN. It absolutely shouldn't. And so I guess my question is, when we—and Mr. Butler pointed this out in his history of the VISN—do we need a VISN? I mean, it looks like—I was trying to figure out what the VISN did and we are here to look at 1, 5, and 22, and I know other Members will have some much more detailed questions, but is it necessary? Maybe we could—we have regional offices and the disability, there are five of them I think in the country, do we need to shrink that?

The question is, I can't figure out what the VISN does. If the VISN couldn't oversee that, what good are they?

Dr. CLANCY. Well, what I think is that VISNs were initially set up, the phrase that was bandied about a lot was laboratories of innovation, and if you achieved the results that then Undersecretary Kizer asked for, how you got there was fine. Since then, I think thinking in contemporary health care has changed quite a bit. For one thing, a whole lot more care, as you know from your own practice, that used to be in the hospital now gets done on an out-patient basis and so forth, which is a very, very different kind of set of challenges.

I believe that the VISNs have a vital role and that we are using this opportunity to learn from other industries. I actually consulted with the Chief Medical Officer of HCA within the past couple of days. Dr. Perlin chairs an advisory group for us and he said the only way you can possibly get to consistency across a large, far-flung system is to have accountable regional leadership, so that you get alignment right down to the unit level. So that is what we are trying to build.

The CHAIRMAN. Well, my time has expired, and I will now yield, but I am going to throw this question out to be answered. What is VISN 23 doing that 1, 5, and 22 didn't do? Just hold your question.

Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And I want to drill down a little bit on the Chairman's question. So, Dr. Clancy, and I ask you to be as specific on this question as you possibly can be, I wanted to zero in on sort of the oversight roles and responsibilities for key leaders within the VISN, but I wanted to drill down specifically on one and that is the Medical Director.

So what is his or her responsibilities very, very specifically in terms of their role and responsibilities to a Central Office, their role and responsibility to medical centers, and making sure that we are optimizing patient care at each and every one of those facilities? If you could be very specific about that, I would appreciate it.

Dr. CLANCY. I just want to be clear, Congresswoman, the Medical Director. There is a Chief Medical Officer at the network level and then for every facility there is a Chief of Staff who is colloquially sort of the top physician. Is that what you mean?

Ms. BROWNLEY. The Network Director.

Dr. CLANCY. The Network Director, okay. So the Network Director has a number of key positions and this we are also standardizing across all of the VISNs. They have a Chief Medical Officer who is attentive to all of clinical oversight across these facilities, frankly keeping an eye on where there are common gaps and deficiencies. For example, sterile processing is an issue that we struggle with, as does much of private sector health care. And as well as making sure that clinicians are held accountable, and that their training and continuing education is up to date.

And, frankly, when they uncover unexpected issues, for example an IT glitch resulting in consults that don't go through as expected, they bring that forward both to the VISN director and also to Central Office, so that we can figure out is this affecting other facilities and networks across the system and so forth.

Ms. BROWNLEY. So then why did some of these disasters happen in some of these VISNs? And if that is the role and responsibilities, why did it happen?

Certainly in New Hampshire, in Massachusetts, it ended up being the headlines in the Boston Globe, and then there seemed to some kind of response to that and we had Inspector General reports. What failed?

Dr. CLANCY. What failed was we did not have a consistent job description for Network Directors in concrete, specific terms that you are asking for.

So when I have visited with networks, and I have visited with quite a few and asked them how do you follow up on these things, what is your oversight function and so forth, tell me what happens if a facility gets in trouble and so forth. What I often heard was, well, we do the following, for example we did this, but that is how our network works, we don't know if that is how other networks do it. So we have not had that uniformity.

It is fair to say that some of our previous Network Directors had a much more hands-off approach for a variety of reasons. I think it is also fair to say that in 2018 that is simply not going to be the path by which we assure that all veterans get great care, period.

Ms. BROWNLEY. Thank you.

Mr. Missal, do you see evidence that there has been a streamlining in these roles and responsibilities across all VISNs?

Mr. MISSAL. No, we haven't seen that. In fact, what Dr. Clancy said I think really was right on point, which is there seems to be confusion about the roles and responsibility of the VISN directors. Let me give you a concrete example.

When we interviewed the VISN 5 director who is responsible for Washington, D.C., he said the buck stops with him, but in the

same interview he said he wasn't responsible for any of the problems that were identified at the facility. So on one level he is saying he is responsible, on the other level he is pointing his finger at the medical center director saying it is that person's responsibility.

So I think there is great confusion out there about what the VISN director is supposed to be doing.

Ms. BROWNLEY. Do you think we need VISNs?

Mr. MISSAL. I think in certain situations they have been very helpful, but it all goes down to the people involved. If you don't have the right people in leadership, if they are not held accountable, I don't think it matters what structure you are going to have. It is going to be problematic.

Ms. BROWNLEY. Do you think the roles and responsibilities of VISNs can be narrowed pretty significantly?

Mr. MISSAL. I think they certainly should be clarified and then we look forward to seeing what VA comes up with in terms of their study of the VISN system.

Ms. BROWNLEY. Thank you.

My time is to an end and I yield back.

The CHAIRMAN. I thank the gentlelady for yielding.

Mr. Coffman, you are recognized for 5 minutes.

Mr. COFFMAN. Thank you, Mr. Chairman.

So one question is, Mr. Missal, so I think in the spring of 2017 on VISN 5 there was a complaint that turned into an OIG report, I just can't see why—and maybe this is to Dr. Clancy as well—why the VISN just didn't respond and correct the problem themselves instead of wait for all the time that it takes to do a VA OIG of a report?

Mr. Missal, why don't you address that first.

Mr. MISSAL. When we issued the interim report, there was immediate action by the Secretary. He replaced the medical center director at the time and made some other changes. We then continued our inspection.

We did see some improvements, certainly not complete improvement, and it wasn't clear to us how much of that was coming from the Secretary versus the VISN versus the medical center. And I guess I would defer to Dr. Clancy for more information.

Mr. COFFMAN. Okay. Let me follow up with a second question for you that the Chairman had raised and that was also raised by the Ranking Member, that is the structure. What you have mentioned, the VISN structure, and I have heard and I am sure everybody on this Committee has heard it, that if you have seen one VISN, you have seen one VISN. In other words, that there is no uniformity in terms of quality and based on the way that it is structured intentionally to allow for innovation, to allow for independence. However, you also, you said in your comment that if you don't have the right people in place, this is not a good structure.

Look, I have been on this Committee now since January of 2013 and the one thing that I have unfortunately found is a lot of times, for whatever reason, there is not the right person in place. So we need a system that inherently makes it more accountable.

And I think if we did away with VISNs and sought more uniformity, is there a savings opportunity there in terms of shrinking the bureaucracy, Mr. Missal?

Mr. MISSAL. I think that is really hard to say. Obviously, VHA is a large, complex integrated health care system. It is important for there to be some consistency. It is also important for there to be flexibility at a local level. And so getting the right governance structure is a very tricky thing that deserves extensive study.

Mr. COFFMAN. Isn't it true, though, that is the more flexibility we grant, it seems like the more problems that there are, when we look at procurement?

Mr. MISSAL. In certain situations, that is correct, yes.

Mr. COFFMAN. Dr. Clancy?

Dr. CLANCY. So, Congressman, you asked about what were the VISN and Central Office doing before the Inspector General issued their interim report. We sent in several investigative teams in a few months prior to April and, frankly, couldn't find anything.

So what was happening was we were hearing from employees, many missives from home emails and so forth, not clearly identifying themselves, with very nonspecific issues. So we would send the Office of Medical Inspector over and so forth.

Incredibly enough, shortly before the Inspector General issued their report, the joint commission said that the D.C. VA, they did pretty well on their accreditation survey, which amazes me to this day. What the VISN and headquarters had seen probably 2 to 3 months out was that there were glaring gaps in hiring and logistics. And if you don't have boots on the ground to actually make sure you have got the supplies, Dr. Roe can be waiting to tell people, but if there is no one there, who is going to get the supplies? That won't actually be very effective.

Since then, we have actually done a lot of hiring. The Chief of Logistics was held accountable for what was going on there and there have been substantial improvements.

Mr. COFFMAN. So when you say the Chief of Logistics has been held accountable, tell me what disciplinary action was taken.

Dr. CLANCY. He was terminated.

Mr. COFFMAN. Oh, he was terminated?

Dr. CLANCY. Yeah.

Mr. COFFMAN. Okay, very good, very good.

Mr. Chairman, I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

And I will now yield 5 minutes to Ms. Kuster. Welcome back to the Committee. You look healthy and well after your little event with a knife. And so welcome back, you look great.

[Laughter.]

Ms. KUSTER. Well, and I want to thank the chair for rescheduling the hearing. My new hip is going great and I really appreciate it. So I want to stay focused on good health care for our veterans.

Thank you very much for appearing before us today and this is a hearing that I had requested of the chair to investigate VISN 1, but I am also attentive to the concerns in VISN 5 and 22.

I don't want to spend a great deal of time looking back, but I think in order to understand where we are and how to restructure,

we need to understand where we have been. So in VISN 1 in New Hampshire, Manchester VA, we were confronted with a four operating rooms, one of which was shut down as a result of a 16-year-long battle with cluster flies. You can imagine the concern there. We had a VA physician that had cut-and-pasted patients' medical records without updating patients' conditions. And we had a situation that is really tragic of patients that suffered from preventable spinal damage, including paralysis, after the hospital failed to provide proper care for a treatable spine condition known as cervical myelopathy.

So in September of 2016, a group of whistleblowers presented their concerns to me and to our delegation on September 6th, 2016. And forthwith, in September, we referred the allegations to the Office of the Inspector General, and the Office of the Inspector General referred the complaints to the Office of Medical Inspector.

Since then, we have been aggressively pursuing this. And I want to thank my co-chair, General Bergman, for coming to New Hampshire for an oversight hearing. We appreciate that. We have worked with Dr. Clancy, with certainly Secretary Shulkin. And I just want to point out a couple of places where I have concerns in order to understand the roles going forward.

And, Dr. Clancy, in response to Julia Brownley you said that the role of the Medical Director is to provide clinical oversight across facilities, and that person reports both to the VISN and to Central Office. When was then Secretary Shulkin first made aware of our concerns from our congressional delegation both to the OIG and to the OSC?

Dr. CLANCY. So I believe, Congresswoman, that the New Hampshire delegation sent then Secretary McDonald a letter copied to Dr. Shulkin in the fall of 2016, but it was—and I know you and I have had this conversation—to protect the confidential of the whistleblowers, general and not very specific about your concerns. I can't speak to what specific actions were taken then.

We became aware of the whistleblower case when the case was referred to the Office of Medical Inspector and then when the spotlight team from the Boston Globe was contacting the VISN and the facility and headquarters.

Ms. KUSTER. And so that is my concern. And, yes, indeed there was a concern of the whistleblowers that they didn't want to come forward and identify themselves and that constrained our ability to press this, but it causes me concern that it would have to go so far as a spotlight team at the Boston Globe. Why wouldn't the Medical Director who was one of the whistleblowers have been able to convey these concerns up through the chain?

I mean, why would they need to become whistleblowers? Why wouldn't, you know, something as serious as paralysis because patients weren't being treated appropriately, why did it go this far is my question?

Dr. CLANCY. The short answer is, I don't know. My hypothesis, with some fair documentation—or confirmation, I guess would be a better way to say it, was that the leadership at that facility was not listening to some of these physicians who were generally concerned.

There is a physician at Manchester who I know well because I trained him when he was an intern and so I called him for a bit of a reality check. And he told me their concerns were genuine, he thought incredibly well of Dr. Kois and a few other people. And I would vastly prefer, which is something I emphasize in just about every time I speak, that if people have concerns they speak up and that we can do something about that.

Now, sometimes people have concerns and we are going to take another look and it won't exactly match what their conclusion was, but much, much better. People calling out problems is the greatest gift we have, and getting into the whistleblower process necessarily delays that for protecting confidentiality and so forth.

Ms. KUSTER. Well, thank you. My time is up, but that is one of the reasons why we have worked together on expanding protections for whistleblowers. And I certainly agree with you, we need to create an environment where concerns are addressed at the earliest possible date.

So I yield back. Thank you.

The CHAIRMAN. I thank the gentlelady for yielding.

Vice Chair Bilirakis, you are recognized.

Mr. BILIRAKIS. Thank you. Thank you, Mr. Chairman, I appreciate it very much.

Earlier this year I got involved in a particular case at Bay Pines with regard to VA Health Care System, again at Bay Pines in St. Petersburg, just outside of my district, where a group of homeless veterans were in a particular facility there, a building, and there was no hot water, adequate, you know, hot water at different various times or heat during the winter for a six-month period of time.

And I was notified and within a week, I contacted Secretary Shulkin and within a week, maybe 3 or 4 or 5 days after I got involved and the Secretary got involved, we remedied the situation, but that should not happen and I know everybody agrees with that. And then the media got involved and the whole community was really outraged.

So my question is for Dr. Gamble. What types of barriers currently exist that prevent the VISNs from taking a more active role? And what do you think VISN directors need to quicker solve these issues when they arise at local medical centers? Is it better monitoring, is it more authority, is that what they need? What do we need to do to help you in this process?

Again, I went directly to the Secretary and we resolved the situation, once I was notified. Again, I was contacted by the media. And, you know, I mean, it is inexcusable for our veterans not to have hot water. They would have to go to another building, outside to another building to take a shower, which is ridiculous. And then again no real air conditioning or heat, for that matter, during the winter.

So if you can answer that question for me, I would appreciate it, Doctor.

Dr. GAMBLE. Thank you, Mr. Congressman, I appreciate the question.

I think it is incredibly important regardless of where you are in an organization, and, again, coming from my time in the military, that it is about leadership. It is about boots on the ground, walking

the terrain, listening to the staff and teams around you, to really identify and realize that, you know, problems as they affect our veterans are critical to deal with in an expedient and timely manner, you know, and I don't know why it had to come up through you all the way to the Secretary for action.

But, again, I think that that also states that whoever brought that forward realized that it was a critical need to push that forward.

You know, I think that, you know, my travels around the VISNs and to some of these institutions, moving ahead, it really revolves around three things, one of which is leadership, second of which is communication, and the third is structure, because structure really sets the culture. And I think it has a lot to do with culture and folks bringing these issues up, and a sense of confidence that they will be dealt with promptly and effectively that really will make the difference going forward.

Mr. BILIRAKIS. Thank you.

My next question for Mr. Missal, does your office have the authority to stop the admission of patients to a medical center when you identify serious health and safety concerns?

Mr. MISSAL. No, we would not have that authority, but we obviously would immediately contact VHA to take whatever action they thought was appropriate.

Mr. BILIRAKIS. Okay.

Dr. CLANCY. And if I could just note—

Mr. BILIRAKIS. Yes, please.

Dr. CLANCY [continued]. —Congressman, that we did actually send patient safety people in a number of times to give us a read. Were they worried, was the risk of harm sufficiently high that we should actually close down some units or just keep going until we rebuilt the supply chain.

Mr. BILIRAKIS. Okay. So, again, how serious do these conditions have to be for you to close down the facility and make that decision? Maybe give me an example.

Dr. CLANCY. I don't have an example right at hand where we have done that, but for example, in one of our facilities several years ago they closed down an ICU for a few weeks. The issue at hand was that an acting director came in and inherited a situation where the facility was very, very short on housekeeping on weekends. So what that meant was that the nurses in the ICU were actually turning over beds and having to do the housekeeping and, you know, when a new patient came in, and the director became very concerned that they were making mistakes because they were exhausted.

So what she did, which I think was exactly the right thing to do, was to close the unit for a few weeks until they could bring more custodial assistance in for the weekend, so that the nurses wouldn't be trying to do two or three different jobs.

Mr. BILIRAKIS. Okay, thank you. Thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Lamb, you are recognized for 5 minutes.

Mr. LAMB. Thank you, Mr. Chairman.

Dr. Clancy, I just want to ask you some questions about the pipeline for people that become network directors, are they always promoted from below essentially, like are they always people that were chiefs of staff of VA facilities?

Dr. CLANCY. They are not only one or two of our current network directors, actually one right now is a physician, most are health care executives and have strong leadership in that capability. Historically, that was exactly where they came from. In recent years, we have begun to recruit as broadly and widely as we can.

So, you know, there are advantages to having people who know the system and have had experience, and several of our most recent network directors, who I think are really doing a terrific job, were terrific medical center directors, but we are continuing to recruit broadly and widely.

Mr. LAMB. When you say recruit, though, are you hiring people from outside the VA for the network director job?

Dr. CLANCY. We would be happy to if we find a good person.

Mr. LAMB. Okay.

Dr. CLANCY. We have not recently, but have certainly interviewed people and they have been fairly competitive, and I would say we are hiring more people outside the VA to be Medical Center Directors.

Mr. LAMB. Okay. Some of whom could then presumably be—

Dr. CLANCY. Yes.

Mr. LAMB [continued]. —promoted to VISN Director. Okay.

Now, several of you have talked about the importance of culture, both making sure that complaints are heard and can kind of rise to the top, but also making sure that there is fast follow-up by the leadership so that things actually get solved. What suggestions do you have for how we actually do that? In other words, how do we find the leaders who are capable of creating that culture and then actually instilling it in the organization?

Dr. CLANCY. You know, that is a terrific question, because when people apply, we tend to review their background, experience, CVs, and so forth for their technical skills. And what seems to me to matter, at least as much is how engaged are they with the people. When I look at our best medical center directors, they know almost everyone who works in that facility.

Now, that is a pretty tall order, some people are more gregarious than others, but it makes a difference. Because if I'm asking you how you're doing and how's your kid doing in Little League or whatever, I have a degree of comfort that I could say to you we have got a problem over here in OR–1, and I'm going to guess you may not have heard this or you have heard that everything is fine, but what I see is not fine.

So a very, very big part of it is that kind of being able to engage and listen to people, and I am noticing more and more of our medical center directors doing this, whether it is a Facebook chat, walk around rounds. Someone earlier referenced walking around and getting out and seeing people. It is management by walking around is another phrase, very, very important. So we are beginning to talk now about how do we build some of that into the interview.

I think it also helps to bring in others into the selection process, which we are doing now at the D.C. VA. So the physicians will

have a role and a voice in who the next director will be and so forth.

Mr. LAMB. Dr. Gamble, you were nodding. If you could just address that and also how do you get a similar level of engagement and strong leadership at the VISN level? I kind of see it for a medical director of a facility because they are in one building every day. They can meet everybody. But what are we doing to promote stronger leadership and accountability at the VISN level?

Dr. GAMBLE. Mr. Congressman, I think it is—network directors have really taken the lead recently in helping to develop a way ahead. One of the key parts of their guidance and assistance to me has been looking at developing a play book for VISN directors so that these head up a consistency of roles, responsibilities, and accountabilities. And one of those is really walking around and getting to see your facilities, get out to meet the people. That is one of the key parts of a network.

There was a—in Kizer's report back in the 90's, there was a notable comment, I believe it was there, that in a network, you had—the span of control was critical. You really could only have between 8 to 12 facilities to really as a network director or VISN directory, really be able to have that control. And that is, I think, really key for the future to set those roles, responsibilities, and accountability, and also give them a terrain of an organization that they can walk around to get to know up close and personally.

Mr. LAMB. Okay. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I thank the gentleman for yielding. General Bergman, you are recognized for 5 minutes.

Mr. BERGMAN. Thank you, Mr. Chairman. And thanks to all of our witnesses here for your testimony. You know, the good news is I am getting to know you because I see you so often. The bad news is I am seeing you too often. So the point is, the flow of communications, as Dr. Clancy and I talked about earlier, as far as bringing in the boots on the ground, the everyday stuff, I am pleased to see that the VA is going to do that so that we, as a Committee, can hear it from those who are involved in the day to day operations.

You know, 18 months into this first term now and in dealing with things that we hold near and dear to our hearts and our veterans' hearts, I am still learning at the cyclic rate. You know, I think VISN 23 touts the SAIL metrics, the strategic analytics for improvement and learning that you have had some success with.

I would like to give you just one data point from my first briefing at an unnamed facility and VA related. But the point is the metric for success proudly touted and in a slide was that they had added eight full-time equivalents to their staff. I am not so sure that is the quality metrics that we are looking at is adding staff. I mean, if they had been related to what that meant to the outcomes and the results for the veterans, that might have had a different quality to it, rather than just saying, "Hey, we added eight more paychecks."

So it is just—fyi it was meant to be a good answer. So I would suggest to you the leadership involved with that maybe needs to just kind of look at things a little different in what a good answer is as it relates to results for the veterans.

And Dr. Clancy, I know you have—I have asked you this before, but I am going to ask again. Do the VISNs have a mission statement, either collectively or individually? Have we got something down on paper? Two or three lines? Four lines? Whatever it is?

Dr. CLANCY. The goal of our current redesign effort is that there is one mission statement that is for all VISNs. Most have a mission statement, but it is not looked at by anyone and we don't verify it. And I would guess that it probably echoes the department's strategic plan that say we are all about personalized veteran-driven high quality care, more or less.

But it needs to be much more engaged. Dr. Gamble's point about a play book I think is quite instructive.

Mr. BERGMAN. Okay, Mr. Butler, you know, same question for you. What do you think of the VISN's mission statement? What do you think it should be?

Mr. BUTLER. What I would say that the American Legion Resolution calls for a study of the current VISNs. And so we advocate that someone look at the VISN's structures and determine the lead way forward to go and whether or not there are changes or improvements that could be made based upon studying the current VISN structure.

Mr. BERGMAN. You know, we could talk about this for a long time and I can see as I look across, I have a fellow Marine, I am—a couple of them. You guys are—you have got me outnumbered now. Not outgunned, but outnumbered. Anyway. My God, I forgot you are over here. Thank you. You have always got my flank.

The point is, in the Marine Corps., every word in a mission statement is a planned word with a specific meaning for what its intent is so it can flow up and down. And I would suggest to you that at different levels of command, sometimes that mission statement might be revised to the level of command that it is meant to oversee. So don't get caught up on one size fits all.

So with that, I yield back, Mr. Chairman.

The CHAIRMAN. I thank the gentleman for yielding.

Mr. Correa, you are recognized.

Mr. CORREA. Thank you, Mr. Chairman. First of all, I just want to thank you, Chairman Roe, for your leadership in the Mission Act, in moving legislation out of this Committee, onto the Senate. I do appreciate what you have done. I know my veterans appreciate your efforts as well. Thank you, sir.

Dr. Clancy, quick question for you. Secretary Shulkin envisioned placing VISN's 1, 5, and 22 in receivership. Any thoughts about what he envisioned?

Dr. CLANCY. So I don't think he had completely followed through on the thought at the time of the D.C. press announcement. We did have subsequent conversations.

Mr. CORREA. It was an envisioning, not an actual plan. So what—

Dr. CLANCY. No. I think what he wanted to do was to say whoa. Whatever VISN is supposed to be doing in these three networks is not working. Therefore, he had called Dr. Gamble in to get him a set of fresh eyes, informed by a great deal of experience outside of our health care system, which I saw as a real asset. But it became clear, I would say within the first 24 hours that the span of con-

trol—it was not possible for someone sitting in D.C. or anywhere else to be running day to day operations at 23 facilities that were vastly disbursed geographically.

So on the ground, the deputy network director, the most senior VISN official, has actually been sort of an acting network director for day to day activities. But Dr. Gamble has been to each of those facilities. Does that help?

Mr. CORREA. A little bit. I guess I am still at a loss when it is a big network, a lot of work, a lot of important work. But it is not exclusive to this country. You have got the Kizers of the world. You have got other large networks that have the same challenges of management, implementation, accountability, responsibility, and liability. And there are some, for lack of a better term, best practices could be employed at the—and I am just trying to figure out why is it that we have been operating the VA as silos and why is it that these discoveries continue to be secrets that nobody knew about?

Dr. CLANCY. So I think the last point you made is hugely important. And in the question about culture, I would have said that what is even more important before that is candor. That you can honestly confront your problems and don't act like it is a secret. Because frankly, if one of our facilities has a problem, it is highly likely that some other facilities are having the same challenge.

And the great power of being an integrated system is that we could learn, rather than have—as a system, rather than having every single facility replicate the painful discovery of a delta between your aspirations and what actually happened—

Mr. CORREA. So, Dr. Clancy, your words whistleblowers are the greatest gift that we have.

Dr. CLANCY. Yes.

Mr. CORREA. Do we have a system to listen to whistleblowers? Do you have a 1–800 number, an anonymous box, and do you have folks that follow up on comments, suggestions, complaints by whistleblowers?

Dr. CLANCY. So that is done differently at most facilities. Some literally have suggestion boxes. Some will say—will do things like having Facebook chats where people can text in questions. Some have townhalls with employees. I don't think there is a magic formula. And there was one—

Mr. CORREA. But there should be a formula at each place. If you don't have a system and I would question whether you have a system at all in all of these places.

Dr. CLANCY. Well, the critical formula for me is saying if there is problems, I want to hear about them. And facility directors who communicate that, generally tend to hear about problems and act on them sooner than not.

Mr. CORREA. So when you have directors that hear about them, do these—the results of these surveys, do they reach Washington, D.C., or are they stuck at the local level?

Dr. CLANCY. We have been strongly encouraging more that we fail as a system if any of our individual facilities—

Mr. CORREA. But I guess my question, and I am running out of time, and that is why I am being—interrupting here. Suggesting, encouraging versus a system of saying this data will be reviewed.

The other day I went to my local doctor. Within a couple of days, I got a text saying, "Can you tell us what your experience was with your doctor?"

Dr. CLANCY. Right.

Mr. CORREA. "Can you tell us what your experience was visiting?" Do you have a system like that where our veterans—

Dr. CLANCY. We do. Yes.

Mr. CORREA [continued]. —can text in their experience and if it is a bad one, do we follow up or that is just another number that we, you know, put away for research in the future?

Dr. CLANCY. We have recently put in a system—we have always had questions at the kiosk before you check out, okay? And we have recently put in a system where veterans can give us realtime feedback from a variety of venues. That can be from a kiosk. They can send us an e-mail. They can drop off a note at the front desk. And that information gets aggregated.

And frankly, what I am hearing from our directors is they love it. Occasionally they feel like they are drowning in information, but—

Mr. CORREA. We all do.

Dr. CLANCY [continued]. —it points out—well, it points out problems, I mean, in the same way that I am sure many people learn from their own office staff, right? Things you thought were fine, except what you are hearing from the actual customer of the veteran is it is not working so well for me. And that is an opportunity to just fix that.

Mr. CORREA. Mr. Chair, I am going to yield. Before I do, I just want to say I think we need to figure out how to protect and listen to whistleblowers—

Dr. CLANCY. Absolutely.

Mr. CORREA [continued]. —to move forward. Mr. Chair, I yield.

The CHAIRMAN. Thank you, gentlemen, for yielding. Chairman Bost, you are recognized.

Mr. BOST. First off, let me start out by saying, you know, I was taught in college about a Peter principle, which somebody is promoted beyond their capability of handling the job and that is where they freeze.

I have got a statement here and, Dr. Clancy, I want to see where you think this should go. In 2008, several congressional Members sent a letter to then VA Secretary James Peake, expressing their concerns about an appointment of Dr. Peter Almenoff to be the assistant deputy undersecretary for health and for quality and safety. Dr. Almenoff, formerly director of the VA Heartland Network, responsible for overseeing the Marion VA Center, Dr. Peter Almenoff had oversight authority over Marion VA Medical Center when nine veterans died due to substandard care. He was promoted to oversee quality and safety for the entire VA in February of 2018.

VA announced that he is now the director of VA's office of reporting analytics, performance, improvement, and deployment, or RAPID health care improvement center to oversee improvement at each low performing health center. And he reports directly to you, Dr. Clancy.

I know the VA central office will review each of the facilities' quality. And if the facility fails to make rapid, substantial progress

in their improvement plan, VA leadership will take prompt action, including changing the leadership of the medical center.

And this is not the first time of a VA employee getting promoted after they failed at their job. Most recently, we have heard of several concerns related to the quality team in Marion and the quality nurse was promoted into the VISN. Where is the accountability? At what point do start looking at your employees and when they fail at a job, do we not—we either get rid of them or we demote them. But no, what we do in the VA is we promote them away so that they don't have to deal with the problems they create. Do you have any answer on that?

Dr. CLANCY. So in general, when people are promoted, we are looking at past performance and any investigations and so forth. I think most large organizations, health care or otherwise, that have employees with an enormous amount of skills that are in the wrong job, before they put them out on the sidewalk would want to figure out how they might be working in a job that is a better fit with the skills that they have.

Mr. BOST. Okay, maybe my concern and I have got another question I have got to ask, but this came to mind. My real concern because, okay, I did not run something the size of the VA, obviously. But I did—was in business and have been in business for years. The concern is that, do you not see with the amount of employees that you have that some of them might all of a sudden say, "Okay, if I just do a bad job here, they will move me somewhere else?"

Because that is what we are seeing. That is the concern I see is, "Okay, I can't do this job, but I still have an education and a degree, so maybe they will move me over there and then I don't have to do this anymore." And call it a promotion.

Dr. CLANCY. In general, I am not that concerned about that. I certainly don't want someone to struggle in a job that their skills are not a good fit with that is not serving veterans, if in fact they might be able to contribute more effectively elsewhere.

And if—to me, the bigger challenge that we struggle with a lot is an inconsistency in values. People who don't have values that resonate with our intent of serving veterans everywhere.

Mr. BOST. Okay. My question here before the time runs out, Marion has a number of issues that have come to light over the past decade. The leadership of the VISN 15, though, does not seem to be adequately addressing my concerns about the morale at Marion. What role does a VISN play with the human resource department, given the unique role of the H.R. personnel have in the VISN? And is there a way that someone at the VISN that is over H.R. can explain to the Marion VA H.R. person how to do their job betterly (sic). That was a great word.

Dr. CLANCY. Thank you, no.

Mr. BOST. More accurately.

Dr. CLANCY. Thank you, Congressman. That is exactly the direction we are going with our VISN redesign is that we will strengthen the capacity and oversight of the H.R. person at the network level so that the person at the facility level, who is responsible for posting jobs and making sure people get onboarded and so forth, actually has someone to consult with and someone who is keeping

an eye over their shoulder to make sure that we are doing a consistent job.

Mr. BOST. Thank you and I yield back.

The CHAIRMAN. Thank you, gentleman, for yielding. Mr. Peters, you are recognized for 5 minutes.

Mr. PETERS. Mr. Chairman, I would defer to Mr. Moulton.

The CHAIRMAN. He is right up after you anyway, so that is fine.

Mr. MOULTON. Thank you, Mr. Peters. Thank you, Mr. Chairman.

So I represent the Bedford VA, as you know, and last week I testified about my concerns with the Bedford VA and the multiple whistleblower cases, on issues to include contract fraud, patient abuse and neglect, and poor facility maintenance had reported at that facility. Adding to that, there are issues with improper medical record management, a Legionnaires outbreak, the Office of Special Counsel findings of widespread asbestos exposure, a hostile work environment, and retaliation.

Now, to Secretary Shulkin's credit, he came up at my request and visited on a Saturday afternoon. And we walked around the Bedford VA and heard their leadership team, or what was left of the leadership team, explain what happened, in particular, with a patient death. And what struck me about it is that there was a lot of effort put into looking backwards and figuring out what had occurred and very little accountability for making sure it didn't happen again.

Now, you have heard from a lot of Marines on this Committee and I think of us as all on the same team here, not Democrats and Republicans. But one of the things we learn in the Marines is that of all of the different leadership steps: coming up with a great plan, doing the reconnaissance to get the intelligence, none of it really matters unless you supervise what happens. It is the most boring step in leadership, supervision. But you have got to make sure that your good plans actually come to fruition, that the Marines get the job done.

And so my question is just what has been changed? What is different at Bedford, and other places, and VISN 1 and elsewhere, to make sure that when we have problems like this, we can ensure that they don't happen again in the future?

I recently met with a new director up at the Bedford VA. It took about 2 years to get that person into place. And I am excited for her to get started. I mean, she is getting started. I think she will do a great job. But I fundamentally want to know what will be different?

Dr. CLANCY. So the Bedford VA is not far from where I grew up and so it is a facility I know reasonably well. And I know that when you visited the first time, there were a lot of problems and, frankly, a lot of publicity in a way that probably makes it a bit difficult for people to be quite as forthcoming, even with respect to legitimate oversight and so forth.

I think the biggest good thing that has happened at the Bedford VA is that we will have a new network director in VISN 1 and we are going to do everything possible for these three networks, the new people to actually prime them for success. So whether they are promoted from within or recruited from outside, they are going to

be—have a two to three month training period, leadership development and so forth, which I think we can learn a lot about from the military. But probably the best thing that has happened at the Bedford VA is identifying and recruiting an effective director. I think she is going to be terrific.

And I think what will be different is that you have someone who knows a lot about how the system works, both locally as a very senior nurse at the Boston VA, and then having worked in headquarters for a couple of years, focused on improving access to care.

Mr. MOULTON. What is the timeline that you expect from her for addressing these issues?

Dr. CLANCY. I expect her to be showing improvements within 1 to 2 two years. I mean, that I can count and measure.

Mr. MOULTON. So up to 2 years to address these whistleblower complaints?

Dr. CLANCY. No, no, no. She is not going to address the whistleblower complaints. We have an external, you know, another office in the department that does that. What she has got to do—

Mr. MOULTON. And, Dr. Clancy, what is their timeline for addressing these complaints?

Dr. CLANCY. I don't know. I would have to take that for the record and get back to you.

Mr. MOULTON. Okay. I would very much appreciate—

Dr. CLANCY. I am happy to do that.

Mr. MOULTON [continued]. —that. You know, the sad thing is that the Bedford VA also has some extraordinary accomplishments.

Dr. CLANCY. Yes.

Mr. MOULTON. They have a remarkable record with regards to mental health care treatment, for example, which we all know is top of the line for veterans in America today. And so part of this is ensuring that we have a VA leadership culture that ensures that problems get fixed. Another part of it is that good practices get shared.

Dr. CLANCY. Yes.

Mr. MOULTON. What are you doing to ensure that good practices that are happening at places like Bedford, which has an opioid prescription rate, Mr. Chairman, half the national average because they are so innovative with mental health care, what are you doing to ensure that those practices get shared?

Dr. CLANCY. So we are doing two things. Over the past couple of years, we have had a big initiative focused on diffusion of excellence where employees across the system are encouraged to submit their best practices. And we actually facilitate their connecting with other facilities, often far away from where they actually take care of veterans. And it has not only been a terrific way to identify good practices, it has been a way for people across our system to learn from folks they otherwise never would have met.

Recently, I heard the individual who is leading that effort explain how he is going to actually take that up another level by identifying other practices. In other words, looking at measurements. What is Bedford doing about mental health care that could be shared with others?

The Bedford VA was part of an initial best practices which focused on helping veterans and their families discuss preferences for

end of life care as sort of a group. You could only do that in VA. And it has been hugely popular with veterans because it is actually less intimidating than a one on one conversation. And they get to kind of process this with other veterans, which is very helpful.

Mr. MOULTON. Thank you. Mr. Chairman, thank you very much for letting me run over.

The CHAIRMAN. No, that is fine. Thanks for being here today and thanks for your service to our country.

I am beginning to think maybe we have too many Marines on this particular—we need a few more Army people. And it has got a very New England tint today.

Mr. Poliquin, you are recognized for 5 minutes.

Mr. POLIQUIN. Thank you very much. That, to me, is you are a lean 6 minutes, Mr. Chairman, but thank you very much.

Make sure I get this right, Mr. Chairman, before 1995 and this would probably go to Dr. Clancy, there—we have about 160 medical centers around the country. And before 1995, they were roughly all autonomous and they were organized in four—loosely in four regional areas. But for the most part, they reported directly to the—to Central VA.

And how in the heck can anybody oversee that? How can they hold them accountable? So in—after 1995, or since 1995, I know you folks originally organized, or we did, 22 VISNs and now they are down to 18. Is that correct? Roughly? Do I have that roughly right?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Okay, so the number of employees went from about 220 and 1,100. And so, to me, what it looks like, Dr. Clancy, is that we have created another sort of middle management bureaucracy here. Mr. Missal, am I pronouncing your name correctly?

Mr. MISSAL. It is Missal.

Mr. POLIQUIN. Mr. Missal, you are the I.G. for this whole ball of wax here. Have you found in your data, in your work that there has been an improvement and accountability in responsiveness and care as a result of this reorganization?

Mr. MISSAL. We haven't looked at that specifically, but what we do look at in all of our work, we try to find what the root cause of an issue may be if we find a problem. Because what our role is and our goal is to help VA get better. And so by identifying anyone who did not act as you would expect, we want to identify it so that VA could take the necessary action.

Mr. POLIQUIN. Thank you. Mr. Gamble, you were appointed by Mr. Shulkin to run VISN 1, 5, and 22 how long ago?

Dr. GAMBLE. I was not appointed to run those VISNs.

Mr. POLIQUIN. Oversee them.

Dr. GAMBLE. That was back on, I believe, March 7th.

Mr. POLIQUIN. Okay, of this year.

Dr. GAMBLE. Of this year.

Mr. POLIQUIN. And are you stationed out of Orlando or are you stationed out of D.C.?

Dr. GAMBLE. I am still living in Orlando, but I am up here most of the week. In fact, since March 7th, I have spent most of my time on the road, out with these VISNs—

Mr. POLIQUIN. Okay.

Dr. GAMBLE. —and facilities.

Mr. POLIQUIN. Okay. We are in VISN 1 up in Togus. We have the first medical facility—medical hospital—VA medical hospital in the country established after the second—excuse me, after the Civil War. Have you been there to visit Togus?

Dr. GAMBLE. I have not been there yet, sir.

Mr. POLIQUIN. Okay. Do you plan on it soon?

Dr. GAMBLE. As soon as I can.

Mr. POLIQUIN. Great, thank you. When will that be?

Dr. GAMBLE. I will have to check my record or my schedule and—

Mr. POLIQUIN. Good. We will check with your office to make sure we know when that is going to happen. Thank you.

There is someone by the name of Mayo-Smith and Weldon. They both retired as the heads of VISN 1 and 22, is that correct?

Dr. GAMBLE. Sorry, Dr. Mayo-Smith was—

Mr. POLIQUIN. Yes.

Dr. GAMBLE [continued]. —the previous VISN director.

Mr. POLIQUIN. Yes, they are gone now, right? And Weldon is gone too. All right, so they are both gone.

Dr. GAMBLE. Twenty-two, yes sir.

Mr. POLIQUIN. Okay. And Williams has been reassigned, correct in 5? So who are running those three VISNs?

Dr. GAMBLE. Right now we have acting medical director. I am sorry, acting VISN directors in those positions. We have Mr. Barrett Franklin, who is in VISN 1.

Mr. POLIQUIN. Thank you.

Dr. GAMBLE. We have Dr. Ray Chung who is in VISN 5.

Mr. POLIQUIN. They are all acting. Okay. I want to go back to what General Bergman said a minute ago. What performance benchmarks do you folks embrace to make sure the accountability is getting better, not worse? What are the specific measures? Give us a couple of examples.

Dr. CLANCY. Well, I—

Mr. POLIQUIN. Sure, Dr.—

Dr. CLANCY [continued]. —have a little more experience. I will take that.

Mr. POLIQUIN. Yeah.

Dr. CLANCY. So one overarching accountability measure is, is the performance of the facilities in your VISN better or worse—

Mr. POLIQUIN. What does that mean?

Dr. CLANCY [continued]. —than it was when you were—

Mr. POLIQUIN. How do you measure that performance?

Dr. CLANCY. What we do is we actually roll up and summarize all performance measures, the same ones used by the private sector reported to—

Mr. POLIQUIN. Okay, let me give you an example. There was a fellow by the name of Dr. Franchini up at Togus.

Dr. CLANCY. Yes.

Mr. POLIQUIN. Dr. Franchini was a foot surgeon at Togus from 2004 to 2010. He botched dozens and dozens and dozens of operations, to the extent that one of our veterans had to have her leg amputated. I repeat that, her leg amputated to take care of the pain because there was no other way to cure it.

Now, here is the think that really hits me between the eyes. Not only did that happen, but it wasn't until roughly 2 years later, 2012, that the former head of surgery who was responsible for getting this out to the victims and also to the public so Franchini couldn't operate in the private sector, it was about 1 to 2 years until that happened.

Okay, you mentioned earlier, Dr. Clancy, that you need to make sure that people have the right job description, so their skill sets can fit in another job. This individual was not fired. He was demoted. Is there a job skill that I am missing here that enables this person to be reassigned within the VA after someone's leg was cut off because of botched surgeries that they did not report for 1 to 2 years? Am I missing a job description here or some sort of skill set that they should allow that individual to stay there?

Dr. CLANCY. Congressman, are you referring to the podiatrist or the person who supervised the podiatrist?

Mr. POLIQUIN. The person who supervised the podiatrist.

Dr. CLANCY. I would have to take that for the record because that piece I am just not that familiar with. I apologize.

Mr. POLIQUIN. Okay. Were you responsible at that time for overseeing the VISNs?

Dr. CLANCY. No, I was—

Mr. POLIQUIN. Who was?

Dr. CLANCY. Prior to me was Dr. Alaigh, before that Dr. Shulkin. What I would say, Congressman, and I didn't get a chance to say that—

Mr. POLIQUIN. Okay. Steve Young is the fellow that is under you, right?

Dr. CLANCY. Yes, uh-huh.

Mr. POLIQUIN. Okay. And then it goes down to the office of network support, then it goes down to the VISNs, right?

Dr. CLANCY. Yes.

Mr. POLIQUIN. But you are the head person, correct?

Dr. CLANCY. Yes.

Mr. POLIQUIN. Okay, so you are responsible.

Dr. CLANCY. Yes.

Mr. POLIQUIN. You just told me you weren't.

Dr. CLANCY. No, I thought you said then. I have been in this job now for 7 months.

Mr. POLIQUIN. Okay. And before that, how long have you been at the VA?

Dr. CLANCY. Four and a half years.

Mr. POLIQUIN. Four and a half years okay. Okay? Go ahead. I will let you finish—

Dr. CLANCY. But I would be happy to get that for the record.

Mr. POLIQUIN. I appreciate it.

Dr. CLANCY. What I was also going to say as a result of Dr. Franchini and a couple of other things, we have put in new requirements for facility and network directors to keep credentialing licenses and so forth up to date. And that is also part of the expectations.

Mr. POLIQUIN. Do me a favor, when you get back to your office and I appreciate it very much, Dr. Clancy, we want to make sure

the person who was responsible for reporting this, is that individual still there or not. I would appreciate that very much.

Dr. CLANCY. Okay.

Mr. POLIQUIN. Thank you, Mr. Chairman.

The CHAIRMAN. Gentleman's time is expired. Mr. Arrington, you are recognized.

Mr. ARRINGTON. Thank you, Mr. Chairman. Mr. Butler, representing a vast array of veterans from various backgrounds, how would you rank in the customer service survey the overall service of the VHA to your veterans? 1 to 10, 10 being excellent, off the chart, zero being non-existent.

Mr. BUTLER. Most veterans that we encounter tell us that the care and services provided by the VA is excellent.

Mr. ARRINGTON. Well, then why are we having this conversation? Because I really don't care how they skin the cat. I don't care how they organize. I care about the results. If it is excellent, why are we even having this hearing?

Mr. BUTLER. But I think that, you know, there are situations where the care or things go awry, and every veteran should have that same experience. So I think that is why we are here today for the exceptions because all veterans' experiences aren't the same.

Mr. ARRINGTON. My perception is very different. My perception isn't that these cases of bad performance and bad service aren't the exception. I think they are too often the rule. But I will—you know, that is your—you are representing veterans and you know your veterans. And so—but I am surprised that we are talking about an exception. That we are spending all thing time, that we have done all these studies because we have done—I have read at least five studies on organizational management.

I care about organizational results. And if they are great, then I—what are we doing here? Do you think they are great, Mr. Missal?

Mr. MISSAL. I think that a number of the issues we have identified are because people haven't done their job and that they don't have the structure in place to ensure that there is accountability.

Mr. ARRINGTON. One of my favorite quotes is that you are either coaching it or allowing it to happen. I think you can overcome organizational structures. I think you can overcome bad systems. I think leadership, I think culture dominate on the outcome. And I think there are real, fundamental, deep seated cultural problems. Do you agree with that or do you disagree with that, at the VA? I am asking you, Mr. Missal.

You are the independent Inspector General. I want an independent assessment. Do you think there is a cultural problem at the VHA?

Mr. MISSAL. In many of the instances that we have looked at, we have seen a cultural problem where people aren't taking responsibility to do the right thing, not performing as they should be, which results in significant problems.

Mr. ARRINGTON. So it is not just the Washington Medical Center, do you think it is systemic or is that just an isolated event?

Mr. MISSAL. We have obviously seen more than just problems at D.C. We have seen them at a number of facilities. Obviously when

either information comes to our attention or through our proactive efforts, we find it. We address them as quickly as possible.

Mr. ARRINGTON. We were talking about how we are going to have a management for performance plan for VISNs and how we are going to define roles and responsibilities and bring clarity to something that is clearly chaotic and unclear. And Mr. Gamble, you have mentioned that the network directors are taking the lead on developing these sort of plans. Did I hear you correctly?

Dr. GAMBLE. They are part of the process, sir.

Mr. ARRINGTON. But why—I get it. I mean, get input from midmanagement, your regional directors, if you will. But I mean, they are looking to the leadership of the VHA to tell them what their mission is. Clearly, they don't know what their mission is. What is expected of them? How will they be graded? What does the scorecard look like? Will they be rewarded if they do a good job? Will they be fired if they don't do a good job?

Why are we asking them to run off and develop a plan for themselves?

Dr. GAMBLE. Mr. Congressman—

Mr. ARRINGTON. What is the plan, Dr. Clancy, for developing these—this sort of strategic management plan for the VISN so that they get it right, they serve our veterans? They are safe, they are happy, they are healthy, and we did right by our heroes. What is the plan?

Dr. CLANCY. That is what you just described. It will ultimately be deemed by central leadership, period.

Mr. ARRINGTON. Do we have a problem with central leadership? How long have you been—how long has the Undersecretary job been unfilled?

Dr. CLANCY. By a permanent political employee, since February of 2017.

Mr. ARRINGTON. I know my time is expired, Mr. Chairman, unfortunately, because I don't feel like I have gotten all of my questions asked or answered, but that is my fault. So I yield back.

The CHAIRMAN. I thank the gentleman for yielding.

Let me—I have a couple—let me just start a second round then. We have only three of us here so let's just go with a second round if you would like to ask a question.

Ms. KUSTER. Thank you very much. And just to pick up where my colleague left off, I will say that I have been in Congress for five and a half years and a number of us on the Committee came in the class of 2012, starting in January of 2013. We are now on our fourth Veteran Secretary, VA Secretary, since I have arrived in Congress.

And so I think that that is part of the situation, to be honest. And I am not trying to be partisan. I want to work together in a bipartisan way as our Committee does, but we need leadership from the top. And so I just want to revisit the details one last time here of New Hampshire and VISN 1. I do have the letter from the U.S. Office of Special Counsel dated January 25, 2018, that I would like to submit for the record that lays out the situation that we had and frankly the lack of leadership and the lack of supervision. If I could enter that for the record?

The CHAIRMAN. No objection.

Ms. KUSTER. The other person that was a focus for us was the director of VISN 1, Dr. Mayo-Smith. And again, I would have to ask you when did Dr. Mayo-Smith first become aware of our referral to the Office of Special Counsel, and did he ever pass his concerns up to central office officials? Because I think that was part of the breakdown for us.

Not only did we not get from the medical director to the VISN, we didn't get from the VISN to the central office, again, until this all played out in the Boston Globe. And this was despite our best efforts to take it to the OIG, take it to the Office of Special Counsel, push forward. What was happening in Washington and in Boston in the 6 months in between?

Ms. CLANCY. So at headquarters, we became aware of the Special Counsel and the whistleblower allegations when they turned to us for assistance after the Inspector General was not able to step up at that point. And this is a routine occurrence. I am not singling them out.

And I would guess that that was February or March of 2017. And then the Office of Medical Inspector went up and had a preliminary report that was sent to Office of Special Counsel, I want to say late May of 2017. And the whistleblowers—and this is all part of the process, were not completely comfortable with the results.

And I think as you know, Congresswoman, we then did a much more extensive review of cases and have consulted directly with Dr. Coy (ph) and others.

Ms. KUSTER. Well, and it—you know, after it was in the Boston Globe that Secretary Shulkin showed up virtually the next day. So, I mean, we did eventually get the attention. But one of the problems I have is when General Bergman and I held this oversight and investigation Subcommittee hearing in New Hampshire. I mean, that is our role. We have oversight. Dr. Mayo-Smith didn't appear to be fully aware of the concerns, even at that point. That was after Dr. Shulkin had come up. And he was—well, I think if General Bergman was here with me, he would say we received unsatisfactory answers regarding the actions taken to rectify this situation.

So I won't beat a dead horse, as they say where I come from, but I do think we need to focus on supervision at each level, and the role of oversight, and how to bring concerns forward. And it sounds as though that is the direction.

I don't know if our witness from OIG has anything more to add about that, what we can do in terms of both streamlining the process and the types of people that we hire that will be focused on supervision and will be focused on continuous improvement.

So for Mr. Missal.

Mr. MISSAL. Yes, I don't know if I have that much more to add. I do want to say, though, with respect to whistleblowers, what we are trying to do is we are trying to make sure that they feel comfortable coming to see us and talk to us about issues. We do protect their anonymity if they so desire. And a good example is the Washington, D.C. matter. We got a confidential complaint from a person at VA and we have been able to protect that person's confidentiality.

And the more situations we have like that, hopefully VA employees and others will feel comfortable that if they come to us, they will be protected. They will be heard. And appropriate action will be taken.

Ms. KUSTER. And I appreciate that because that is a concern that I have. I continue to have whistleblowers come. And in the case that I have been talking about today, there was a long period of delay because the whistleblowers were concerned about their anonymity. Dr. Coy is a physician in the facility and wanted to continue to do his work.

So we have passed legislation out of this Committee to address whistleblower protection. And I will yield back. But I want to thank, again, Dr. Roe for holding this hearing. And I think our oversight role is significant and we take it very seriously in a bipartisan way. And I appreciate you coming forward. Thank you.

The CHAIRMAN. Mr. Arrington, you are recognized.

Mr. ARRINGTON. Thank you, Mr. Chairman. And I really appreciate you extending this for a second round because I have this general frustration, and I know my colleagues feel the same. And I can't imagine how the veterans must feel because, you know, you talked about how you would have been fired for some of these things. And the reason you would have been fired is because the health system you worked for would go out of business if they let you continue to do this thing.

But the VA won't go out of business. And that is a fundamental challenge to breed this sort of culture of accountability without those external competitive forces. It is just really difficult. It is really difficult. And on top of that, I think Ms. Kuster is right. I mean, the political leadership is a key link in the chain of accountability up to us. Without them, I mean, I feel sometimes a little guilty for beating on you guys but you all are part of the problem and the opportunity.

But without the continuity and political leadership, and I don't know if that is the Senate that is not working to get them through, or if it is the administration not putting them up but it is really, really frustrating. And I think you are going to get this sentiment as long as we have these gaps and the disconnects in the accountability chain.

Ms. Clancy, how would you rank order the VISNs? If I just said rank order the VISNs from the best to the worst, could you do that for me? Could you submit that to the Chairman and the Committee?

Dr. CLANCY. I would be happy to. And I agree—

Mr. ARRINGTON. Does that exist today?

Dr. CLANCY. I could look at a number of different dimensions. And respectfully, I would want to submit that for all of the problems you hear about in general, either we don't do enough of a job or if it bleeds, it leads. We—

Mr. ARRINGTON. Sure. I am—I know there—

Dr. CLANCY. We don't share the people who are doing well.

Mr. ARRINGTON. Here is my thing. I know there are good people who are well meaning and they want it to work. I think the system is fundamentally flawed. I think we have a lot to overcome. I think we have to do our job better. I think you have to do your job better.

But let's get back to this idea of rank order.

Dr. CLANCY. Yes.

Mr. ARRINGTON. That supposes there is a scorecard. So there is a scorecard for the VISNs?

Dr. CLANCY. Yes.

Mr. ARRINGTON. And I would like a copy. Would you submit a copy to the Chairman and the Committee so we can see what their performance metrics are?

Dr. CLANCY. Uh-huh.

Mr. ARRINGTON. Okay. So that should be pretty clear then, if they have outcome measures that they know they have to meet, what happens if they don't meet those outcome measures?

Dr. CLANCY. Then they have some serious conversations with their boss and that becomes—

Mr. ARRINGTON. When is the last time the seriousness got to a removal because they just were not serving the veterans and they just consistently missed the mark on outcomes?

Dr. CLANCY. I have had a couple of direct experiences in the past couple of years. And it wasn't an up or out kind of thing. It was like no, there is no way you would get a recruitment/retention incentive if the performance in your network is not helping, and that person left.

Mr. ARRINGTON. The Veterans Integrated Service Network is what VISN stands for. I find it very ironic. I feel like it should be named the Veterans Siloed Aimless Unaccountable Service Network. That is my perception. That is my takeaway from reading this, from listening to you guys.

What is the VHA's central role versus the role of the VISN in managing these medical centers and holding them accountable for serving our veterans? Is it clear or is there overlap? Is there confusion at that level as well?

Dr. CLANCY. There has been confusion at times, which is why we are working on clarity. And you absolutely cannot have a clear plan and roadmap for VISNs unless we have got that straight. In general, central office is going to set vision, and strategy, and tactics, and make sure that there are resources available. If some facilities need more, then they should get that, or some networks and so forth.

And frankly, for identifying the right kind of leadership, because I agree with you that leadership and culture are way, way at the top.

Mr. ARRINGTON. It seems to me that they are not laboratories of innovation. They are laboratories of inefficiency. And they will continue to be until they are held accountable, until there is clarity in their mission, until they are held accountable for their performance.

And I don't—I sit through a lot of hearing on IT systems, especially, and how they are so much frittered away on trying to do something internally when you can get it off the shelf. One business doing it one way. Another business is doing it a different way. Even though it may be working and they could share best practices, I am out of time, but I am going to continue to press in on this notion of accountability. And I hope we get more political leadership in so we can have these same discussions.

Mr. Chairman, you have been very generous and very patient. Thank you. I yield back.

The CHAIRMAN. I thank the gentleman for yielding and at this time, Ms. Kuster, do you have any closing comments?

Ms. KUSTER. Just very briefly, I do want to, you know, make that comment that we do need leadership from the top and, frankly, we need some consistency over a period of time. I mean, four Secretaries and I have only been here for 5 years seems a little—we are churning through VA Secretaries. So I hope that the President will appoint and the Senate will confirm the Secretary in due course and we will be able to move forward with our oversight role.

I think accountability, you are hearing this message in a bipartisan way. The role of supervision and the role of oversight is critically important, and we will continue to work together. So thank you, Dr. Roe, and appreciate you scheduling this hearing. And thank you again for accommodating me.

The CHAIRMAN. Thank you, all. And I want to thank the Committee Members for being here today. And I have just one quick question.

Dr. Shulkin wanted to have a planning on the VISN reorganization done by July 1st. Is that still going to happen without the leadership—

Dr. CLANCY. Yes.

The CHAIRMAN. It is—

Dr. CLANCY. Yes.

The CHAIRMAN. So July 1st we will have that.

Dr. CLANCY. Well, we will present that to the department leadership, but shortly thereafter, we would look forward to briefing you on this.

The CHAIRMAN. Yes, well thank you very much for that, Dr. Clancy. And I think you sense our frustration, but opportunity here with—I think the OIG has laid out a very clear pathway about how we should go forward. And I think Mr. Moulton brought up something that I, again, had a question earlier was what is 23 doing that 1, 5, and 22 are not doing? And that should be pretty simple inside. And it is still unclear to me if I am a VISN director, what power I have.

If something is going—in other words, if I am sitting in the VISN in Nashville, what power do I have over Mountain Home Medical Center in Johnson City, Tennessee. It is not clear to me, even after today's hearing, what I have. Could I go and would I be instrumental in removing a poorly performing medical center director—

Dr. CLANCY. Yes.

The CHAIRMAN [continued]. —or would I not? I could.

Dr. CLANCY. You would—could.

The CHAIRMAN. Could I fire them?

Dr. CLANCY. Yes.

The CHAIRMAN. As a VISN director, I can fire a medical center without checking with you and the Secretary?

Dr. CLANCY. I think in general they would check and make us aware, but yes. And when I have called that VISN director to say I had—was hearing things from a particular facility, she has cheerfully cut her vacation short to go spend a day or two there to figure

out what is going on, you know, so she can see it herself, which is exactly what you want.

The CHAIRMAN. Do all of these VISN directors understand that they have that authority and power and can—and do the medical center directors understand my boss is right here, not all the way at the central office in Washington, D.C. But I have got a boss close by that can terminate me?

Dr. CLANCY. Yes.

The CHAIRMAN. They do understand that?

Dr. CLANCY. Yes.

The CHAIRMAN. Has it ever happened?

Dr. CLANCY. Yes.

The CHAIRMAN. A VISN director has fired a medical center director?

Dr. CLANCY. Yes.

The CHAIRMAN. Can you tell me who that is or where—maybe we will do that off the record.

Dr. CLANCY. Yeah, I could—

The CHAIRMAN. I would prefer to do that off the record.

Dr. CLANCY. Okay, that would be fine.

The CHAIRMAN. Just to see that that has happened. But anyway, I want to thank you all. It has been helpful. I think you see the Committee wants to. I think legislation last week, 14 bills we passed yesterday. 11 of them by unanimous consent—voice voted, I mean, and 3 by—I don't think there was a single—or 2 or 3 no votes yesterday on all of those bills.

So you have a Committee and a Congress that really wants the VA to work. We truly do. We thank the IG for helping us point out these problems. And Mr. Butler, as always, thank you for the Members and the VSOs who are always tremendously helpful to us in guiding us and the Committee.

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

Without objection, so ordered.

The hearing is adjourned.

[Whereupon, at 12:05 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Carolyn Clancy, MD

Good morning Chairman Roe, Ranking Member Walz, and Members of the Committee. I appreciate the opportunity to discuss the proposed redesign of the current Department of Veterans Affairs' (VA) Veteran Integrated Service Network (VISN) structure and the status of remedial actions at VISNs 1, 5, and 22. I am accompanied today by Dr. Bryan Gamble, Deputy Chief of Staff at the Orlando VA Medical Center (VAMC).

On March 7, 2018, former VA Secretary David Shulkin announced VA would undertake a systematic review of the VISNs, with a specific focus on VISNs 1, 5 and 22. These three VISNs were challenged with leadership and management issues, low performing facilities, and culture issues. The purpose of the review was to identify VISN strengths and weaknesses, and create a plan to improve VISN oversight, accountability, performance and strengthen lines of communication with VAMCs within that VISN and VA Central Office (VACO). Based on his extensive leadership experience in the military health system, Dr. Bryan Gamble was asked to lead this review and provide recommendations with the goal of informing the redesign process.

Within the Veterans Health Administration (VHA), at times, functional alignment among VACO, VISNs and VAMCs has not always been clear. Our goal is to streamline business processes, ensure clearly defined roles, responsibilities and authorities among all levels in VHA, so that we are functioning in a way that is more efficient, produces better results and accountability. We have also been working with our national leadership council to develop a new model of governance to help shape the culture, and set expectations and requirements for improved care for Veterans.

Reorganization

A VISN consists of a geographic area which encompasses a population of veteran beneficiaries. The VISN is defined on the basis of VHA's natural patient referral patterns; numbers of beneficiaries and facilities needed to support and provide primary, secondary and tertiary care; and, to a lesser extent, political jurisdictional boundaries such as state borders. Under the VISN model, health care is provided through strategic alliances among VAMCs, clinics and other sites; contractual arrangements with private providers; sharing agreements and other government providers. The VISN is designed to be the basic budgetary and planning unit of the Veterans health care system.

In 1995, VA adopted a new VISN organizational structure to flatten and decentralize VHA's field organization by replacing 4 regions, 33 networks, and 159 independent VAMCs with 22 VISNs that report directly to the Office of the Deputy Under Secretary for Health for Operations and Management. Since that time, two significant reorganizations have occurred resulting in our current structure of 18 VISNs. In addition to these changes in geographic boundaries, investments have been made to standardize the management and oversight of VISNs. VHA has standardized the organizational makeup of the VISN staff to ensure uniformity, as well as strengthening the oversight and management of these positions from VACO. VHA also created a single organizational chart adopted by each VISN office and implemented Quarterly Network Director reviews, which allows for a formal assessment of a VISN's progress at implementing changes and directives.

Systematic review

Since former Secretary Shulkin's announcement, a team led by Dr. Gamble has visited VISNs 1, 5, 22. To look at best practices, the team also visited consistently high performing VISN 23. This team also completed site visits to VAMCs within the following VISNs: Manchester, NH; White River Junction, VT; Loma Linda, CA; Phoenix and Prescott, AZ; Baltimore, MD; Minneapolis, MN and Washington, D.C. Interviews with leadership and employees were performed; walking tours and in-

spections of facilities were conducted and performance improvement group meetings were attended. There also were employee listening sessions and clinician-only listening sessions that did not include the facility leadership team.

A resounding theme was a dedicated workforce set on providing veterans with the best health care possible, and a clear understanding and willingness from leaders and employees at ALL levels to improve upon deficiencies wherever found. While these three challenged networks are vastly different geographically, the assessment team found common themes across these networks and facilities that included the following opportunities for improvement:

- Inconsistency of Human Resrouces services and hiring;
- Additional emphasis needed on education and training;
- Unintended consequences of Management by Measurement;
- Leadership challenges including turnover, consistency and psychological safety; and
- Employee morale.

VHA is committed to ensuring Veterans get the best care. The findings from this review will be combined with feedback from Network Directors and our on-going modernization effort to formulate the plan for VISN redesign.

Washington DC VA Medical Center OIG Report

One of the key concerns of this committee is the progress of the Washington, DC VAMC. While there is still work to be done, significant progress has been made. In March 2018, the VA Office of Inspector General (OIG) released the report, "Veterans Health Administration - Critical Deficiencies at the Washington DC VA Medical Center." In summary, OIG found that the DC VAMC (within VISN 5) has for many years suffered a series of systemic and programmatic failures that made it challenging for health care providers to consistently deliver timely and quality patient care.

Over the past year, substantial progress has been made on the concerns raised by the OIG. These improvement efforts include:

- Establishment of the Incident Command Center (ICC) at the Washington, D.C. VAMC: ICC implemented a robust oversight process that identified and promptly addressed new supply or equipment shortages. ICC instituted a 24-hour hotline for ordering urgent and emergent medical supplies.
- Assured all patients were safe and none were harmed: VHA's National Center for Patient Safety launched a rapid-response approach with onsite visits, biweekly and weekly calls with the facility and VISN and ensured all patient safety issues were appropriately addressed. As of January 31, 2018, the facility has cleared their backlog of patient safety incident reports.
- Awarded contract to construct a 14,200 square-foot space for Sterile Processing Services. The $8.9 million project will be completed in March 2019. More than $3.1 million in surgical instruments have been purchased to ensure an appropriate inventory based on the needs of the Veterans served and our surgical teams.
- Transitioned inventory to the General Inventory Package: Medical Surgical Primary Inventory has been entered in the system and the periodic automatic replenishment levels are being validated to ensure stock outages do not occur.
- Secured the off-site warehouse to restrict access and protect medical equipment and supplies.
- Eliminated all pending prosthetics consults greater than 30 days, more than 9,000 to zero.
- Ensured ordering of prosthetics is not interrupted by end-of-fiscal-year financial transitions: At the end of fiscal year 2017, there was no disruption of prosthetic ordering due to lack of funds.
- Allocated resources and expedited hiring into Logistics, Sterile Processing Service vacancies: A year ago, Logistics Service at the DC VAMC was understaffed. Today, 54 staff have been hired; with only 7 positions remaining under recruitment. Sterile Processing Service currently has 15 Sterile Processing Service staff vacancies, 10 of which are currently filled with contract staff.

We know looking at how we operate our networks is imperative. To get the type of accountability that is needed, and to ensure the best quality care this Nation can provide our Veterans is delivered, we have to take a critical look at processes, layers and leaders to ensure we do not see the failures that we saw at the Washington, DC VAMC. As VHA and the Washington, DC VAMC move forward, we are putting in place a reliable pathway for all facilities, VISNs, and business lines to escalate high-priority concerns to senior leadership for prompt action and follow-up. We en-

courage all employees to speak up and raise concerns to leadership. They are an integral part of our front-line safety net and we take their concerns seriously.

Conclusion

We look forward to this opportunity for our new leadership and improvement efforts to further 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 Committee's continued support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. This concludes my testimony. My colleagues and I are prepared to respond to any questions you may have.

Prepared Statement of Michael J. Missal

Mr. Chairman, Ranking Member Walz, and members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent report, Critical Deficiencies at the Washington, DC VA Medical Center, and how those findings are indicative of a breakdown of oversight at several levels within the Department of Veteran Affairs (VA).[1] Since becoming Inspector General two years ago, I have made VA leadership and governance issues a priority for our work, recognizing that deficiencies in these areas ultimately affect the care and services provided to veterans and allow significant problems to persist unresolved for years.

BACKGROUND

VA's Veterans Health Administration (VHA) has over 9 million enrolled veterans. It manages the largest integrated healthcare system in the nation, with over 145 VA medical centers (VAMCs) and approximately 1,230 outpatient sites. Oversight for these VAMCs and outpatient sites is the responsibility of 18 regional networks called Veterans Integrated Service Networks (VISNs). VHA established the VISN offices to improve access to medical care and ensure the efficient provision of timely, quality care to our nation's veterans. In 1995, VHA submitted a plan to Congress called Vision for Change that restructured VHA field operations into VISNs. VHA specifically decentralized its budgetary, planning, and decision-making functions to the VISN offices in an effort to promote accountability and improve oversight of daily facility operations.

The OIG has had a longstanding focus of governance issues in VHA. For example, in March 2012, the OIG issued two reports dealing with VISN management and structure: the Audit of VHA's Financial Management and Fiscal Controls for Veterans Integrated Service Network Offices and the Audit of VHA's Management Control Structures for Veterans Integrated Service Network Offices.[2] Our work determined that VHA did not have adequate data to monitor VISN operations or staffing levels. This weakness led to inadequate oversight of VISN operations, a lack of accountability, and noncompliance with policies. Work we have conducted since that time suggests that there continues to be leadership and governance issues between medical centers and their VISN, as well as between VISNs and the VA central office. Strong leadership and governance are critical to not only consistently achieving goals, but also to creating a culture that fosters personal accountability and positive change, frequent and effective communications, and compliance with policies and high-quality standards. Where there are deficiencies in leadership and governance there likely will be a cascade of persistent and pervasive problems like those we found at the DC VAMC. Although the report on that facility is our focus for this testimony, the lessons learned can be applied to VISNs and medical centers across the nation.

A CASE STUDY: THE WASHINGTON, DC VA MEDICAL CENTER

The OIG received information from a confidential source about the Washington, DC VAMC (DC VAMC) in March 2017 alleging that patients and resources were at risk. Due to the seriousness of the allegations and the initial findings, the OIG issued an interim report on April 12, 2017, that included the following findings:[3]

- Inaccurate and underutilized supply, instrument, and equipment inventories that made it difficult to meet healthcare provider and patient needs

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[1] The report was published on March 7, 2018.
[2] Both reports were issued on March 27, 2012.
[3] Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC

- Inadequate product safety recall processes
- Dirty conditions in some clean/sterile storerooms
- Millions of dollars in noninventoried supplies and equipment
- Numerous vacancies in key positions that would make remediation of these conditions difficult

The OIG continued the inspection for the next nine months and reported in March 2018 on significant pervasive problems that affected risks to patient care and safety, service deficiencies that impeded healthcare providers' efforts, lack of control over assets, and leadership failures at multiple levels of VA. The report also details that many management offices at VHA Central Office (VHACO), VISN 5 leaders, and leaders at the DC VAMC had been given reports regarding many of these documented problems but they failed to appreciate the impact on patient care or had failed to take the necessary actions to correct the problems in many cases.[4] Significantly, we did not find any patient deaths or other adverse clinical outcomes relating to these deficiencies, primarily due to the efforts of a number of committed healthcare professionals who improvised as necessary to ensure veterans received the best possible care under the circumstances. The final report contained 40 recommendations addressing deficiencies in multiple core functions of the DC VAMC's operations-all of which were agreed to by VA.

Service Deficiencies Affecting Patient Care

Although the medical center and VISN 5 have taken steps to address the supply chain inventory management issues described in the OIG Interim Report (such as detailing additional personnel to enter data into the authorized inventory system), problems persisted during the time of our inspection in getting supplies, instruments, and equipment to patient care areas when they are needed. The OIG identified wide-ranging factors involving multiple deficiencies across several key services in the medical center, including the following:

- Continuing supply chain and inventory management problems
- Unsafe storage of clean/sterile supplies
- Deficiencies in the Sterile Processing Service
- Backlogs of open and pending prosthetic consults
- Staffing shortages and human resources mismanagement
- Lack of control over assets

Supply Chain and Inventory Management Problems

The Generic Inventory Package (GIP) is the authorized software program used by VHA medical facilities to manage the receipt, distribution, and maintenance of supplies. The DC VAMC was required to use the GIP system until early May 2015 when the facility was directed to implement a new inventory system called Catamaran. However, as noted in the final report, medical center staff informed the OIG that the Catamaran system was never relied upon. Although the medical center had nominally transitioned to Catamaran in May 2015, VHA Procurement and Logistics Office (P&LO) staff were aware by January 2016 that the medical center had reverted to its manual inventory management practices and was not using the Catamaran system. These staff told OIG inspectors that they had no authority over the medical center, could not compel it to comply, and did not escalate the matter to VHA P&LO leaders. VHA subsequently terminated the Catamaran contract. Prior to the OIG receiving the allegations discussed in our report, VA's Policy, Assistance, and Quality (PAQ) staff from the VHA P&LO, conducted a review of inventory management at the medical center. PAQ staff determined in its January 2017 report that the medical center did not have a VHA-authorized inventory system in place.

On March 21, 2017, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) instructed the VISN 5 Director and the Medical Center Director via an emailed memo to provide an action plan addressing the PAQ concerns. Staff were detailed to the DC VAMC to take corrective action. Despite those efforts, the concerns were not adequately addressed and the OIG final report provided many examples of how inventory mismanagement contributed to the lack of medical supplies being available where and when they were needed, including oxygen nasal cannula tubing, disposable surgical staplers, and tubing for blood transfusions.

We continued to find ongoing inaccuracies in the data entered in GIP. Even for a small number of items, the medical center could not reconcile its actual inventory with the data in GIP. As a result of the medical center's underutilization of GIP

[4] VISN 5, VA Capitol Health Care Network, includes the Washington, DC VAMC.

(estimates of 15–25 percentage of items included), it could not rely on the system to identify when supplies were running low or out of stock.[5] The product recall process was also vulnerable because an accurate inventory was not kept. The medical center did institute a stop-gap measure to deal with supplies that may have been subject to a recall, but that was inadequate because Logistics Service and clinical staff had no way of verifying that all specified items had been removed from use. Without an accurate inventory, there is a heightened risk to patients that recalled products could be mistakenly used. In addition to patient risks associated with the medical center running out of supplies or using recalled products being elevated, the lack of accurate stock levels contributed to urgent reordering, some overstocking, and waste of government resources.

Unsafe Storage of Clean/Sterile Supplies

To advance both patient safety and sound financial management, inventoried items must be secured and maintained in clean conditions. Proper storage of clean/sterile supplies is essential to preventing contamination and patient infections, as well as product deterioration. According to VHA directive, to maintain supplies properly, clean/sterile storerooms must have stable temperature and humidity, restricted access, weekly shelf-cleaning by Logistics Service staff, and solid bottom shelves at least eight inches from the floor. Logistics Service staff must sign a weekly log stating that the area has been checked for expired supplies, cleanliness, and damage. While Logistics Service staff have responsibility for some specific cleaning tasks in clean/sterile storerooms, the Environmental Management Service (EMS) is responsible for the overall cleanliness of the rooms.

EMS and Logistics Services reported having difficulties hiring and retaining qualified staff. VISN 5 knew of the staffing shortages in EMS in early fiscal year (FY) 2017 and knew of the Logistics Service staffing issues as early as 2014 from an external consultant's report. However, adequate steps to remedy the deficiencies were not taken.

After our interim report, we noted some improvements in the cleanliness of storage rooms. The medical center had entered into a contract with a commercial cleaning service in June to supplement the medical center EMS staff but some areas were still of concern. As of September 2017, the Acting Human Resources Director reported to the OIG that 138 of 147 authorized EMS positions were filled.

Deficiencies in the Sterile Processing Service

The OIG detailed multiple deficiencies in the Washington DC VAMC's Sterile Processing Service (SPS). These ranged from broken and discolored instruments reaching clinical areas; incomplete surgical trays in the operating room; improper tracking and reprocessing procedures for loaner instruments; missing or expired SPS supplies; failure to follow reprocessing instructions; inadequate documentation of staff competencies; and not separating clean and dirty items in satellite reprocessing areas.

These problems were not new. Prior reviews were shared with the medical center, the VISN, and VHACO that consistently revealed deficiencies in SPS processes and procedures, staffing and leadership within SPS, and environment of care concerns that dated back to at least 2015. The National Program Office for Sterile Processing reported concerns in April 2015, September 2015, and October 2016. The October 2016 report had 140 corrective actions including some repeat findings. In response to why conditions were uncorrected for so long, SPS managers cited chronic understaffing of SPS and difficulties retaining qualified personnel.

In November 2017, the OIG received a complaint about cancellation of nine surgeries at the medical center. The OIG confirmed the cancellations and that the medical center had reported to VHACO that spotting and discoloration were found on some instruments. A contractor was hired and examined 8,931 pieces of equipment and instruments over a two-day period. The contractor reported finding rust on about 30 instruments; those items were polished and returned to service. On further inspection the same contractor recommended replacing 216 instruments. Our report found that historically even when new instruments were purchased, they could not always be reprocessed appropriately nor were they always stored appropriately. In its response to the OIG report, VA stated that it purchased more than $3 million in surgical instruments and contracted to construct additional space for SPS.

Backlog of Open and Pending Prosthetic Consults

[5] In response to OIG findings, VA has reported that the DC VAMC has transitioned inventory to the GIP system and addressed stock levels, which will be assessed in OIG's follow-up process.

VHA requires that quality patient care be provided by furnishing properly prescribed prosthetic equipment, sensory aids, and devices in an economical and timely manner. To order a prosthetic appliance or implant, a medical center provider must initiate and submit a consult (a request for an item that allows for subsequent tracking) in the electronic health record to the Prosthetics Service.

A prosthetic consult is considered "closed" when a patient receives an in-stock item, a purchasing agent ships an in-stock item to the patient, or a purchasing agent places an order with a vendor for a nonstocked item to be shipped directly to the patient. A prosthetic consult is placed in a "pending" status if other actions must be taken before the consult can be completed and should be documented in the prosthetic consult to allow for tracking through completion. VHA business practice guidelines for prosthetic consult management states that pending prosthetic consults "must be reviewed at least weekly by the Chief, [Prosthetic and Sensory Aids Services] and the Prosthetic employee responsible for completing that consult." VHA requires the closure of pending prosthetic consults upon the earlier of 45 working days or 60 calendar days.

Medical center and VISN 5 leaders became aware of the increasing number of open and pending prosthetic consults in May 2016 but due to incomplete administrative actions by the medical center leaders to provide access to its systems, VISN 5 could not take the necessary steps to provide assistance in addressing the increasing number of open and pending prosthetic consults.

To resolve the consults backlog identified by the OIG, the Acting Medical Center Assistant Director reported VA had efforts in progress to hire staff, redesign the organizational structure, claim 2,000 square feet of warehouse space for inventory, and develop a walk-in clinic. In addition, he reported that nine purchasing agents had been assigned from across VHA to assist with resolving open and pending prosthetic consults.

On August 29, 2017, OIG staff spoke with the Acting Chief of Prosthetics who confirmed that through the use of additional staffing, the medical center had been able to reduce the number of prosthetic consults to approximately 6,130, of which 3,800 were more than 30 days old. Also in August, the DC VAMC chartered an Administrative Investigative Board to determine accountability for the failures identified within the Prosthetics Service. In its response to our final report, VHA stated that "as of January 2018, the DC VAMC had no pending prosthetics consults over 30 days." We will verify this information during our follow-up process.

Staffing Shortages and Human Resources Mismanagement

Medical center personnel often attributed deficiencies in Logistics Service and SPS to chronic understaffing. To obtain additional staff, the medical center's policy specifies that Service Chiefs must determine the minimum number of positions needed to perform the functions of their services and submit requests for new positions or changes in the grade of already approved positions to the Resource Management Committee (RMC). The Associate Director of the medical center chairs the RMC, which makes recommendations to the Director regarding approval or disapproval of these requests, based in part on budgetary considerations. The medical center Human Resources Management (HR) is responsible for executing actual hiring actions.

The OIG determined that Logistics Service and SPS had experienced historically high vacancy rates. A number of factors contributed to these rates, including a failure to maintain accurate data on the numbers of authorized positions throughout the medical center; the RMC not performing its duties in accordance with policy; and HR not completing hiring actions appropriately.

The OIG confirmed that high turnover rates in HR leadership may have contributed to the failure to resolve staffing issues. VHACO and VISN 5 provided teams and personnel to support the medical center's general HR functions, but the DC VAMC did not implement action plans developed from those consultative site visits.

VA reports progress in hiring but vacancy rates for SPS staff are still high at the medical center, although VA reports some of those positions being filled by contractors in their response to the OIG report.

Lack of Control Over Assets

The medical center continually mismanaged significant government resources and did not adequately secure veterans' protected information. Its financial and inventory systems produced inadequate data, lacked effective management controls, and yielded no reasonable assurance that funds were appropriately expended. Accordingly, the OIG could not estimate the loss to VA as a result of the failings identified in the final report. A number of examples are provided in the report, however, that show significant overpayments for particular products; unsecured access to and mis-

management of more than 500,000 items accumulated in an off-site warehouse that included purchases not meeting medical center needs, overstocked items, and some items that appeared damaged; abuse of purchase cards; and other failures to use taxpayer dollars appropriately.

The following are examples of how government resources were at risk for or subject to fraud, waste, and abuse:

- There was excessive use of government purchase cards for medical equipment and supply purchases (89 percent of the medical center's total purchase card use was for medical supplies) instead of approved federal contracts that leverage buying power and helped ensure appropriate pricing and purchasing. Purchase card use was not as closely scrutinized and did not take advantage of the typically lower prices associated with buying under federal contracts. They were misused, in part, because leaders failed to ensure proper controls or fix an inventory system-which sometimes led to urgent purchases needing to be made on purchase cards for quick delivery as a workaround for supply problems.
- The VISN 5 Agency/Organization Program Coordinator (A/OPC) for the purchase card program reported potentially fraudulent purchase orders to medical center leaders and the Chief of Prosthetics in September 2016. After no action was taken by either, the VISN 5 A/OPC took action to reduce a purchasing agent's limit and initiated an audit. Also VA policy limited the number of purchase card accounts for which an approving official is responsible to not more than 25. At the medical center, the Chief Logistics Officer (CLO) was responsible for approving expenditures made by all of the 86 cardholders.
- A general lack of controls was found over acquisition of medical supplies and equipment, including the inability to consistently provide documentation such as purchase orders, invoices, receiving reports, or other item-level records required for proper auditing. For example, the medical center incurred nearly $875,000 in rental fees for three specialized hospital beds for patients' in-home use that could have been purchased new for a total of about $21,000.
- The medical center failed to segregate duties so that the same individual was not both purchasing and receiving or inventorying goods to ensure the integrity of procurement processes and prevent theft or abuse.
- The medical center lacked an updated and accurate inventory for nonexpendable equipment. VA requires medical facilities to perform an annual physical inventory of all nonexpendable items and maintain an Equipment Inventory List (EIL). EIL includes all nonexpendable property with assigned numbers that correspond to the responsible department. Although the EIL Custodial Officer is responsible for completing and signing the EIL, the Medical Center Director and CLO (or their designee) must ensure accountability and oversight for all nonexpendable property and equipment in their facility. The Medical Center CLO failed to submit data for the VHA Quarterly EIL reports for three years. Furthermore, a March 2017 memo from the DUSHOM to the VISN Director and the Medical Center Director stated that Reports of Survey listing lost or stolen property had not been completed for more than five years.
- Because of failures in Records Management, more than 1,300 boxes of unsecured documents, including some patient protected health information and personally identifiable information were found in various locations including the off-site warehouse, on-site storage, the DC VAMC basement, and a dumpster.

Risks to Patient Care

It is clear that functions typically thought of as administrative in nature can have a profound impact on the ability of healthcare providers to do their jobs effectively and on the risk of harm to patients. During extensive interviews conducted by the OIG's Rapid Response Team and other personnel, 13 healthcare providers stated that they had reported their concerns to the Chief of Surgery and 12 healthcare providers stated that they had reported supply, instrument, or equipment concerns to the Medical Center Chief of Staff. As I will discuss further, these and other issues at the DC VAMC were reported to the VISN and by program offices within VA.

For our review, OIG healthcare staff independently reviewed the care provided to 124 DC VAMC patients to determine if they experienced adverse clinical outcomes because their healthcare provider did not have the appropriate supplies, instruments, or equipment. As discussed earlier, while the OIG did not find that patients suffered adverse clinical outcomes for the review period, staff provided several examples that illustrated an impact on patients when supplies, instruments, and equipment were not available when needed. These included unnecessary anesthesia, prolonged procedures or hospitalizations, and alternative surgical techniques due to failure to ensure the availability of instruments or supplies. For example, a

"mesher" used to place small holes in the skin to assist with drainage had a missing handle and the surgeon needed to conduct the procedure manually, which can result in uneven drainage. In some cases, procedures needed to be delayed, rescheduled, or required staff to leave the facility to borrow what was needed from a nearby private hospital. For example, an instrument was not sterilized since its last use and was unavailable to the surgeon after the patient received general anesthesia, resulting in the procedure being cancelled and rescheduled two days later, which unnecessarily exposed the patient to the risks associated with the anesthesia. In another case, staff went "across the street" to a medical facility to acquire mesh while the operation was ongoing. We found that staff lacked confidence that managers and leaders overseeing the facility would fix these problems and resorted to creating their own workarounds to ensure patients received proper care.

Patient Safety Reports

Patient safety reports allow for the reporting and tracking of adverse events and "close calls" as well as allowing VA medical facilities to identify and address unsafe conditions. For the interim report review, OIG staff found 193 patient safety reports at the DC VAMC since January 1, 2014, were entered into VHA's National Center for Patient Safety (NCPS) database. However, we determined that the number of patient safety events was under-reported and at least 376 patient safety events related to supplies, instruments, or equipment were reported within the medical center. Of those, 206 patient safety events were entered into the facility's system, but were not entered into the VHA database as required. Overall, the DC VAMC failed to appropriately score, trend, and record patient safety events and the patient safety manager did not properly identify that further analysis was warranted.

Within an individual medical center, the patient safety manager can identify emerging trends that could potentially compromise patient safety through event reporting and analysis. At the national level, the VHA NCPS analyzes data reported from all medical facilities to identify emerging trends that have the potential to compromise patient safety in multiple facilities. At DC VAMC, although data were available, the patient safety manager did not detect the widespread nature of the supply, instrument, and equipment problems until June 2016, when an individual root cause analysis was conducted on an incident involving the use of expired surgical supplies during a surgical procedure.

Other mechanisms for aggregating information to inform VISN and medical center leaders about emerging issues include the work of quality management and safety committees. The OIG conducted an extensive review of meeting minutes from the Executive Committee of the Governing Body (ECGB), which is responsible for oversight of critical quality and patient safety monitors, and its subordinate committees. The ECGB oversees the Medical Executive Committee and Quality Council as well as other organizational patient safety and performance improvement initiatives.

VHA policy requires the ECGB to keep minutes that describe and track issues to resolution, as well as to make recommendations to leaders. The OIG review of minutes from October 2015 through April 2017 revealed a pattern of reporting and oversight deficits. In addition to the ECGB meeting minutes, the OIG reviewed meeting minutes of other committees that provide oversight for patient safety and performance improvement initiatives. Review of the Director's morning report also revealed a lack of appropriate follow-up actions for surgical instrument issues.

The OIG confirmed through interviews and analyses of documents provided that action plans, if implemented, were not consistently effective at resolving issues as evidenced by ongoing deficiencies in many areas. The VISN Quality Management Officer who has responsibility for overseeing all aspects of quality management and performance improvement at VISN 5 facilities acknowledged these concerns in an interview with OIG staff, and reported that he would be "pushing for a rapid process improvement initiative." VA has also reported that following our findings, the DC VAMC cleared its backlog of patient safety incident reports.

Failures in Leadership

It is clear that information and documentation outlining some, if not most, of the failings in the medical center reached responsible officials in DC VAMC, VISN 5, and VHACO as early as 2013, but actions taken did not effectively remediate the conditions.

From 2013 through 2016, the DC VAMC and VISN 5 received at least seven written reports detailing significant deficiencies in Logistics, Sterile Processing, and other Services, many of which were identified as persistent at the time of the OIG 2017 on-site visits.

- Management Quality Assurance Service (MQAS) Report (2013) - This report evaluated the performance of selected areas of logistics operations and identified areas requiring improvement. This report was provided to the Medical Center Director in January 2013 as well as VHACO Procurement and Logistics Office (P&LO) and VISN 5 leaders. It contained 52 conditions including nine repeat findings and two concerns related to compliance with VA and VHA directives that required management attention.

There was an exchange of information between MQAS and the Medical Center Director in March and May 2013 but in December 2013, MQAS staff emailed medical center staff requesting an update as the completion dates were past due. Again in February 2014, MQAS staff reached out for an update but the Medical Center did not respond. In June 2014, MQAS requested assistance from VHA P&LO. VHACO contacted the VISN CLO for an update and to offer assistance. Moreover, the VISN 5 CLO admitted that the VISN "may have dropped the ball on response." In October 2014, MQAS advised the VISN 5 CLO that they would elevate these issues if the DC VAMC did not provide information. The medical center responded in piecemeal fashion. In December 2015, MQAS determined based on representations from the Medical Center, that all but one recommendation was satisfied. As late as February 2017, MQAS continued to follow up with DC VAMC Logistics Service for required reports.

- VISN 5 Network External Review (NER) (2013) - Each VISN was required to conduct an annual review of its facilities' logistics operations. In May 2013, the VISN Director sent the Medical Center Director the NER relating to Logistics Service containing 55 observations including a finding that the medical center was not using GIP to manage its inventory. In June 2013, the Associate Medical Center Director responded and provided estimated implementation dates for each of the 55 areas.
- VISN 5 Consultant Report (2013) - In December 2013, at the direction of VISN 5, a consultant reviewed the medical center's Facility Management Service and Safety Programs. The report was presented to medical center leadership and detailed numerous concerns, including that "the Sterile Processing Service (SPS), a high visibility program with critical responsibility toward patient safety, is working in an area that was identified to be outside of required environmental controls (humidity), and environmental monitoring is not being consistently or continuously conducted." In addition, the consultant noted that documentation of SPS staff competencies was not available. The OIG is unable to determine what remedial efforts were made, if any. Any improvements were not sustained because the SPS deficiencies identified in the 2013 Consultant Report persisted at the time of the 2017 OIG site visits.
- VISN 5 Logistics Study (2014) - VISN 5 engaged an external consultant to study Logistics Service operations within its facilities in 2014. After reviewing the consultant's observations, the VISN noted the DC VAMC's Logistics Service staffing was significantly lower than similar facilities and the facility had high staff vacancy rates in both the expendable supply and nonexpendable equipment Logistic Service. The medical center's CLO attempted to increase staffing but contended efforts were impeded by a lack of support from the medical center's HR staff. The OIG identified emails alerting the leadership of this issue.
- Nursing Report (2016) - VISN 5 reviewed nurse staffing and related issues in its facilities in 2016. In May 2016, the VISN shared the results with the DC VAMC Director, which included the facility was short approximately 98 nurses and the supply chain was broken. The Medical Center Director acknowledged the vacancies and commented that there were no sentinel events at the facility.
- National Program Office on Sterile Processing (NPOSP) Reports (2015 and 2016) - In April 2016, the medical center reported it had "closed" (satisfied) 25 of 28 recommendations arising out of the September 2015 site visit. The medical center reported that it planned to resolve two recommendations on or before May 20, 2016, and that the final recommendation relating to workflow would be addressed during a renovation of SPS planned for 2017. However, a repeat visit from NPOSP in October 2016 identified recurring issues previously reported as resolved, including environmental issues, lack of SOPs, and inadequate documentation of staff competencies. NPOSP issued additional recommendations, some of which were repeat findings from the 2015 visits.

In response to the October 2016 NPOSP recommendations, the medical center submitted another detailed action plan on December 9, 2016, with periodic progress updates thereafter. Documentation shows that the medical center updates falsely reported that some action items identified in the NPOSP 2016 visit had been com-

pleted, resulting in VISN 5 reopening an action item in April 2017 previously reported as corrected.

The chronic medical center deficiencies noted in the 2013–2017 reports speak to leaders' at various levels inability or unwillingness to implement and sustain lasting change within various services.

Ineffective Follow Up

Turnover and inadequate governance affect remediation. For example, in terms of staffing, the DC VAMC has had five Associate Directors since 2013, most of who assumed the role in an acting capacity. The Associate Director is responsible for the managerial and administrative services and operations that are the subject of the report, including Logistics Service, HR, Fiscal Service, and EMS. Lack of consistent leadership in this key role since December 2015 made it more likely that the medical center managerial and administrative deficiencies would remain unaddressed.

Many recommendations from previous reports concerning the sterile processing of instruments and Logistics Service functions were deemed implemented or "closed" but were not effectively addressed. VISN 5 leaders and some VHACO personnel were aware of many of the problems identified and did not ensure that adequate corrective action had been taken by the medical center to address them. Methods used by the VISN and VHACO to oversee the medical center were either inadequate or did not include accurate or complete data on key aspects of medical center operations. As the Director of VISN 5 acknowledged, the VISN responsibility should be to intervene when it has notice of a problem. Or, as the Director bluntly conceded, "the buck stops with him."

There has been significant focus recently on the ratings given by the Strategic Analytics for Improvement and Learning (SAIL). The DC VAMC was rated a 2-star (slightly below average) rating from 2011 through the third quarter of FY 2015, and then improved to a 3–Star (average) rating, maintaining that rating through March 31, 2017.[6] The SAIL rating is based on clinical measures but does not include supply chain inventory and logistic issues even though such functions have clinical impact. The SAIL model incentivizes facilities to take action to improve the quality of care, however its minimal focus on administrative functions that support patient care can leave patients vulnerable.

Our report also found that VHACO receives information daily from medical centers and VISNs to inform policymaking, but that information is not always shared with officials who can take action to remedy the deficiency.

OTHER OIG WORK ASSESSING LEADERSHIP AND GOVERNANCE

We seek to address in all of our work-whether an audit, review, or inspection-the underlying cause (or causes) of the identified condition and who is responsible. This focus has revealed that there is often a lack of oversight for compliance with policies and procedures, reporting mechanisms are not reliable, and operations are not effective or efficient.[7]

One specific example is the change we made in April 2017 regarding our cyclical review of VAMCs. We now include a review section on the leadership at the facility when conducting our Comprehensive Healthcare Inspection Program (CHIP) reviews. We provide a descriptive evaluation of VHA facility leadership performance and effectiveness as evidenced by the reduction of organizational risks and provision of quality care that result in positive patient outcomes and experiences and optimal levels of employee engagement and satisfaction. Our work will continue to examine leadership and governance issues throughout VA.

CONCLUSION

We found critical deficiencies in our inspection of DC VAMC. Although the findings and recommendations focus on improvements in that facility, the issues raised could be used almost as a checklist for other facilities, VISNs, and VHA leaders.

While the concrete deficiencies present significant challenges, we believe the greatest obstacle to change is the sense of futility or culture of complacency among some staff and leaders. At the core, the DC VAMC report is about the breakdown

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[6] VA no longer publishes star ratings but based on SAIL data, the facility is currently between 1 and 2 stars.

[7] Healthcare Inspection - Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma, November 2, 2017; Review of Research Service Equipment and Facility Management, Eastern Colorado Health Care System, March 29, 2018; Audit of Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls, May 7, 2018.

of systems and leadership at multiple levels, and an acceptance by many personnel that things will never change. This was evidenced by

- staff that got used to "making do,"
- acceptance or normalization of non-compliant practices,
- acceptance of information/data at face-value without asking the next question, and
- willingness to rationalize poor practices with "nobody's been harmed."

We fervently believe that VHA has talented and committed people that could lead the turnaround at the DC VAMC and other facilities. We saw healthcare professionals and other staff making significant efforts to ensure patients were safe and receiving quality care by using workarounds or trying to do the right thing. With time and concerted effort, we know that positive change can be realized. VHA needs to recognize the urgency in making strong leadership decisions now to oversee that change.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.

Prepared Statement of Roscoe G. Butler

Chairman Roe, Ranking Member Walz, and distinguished members of the Committee; on behalf of National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime service organization for veterans, comprised of more than 2 million members, and serving every man and woman who has worn the uniform for this country, we thank you for inviting The American Legion to testify today to share our position regarding the current status of remedial actions at VISNS 1,5, and 22.

Background

In 1994, the Veterans Health Administration (VHA) was structured into four regions, and individual VA medical centers reported directly to VHA for budgeting and program management purposes. At that time, VHA was responsible for the care of approximately 25 million veterans.

Each region was led by a region director located in the field (Linthicum, MD; Ann Arbor, MI; Jackson, MS; and San Francisco, CA). The four region directors supervised the operation of the medical care facilities in their regions (which ranged from 36 to 45 facilities per region).

The veterans health care system is the largest health care system in the United States, although it is an anomaly in American health care in so far as being a centrally administered, fully integrated, national health care system that is both funded and operated by the federal government. As it grew in size and complexity, the system became increasingly cumbersome and bureaucratic. It was often perceived to be unresponsive to individual needs and changing circumstances. It seemed to be chronically underfunded and short of staff and supplies, despite its rising costs. By the mid-1990s, the system was widely criticized for being difficult to access, for having long wait times and poor service, for providing care of unpredictable and irregular quality, and for being inefficient and expensive. Many policymakers and health care professionals questioned whether it had a future. [1]

By 1994, the VA had grown to be the country's largest health care provider, with an annual medical care budget of $16.3 billion; 210,000 full-time employees; 172 acute care hospitals, which had 1.1 million admissions per year; 131 skilled nursing facilities, which housed some 72,000 elderly or severely disabled adults; 39 domiciliaries (residential care facilities), which cared for 26,000 persons per year; 350 hospital-based outpatient clinics, which had 24 million annual patient visits; and 206 counseling facilities, which provided treatment for posttraumatic stress disorder (PTSD). The VHA also partnered with almost all states to fund state-owned skilled nursing facilities for elderly veterans and administered a contract and fee-basis care program paying for $1 billion of out-of-network services each year. [2]

[1] Kizer KW, Dudley RA. Extreme makeover: Transformation of the veterans health care system. Annu Rev Public Health. 2009;30:313–39. doi: 10.1146/annurev.publhealth.29.020907.090940.

[2] Kizer KW, Dudley RA. Extreme makeover: Transformation of the veterans health care system. Annu Rev Public Health. 2009;30:313–39. doi: 10.1146/annurev.publhealth.29.020907.090940.

The VHA was a system based on inpatient care, in contrast to substantially less expensive and patient-friendly ambulatory care. Specialists rather than primary-care physicians dominated the workforce. Finally, like many publicly funded health systems throughout the world, the client base was increasingly needy and growing in numbers.

There was widespread consensus that the veterans health care system needed a major overhaul but little agreement about how to effect the change. Further, the system had to remain fully operational while it was being overhauled.

In 1994, President Bill Clinton appointed Dr. Kenneth Kizer as VA Undersecretary for Health. Dr. Kizer inherited an organization famous for low quality, difficult to access, and high-cost care.[3] Under new leadership recruited from outside the system-the first time this had occurred in more than 30 years-a plan to radically transform VA health care was developed in the winter of 1994–1995, vetted with the Congress (as required by law) and the VA's myriad stakeholders in the spring and summer of 1995, and launched in October 1995.[4]

In March 1995, Dr. Kizer submitted a plan to Congress titled The Vision for Change - A Plan to Restructure the Veterans Health Administration.[5] The reorganization plan was the first step in VHA becoming a more efficient and patient-centered health care system.

This new structure intended to decentralize decision-making authority regarding how to provide care and integrate the facilities to develop an interdependent system of care through a new structure - the Veterans Integrated Service Network (VISN). The VISN's primary function was to be the basic budgetary and planning unit of the veterans' health care system.

Dr. Kizer's plan suggested that the number of staff needed to manage a VISN would range between seven and ten full-time employees initially, which over the years ballooned to 220 employees working at the VISN. The geographical boundaries for each new VISN were defined based on natural patient referral patterns at VA medical centers and outpatient clinics, the number of enrolled veterans in the system, and the type of facilities needed to provide care.[6]

In September 1995, Congress authorized VA to implement the plan. The 22 network directors were officially named on September 21, 1995. VISN Directors began assuming their new positions in October 1995, and all were on board by January 29, 1996. The transition of operations from the regional offices to the networks commenced in October 1995.

In October 1995, the restructuring of VHA headquarters also begun. Restructuring included eliminating certain positions and offices, reorganizing other offices and functions, and establishing new offices of Policy, Planning and Performance; Chief Information Officer; and Employee Education. In addition, the Chief Network Officer became part of the integrated Office of the Under Secretary for Health.

At the same time VHA was tasked with implementing Dr. Kizer's VISN for Change, it also had the daunting task of implementing one of the most dramatic legislative changes impacting veterans health care in the 20th century, The Veterans' Health Care Eligibility Reform Act of 1996.[7] This law was enacted to help VA improve its management of care and provide this care in more cost-effective ways; it also sought to increase veterans' equity of care. To improve cost-effectiveness, the act allowed VA to provide needed hospital care and health care services to veterans in the most clinically appropriate setting.

Since then, VISN staff and functions have expanded way beyond the original intent of Dr. Kizer's Vision for Change. Since the creation of VISNs in 1995, there has been a significant shift in veterans' demographics and geographically where they access care; however, VA has not reassessed the VISN structure.

In September 2016, the Government Accountability Office (GAO) issued a report entitled VA Health Care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed. GAO reported that internal and external reviews of VHA operations have identified deficiencies in its organizational structure and recommended changes that would require significant restructuring to address, including eliminating and consolidating program offices and reducing VHA central office staff. However, VHA does not have a process that ensures recommended organi-

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[3] https://rogerlmartin.com/docs/default-source/Articles/incentives-governance/aligningthestars

[4] Kizer KW, Dudley RA. Extreme makeover: Transformation of the veterans health care system. Annu Rev Public Health. 2009;30:313–39. doi: 10.1146/annurev.publhealth.29.020907.090940.

[5] https://www.va.gov/HEALTHPOLICYPLANNING/vision—for—change.asp

[6] https://www.burr.senate.gov/imo/media/doc/VISNAct.pdf

[7] https://www.congress.gov/bill/104th-congress/house-bill/3118

zational structure changes are evaluated to determine appropriate actions and implemented. [8]

For example, VHA chartered a task force to develop a detailed plan to implement selected recommendations from the independent assessment of VHA's operations required by the Veterans Access, Choice, and Accountability Act of 2014. [9] It found, among other things, that VHA central office programs and staff had increased dramatically in recent years, resulting in a fragmented and "siloed" organization without any discernible improvement in business or health outcomes. It recommended restructuring and downsizing the VHA's central office. [10] The task force of 18 senior VA and VHA officials conducted work over six months, but did not produce a documented implementation plan or initiate implementation of the recommendations. Without a process that documents the assessment, approval, and implementation of organizational structure changes, VHA cannot ensure that it is making appropriate changes, using resources efficiently, holding officials accountable for taking action, and maintaining documentation of decisions made.

In October 2015, VHA began to implement a realignment of its VISN boundaries, which involves decreasing the number of VISNs from 21 to 18 and reassigning some VA medical centers (VAMC) to different VISNs. VHA officials anticipate this process will be completed by the end of fiscal year 2018. VHA officials on the task force implementing the realignment told GAO they thought VISNs could implement the realignment independently without the need for close monitoring. VHA also did not provide guidance to address VISN and VAMC challenges that could have been anticipated, including challenges with services and budgets, double-encumbered positions (two officials in the same position in merging VISNs), and information technology. Further, VHA officials said they do not have plans to evaluate the realignment. VHA's actions are inconsistent with federal internal control standards for monitoring (management should establish monitoring activities, evaluate results, and remediate identified deficiencies) and risk assessment (management should identify, analyze, and respond to changes that could affect the system). Without adequate monitoring, including a plan for evaluating the VISN realignment, VHA cannot be certain that the changes are effectively addressing deficiencies; nor can it ensure lessons learned can be applied to future organizational structure changes.

In March 2018, former VA Secretary David Shulkin announced his plan to reorganize the department's central office by May 1. [11] May 1st has come and gone, but the reorganization has not occurred. A statement from Dr. Shulkin's March 2018 release, he stated:

"The VISN model was put in place close to 20 years ago, a very innovative model that has served VA well," Shulkin said. "But like any business, the times change, the needs change and it's time for us to look at how we operate our networks differently to get the type of accountability that's needed to make sure we don't see the failures that we saw here in the Washington, D.C. VA."

Dr. Shulkin also discussed the appointment of a special team to work with its national leadership council to develop a nationwide reorganization plan for its 23 VISNs, which was due to the secretary by July 1. [12]

On March 8, 2018, Dr. Shulkin announced the appointment of a new executive in charge, Bryan Gamble, to oversee three VISNs: the New England Health Care System and the Capitol Health Care Network, which includes Washington, D.C., and parts of Maryland and Virginia, as well as the Desert Pacific Healthcare Network in California, New Mexico and Arizona. [13]

The Way Forward

The purpose for creating the VISN structure was to decentralize decision-making authority regarding how to provide care and integrate the facilities to develop an interdependent system of care through the VISNs. The VISN's primary function was to be the basic budgetary and planning unit of the veterans' health care system. However, as we all know, the VISN structure has morphed into a broader operation, consuming more staff, resources, funding, and physical space.

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[8] GAO report (Oct 27, 2016): VA Health care: Processes to Evaluate, Implement, and Monitor Organizational Structure Changes Needed

[9] https://www.congress.gov/bill/113th-congress/house-bill/3230

[10] https://www.va.gov/opa/choiceact/documents/assessments/integrated—report.pdf

[11] https://www.usatoday.com/story/news/politics/2018/03/07/va-chief-consolidates-oversight-23-va-hospitals-start-restructuring-effort/404632002/

[12] https://www.dav.org/learn-more/news/2018/va-secretary-announces-immediate-transformations-in-wake-of-scathing-ig-report/

[13] https://federalnewsradio.com/veterans-affairs/2018/03/shulkin-promises-reorganization-plan-for-va-central-office-after-troubling-ig-report/

As more veterans enrolled in the VA health care system, the VISN responsibility for budget and planning increased and it became more difficult for the VISN to manage. Reoccurrence of system- wide failures are becoming routine that are attributable to leadership failures at the VAMC, VISN and Central Office level. According to the March 7, 2018 VAOIG report citing Critical Deficiencies at the Washington DC VA Medical Center, the VAOIG cited numerous failures at the Washington DC VA Medical Center, the VISN, and VA Central Office.[14] Medical Center, VISN 5, and some VACO leaders knew for years about at least some of the problems outlined in the VAOIG report. The report stated information and documentation outlining some of the failings in the Medical Center reached responsible officials in the Medical Center, VISN 5, and VACO as early as 2013, but there where failures at multiple levels of leadership, in accountability, responsibility, and oversight. This lack of ownership and a pervasive practice of shifting blame to others contributed to a culture of complacency and neglect that placed both patients and assets of the federal government at risk.

Clearly, Dr. Kizer's VISN model is no longer living up to expectations, but rather has grown into a high cost ineffective operation.

In 2016, The American Legion membership voiced serious concerns about the effectiveness of the VISNs and passed Resolution 194, entitled Department of Veterans Affairs Veteran Integrated Service Networks. The resolution urges Congress to direct the GAO and VAOIG to conduct a comprehensive study to include purpose, goals, objective, budget and evaluation of the effectiveness of the VISN structure.[15]

The American Legion applauds former Secretary David Shulkin for proposing to look into reorganizing the VISN and VA Central Office. The American Legion believes that the Central Office and VISN realignment is in keeping with Resolution 194, and should continue its course with Veteran Service Organizations being consulted throughout the process to ensure, from a veteran perspective, their concerns are addressed.

Conclusion

As always, The American Legion thanks this Committee for the opportunity to elucidate the position of the 2 million veteran members of this organization. For additional information regarding this testimony, please contact Assistant Director of the Legislative Division, Jeff Steele, at (202) 861–2700 or jsteele@legion.org.

Statements For The Record

U.S.Office of Special Consel, Henry J.Kerner Special Counsel

January 25, 2018

The President The White House
Washington, D.C. 20500
Re: OSC File Nos. DI–16–5687. DI–16–5688, DI–16–5689, and DI–16–5690

Dear Mr. President:

Pursuant to 5 U.S.C. §1213(e)(3), I am forwarding reports from Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Department of Veterans Affairs (VA), VA Medical Center Manchester (VAMC Manchester), Manchester, New Hampshire. The four whistleblowers in this matter, Dr. Ed Kois, Dr. Stuart Levenson, Dr. Ed Chibaro, and Dr. Erik Funk (the whistleblowers), who consented to the release of their names, disclosed that a large number ofVAMC Manchester patients have developed serious spinal cord disease as a result of clinical neglect at the VA; that the former Chief of the Spinal Cord Unit, Dr. Muhammad Huq improperly copied and pasted patient chart notes for over 10 years; and that VAMC Manchester's operating room (OR) has repeatedly been infested with flies.

These cases are representative ofVA's ongoing difficulties in providing appropriate and expeditious patient care and appear to demonstrate issues with VA' s efforts to ensure allegations are appropriately reviewed. The agency reports received by the Office of Special Counsel (OSC) were not fully responsive and were frequently evasive in their reluctance to acknowledge wrongdoing.[1]

[14] https://www.va.gov/oig/pubs/VAOIG–17–02644–130.pdf

[15] American Legion Resolution No. 194 (2016): Department of Veterans Affairs Veteran Integrated Service Networks

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a

It appears that the VA acknowledged and responded to confirmed wrongdoing after the publication of a July 15, 2017, Boston Globe article based on information provided by the individuals identified above and others.[2] The VA was on notice of these allegations when OSC referred them for investigation in early January 2017, but did not take any action to remove responsible management officials or initiate a comprehensive review of the facility until after the Boston Globe article was published in July. This sends an unacceptable message to VA whistleblowers that only the glaring spotlight of public scrutiny will move the agency to action, not disclosures made through statutorily established channels.

1 Background

The whistleblowers' allegations focused on the care of patients with a serious spinal cord condition known as myelopathy. They noted that despite the significant decline in prevalence of this condition in the general population of the United States, 100 out of approximately 170 patients treated in the VAMC Manchester Spinal Cord Unit had some degree of myelopathy. The whistleblowers attributed this high incidence to a number of factors, including:

- Under VA policy, patients with these conditions are referred to VA's Boston Spinal Cord Injury and Disorder (SCI/D) Center for more complete evaluation. The whistleblowers alleged that transfers between the VAMC Manchester and the Boston SCI/D Center were not performed in a timely manner, in violation of agency policy.
- The whistleblowers alleged that surgical care at the Boston SCI/D Center was also substandard. They provided two illustrative examples: (1) a patient who developed a spinal infection and eventually died from surgical complications after surgeons damaged his dura mater during a procedure; and (2) an instance where a patient developed a spinal infection after surgery but survived.
- The whistleblowers alleged that the prior chief of the Spinal Cord Unit, Dr. Muhammad Huq, engaged in the inappropriate practice of copying and pasting chart notes for patients between 2002 and 2012. They asserted that this misconduct contributed to the high incidence of myelopathy in the VAMC Manchester patient population.

In addition to the allegations connected to myelopathy, the whistleblowers further alleged that the VAMC Manchester OR has been repeatedly infested with flies. Starting in 2012, after the OR was remodeled, the rooms in this suite have consistently been infested with flies during warmer months. While the VAMC Manchester has attempted to remediate this problem by hiring exterminators to perform pest-control measures and installing UV fly lights, the flies have returned during the spring and summer every year. The whistleblowers asserted that surgeries have been cancelled and delayed due to these unsanitary and unsterile conditions.

IL The Agency Reports

OSC found that a substantial likelihood of wrongdoing existed based on the information provided by the whistleblowers, and referred the matter to former VA Secretary Robert McDonald to conduct an investigation pursuant to 5 U.S.C. § 1213 (c) and (d). The matter was investigated by the Office of the Medical Inspector (OMI), which provided OSC with a report on June 20, 2017. The report contained internally inconsistent conclusions at odds with the information adduced in the investigation. OSC requested two supplemental reports to address many of these issues and provide updates on external chart reviews. With respect to spinal cord care:

- VA Investigators found that in fiscal years 2015 and 2016, 11 consult appointments, or 20 percent of appointments, were not made in the required time, and

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gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, he is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. U.S.C. § 1213(eX2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e){l).

[2] Jonathan Saltzman and Andrea Estes, "At a four-star veterans' hospital: Care gets 'worse and worse,'" Boston Globe (July 15, 2017), available at https://www.bostonglobe.com/metro/2017/07/15/four-star- case-failure-manchester/n9VV7BerswvkL5akCgNzvK/story.html.

in more than half of these instances there was no documented reason for the delay. In spite of these findings, VA Investigators were "unable to substantiate" that the referral process from VAMC Manchester to the Boston SCI/D Center created undue delays in care.

- Regarding the patient who died from surgical complications, the VA noted it was "unclear" if the surgery contributed to his disease progression, but later concluded that his care was appropriate. Neyertheless, it stated that the treatment of this patient, as well as six others, would be reviewed by an independent, non-VA external reviewer, raising questions regarding the sufficiency in the initial review of this information.

During his interview, Dr. Kois provided OMI with 97 patient charts that he viewed as evidence of substandard care. OMI initially determined that in 74 of 97 cases, care was appropriate. However, in supplemental reports, the VA indicated that external non-VA reviewers would examine these charts to determine whether appropriate care was provided. The VA anticipates this review will be completed in February 2018. In light of the ongoing review of patient charts, OSC finds the VA cannot yet conclude whether the whistleblowers' allegations were unsubstantiated.

The VA's decision not to interview Dr. Chima Ohaegbulam, a non-VA employed neurosurgeon with experience treating myelopathy patients, is at odds with the VA's prior assertion that review by external experts was necessary. Dr. Ohaegbulam treated many of the patients at issue in this matter on a fee basis after referral from the VAMC Manchester, and was uniquely positioned to assist in the review of the patient care rendered. In a supplemental report, the agency asserted that it was unnecessary to interview Dr. Ohaegbulam as Dr. Kois provided sufficient documentary evidence.

The findings regarding Dr. Huq were flawed due to their inconsistency. The report first acknowledged that he engaged in the practice of inappropriately copying and pasting chart notes between 2008 and 2012, but asserted no harm resulted because associated patient records did not contain any indicia of adverse patient outcomes. The report subsequently acknowledged that investigators only reviewed his charts from a limited time period, yet claimed they had sufficient information to broadly conclude that no patients were harmed.

VAMC Manchester management was on notice of Dr. Huq's misconduct as early as 2008; however, no disciplinary or corrective action was tak;en until 2010. Despite the fact that nurses raised concerns to facility leadership during this time, there was no explanation for the delay. Dr. Huq received a verbal counseling in November 2010, but continued copying and pasting chart notes. He was issued a written counseling for this continued misconduct in late 2011. In early 2012, he was counseled again after the discovery of additional instances of copying and pasting. Finally, in July 2012 VA reassigned Dr. Hug to Primary Care on a full-time basis, then transferred him to another VA facility in August 2015.

Despite this long-established history of misconduct, investigators determined that there were no adverse patient outcomes attributable to this practice, after reviewing the care of patients whose charts were copied and pasted. Notwithstanding this conclusion, investigators indicated they were unable to review Dr. Huq's notes prior to 2008. Rather, their conclusions relied on a review of the audits associated with prior disciplinary action. Accordingly, OMI was unable to review six years of patient outcomes, or more than half of the total time Dr. Hug worked in this unit. Given the seriousness of the medical issues involved, a review of Dr. Huq's entire history with the unit appears appropriate, especially given the ease of obtaining these medical records, which under agency policy, must be maintained for 75 years.

With respect to the alleged fly infestation, the report found that the OR #2 was repeatedly infested with cluster flies starting in the early fall of 2014. The room was terminally cleaned, but flies returned later in the fall and the following winter. A pest control company was hired in April 2015, but did not spray insecticides outside the building during that summer. In August and September of 2015, staff again began noticing cluster flies in OR #2. The room was eventually closed due to this issue from September 2015 until January 2016. Despite additional efforts, flies were still observed in the room in January 2017. The report stated that cluster flies pose no known health problems to humans, but subsequently acknowledged that "flies of various types" were found in a light trap during a site visit, suggesting that additional species of insects were present. The report explained that despite the closure of this room, no surgeries were delayed.

Ill The Whistleblowers' Comments

The whistleblowers' comments highlighted inconsistencies in the reports, and were the basis for OSC requesting two supplemental reports from the VA. Notably,

the whistleblowers' comments questioned the sufficiency of the investigation, explaining that OMI appeared dismissive of Dr. Kois' efforts to provide patient charts, and that their findings did not appear to analyze the large number of assistive durable medical devices given to patients as evidence of worsening function and clinical neglect.

The whistleblowers also voiced concerns regarding the failure to interview Dr. Ohaegbulam, and challenged the specific clinical conclusions reached regarding the two illustrative examples provided in their initial disclosure. The comments further reflected the concern that the review of Dr. Huq's patients was limited and appeared to ignore the connection between his conduct and the decline in function of many spinal cord patients.

Finally, the comments noted that OMI appeared to dismiss and ultimately did not investigate serious allegations provided to them by the whistleblowers, including dirty and rusted surgical instruments. The whistleblowers asserted that it was "clear that [OMI] had no interest in a fair and impartial and complete investigation into the systemic problems that directly impacted patient care in Manchester."

JV The Special Counsel's Analysis and Findings

I have reviewed the original disclosures, the agency reports, and the whistleblowers' comments. I have determined that the reports meet the statutory requirements, but the findings do not appear reasonable.

First, I note that the agency appears to have chosen not to review allegations concerning dirty and potentially contaminated surgical instruments because they did not appear in OSC's original referral letter. This position is at odds with the conduct and disposition of prior investigations of allegations referred by OSC. It further demonstrates a myopic approach that could potentially cause harm by ignoring allegations of substantial and specific dangers to public health and safety.

I take further issue with the recommendations in the report when viewed in light of the VA's response after the Boston Globe article was published in July. Notably, the initial OMI report simply recommended additional chart reviews, routine monitoring of chart entries, and that OR staff continue checking for flies in the suite before starting procedures.

The Boston Globe article was published late in the day on Saturday, July 15, 2017. It discussed the spinal cord care issues, Dr. Huq's conduct, flies in the OR, and dirty surgical instruments. On Sunday July 16, within hours of the Boston Globe's publication, VA Secretary David J. Shulkin removed VAMC Manchester's Director Danielle Ocker and Chief of Staff James Schlosser pending the outcome of a "top to bottom" review of the facility. On August 4, Secretary Shulkin visited the hospital, and subsequently removed the Head of Patient and Nursing Services, Carol Williams. Secretary Shuklin also indicated that the department planned on spending $30 million dollars at VAMC Manchester to improve care.

Significantly, OSC had already referred these same allegations to the VA in early January 2017, six months before the Boston Globe story ran. The contrast between the VA's response to the Boston Globe vis-a-vis OSC highlights the issues OSC has with VA's reply to OSC's referral and the whistleblowers' allegations. The VA did not initiate substantive changes to resolve identified issues until over seven months had elapsed, and only did so after widespread public attention focused on these matters. It is critical that whistleblowers be able to have confidence that the VA w. ill addres.s public health and safety issues immediately, regardless of what news coverage an issue receives.

Given the ongoing and potentially lengthy chart reviews of patients involved in these matters, OSC will request updates on the progress of this analysis as well as findings when the reviews are completed. Specifically, OSC will request an update in writing every six months regarding the disposition of these reviews, and the expected timeline for completion. OSC will also request a summary of the findings upon completion.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, unredacted versions of the agency reports, and the whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed the letter to the President, the whistleblowers' comments, and redacted copies of the agency reports in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner Special Counsel
Enclosures