ENSURING QUALITY HEALTHCARE FOR OUR VETERANS

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT OPERATIONS

OF THE

COMMITTEE ON OVERSIGHT AND REFORM

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ENSURING QUALITY HEALTHCARE FOR OUR VETERANS

Thursday, June 20, 2019

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON GOVERNMENT OPERATIONS,
COMMITTEE ON OVERSIGHT AND REFORM
Washington, D.C.

The subcommittee met, pursuant to notice, at 1:59 p.m., in room 2154, Rayburn House Office Building, Hon. Gerald E. Connolly (chairman of the subcommittee) presiding.

Present: Representatives Connolly, Norton, Sarbanes, Lawrence, Lynch, Raskin, Meadows, Massie, Hice, Comer, and Steube.

Also present: Representative Wexton.

Mr. CONNOLLY. The subcommittee will come to order. Without objection, the chair is authorized to declare a recess of the subcommittee at any time.

The Subcommittee on Government Operations is convening today to hold this hearing on ensuring quality healthcare for our veterans. I now recognize myself for five minutes to give an opening statement.

Nearly 100,000 veterans living in the Washington, DC, northern Virginia, and Maryland area depend upon the Washington, DC. Veterans Affairs Medical Center for their medical care. For years, serious and urgent problems festered at this medical center, endangering the lives and care of these veterans.

From 2013 to 2016, leadership at the medical center and the Veterans Health Administration received at least seven written reports detailing significant and substantial deficiencies. It is, in our view, shameful how many warning signs were ignored and for too long.

In March 2017, a confidential complainant alerted the VA Office of the Inspector General to equipment and supply issues, and I quote, sufficient to potentially compromise patient safety. The conditions were so appalling that the Office of Inspector General took the highly unusual step of issuing an interim report in April of that year. The ensuing investigation culminated in the scathing March 2018 critical deficiency report which really was the genesis of today's hearing.

There are far too many glaring problems in this 158-page report to enumerate, but the OIG did issue 40 recommendations, and we need a mechanism to monitor the progress and continuing implementation of those 40 recommendations. At the root of the deficiencies is what the Inspector General, Michael Missal, politely deemed, and I quote, a culture of complacency, but what I, frankly,

would have called a culture of indifference, indifference to their patients.

Leaders at multiple levels failed to address, according to the IG, failed to address previously identified serious issues with a sense of any urgency or purpose—or purpose. In interviews, leaders frequently abrogated individual responsibility and deflected blame to everybody else. How else do you explain the laundry list of critical deficiencies known to VA leadership that threatened harm to patients, and yet these problems persisted for the better part of a decade?

Last month, my colleague, Eleanor Holmes Norton, and I visited the facility and met with the new director, Mr. Heimall, and his senior leadership team for several hours about actions that have been taken to address the exigent concerns raised by the OIG. Shortly after that visit, Ranking Member Meadows and I sent the director a letter requesting information regarding mental health treatment at the D.C. medical center.

Today, I am here to put the leadership on notice. Congress will not stand for continued failures that threaten the health and safety of our veterans at what ought to be the VA's flagship medical center. Unfortunately, it's anything but. According to the OIG, the D.C., Virginia—veterans medical center put veterans at risk through needless hospitalizations, unnecessary anesthesia, failure to use preferred surgical techniques, all because important supplies, instruments, and equipment were not always accessible.

As of March 31 of 2017, the facility had a backlog, a backlog of 10,904 open or pending consults for prosthetic items ranging from eyeglasses and hearing aids to surgical implants and artificial limbs. One patient waited more than one year for his prosthetic leg. This is a veteran we're talking about. And eventually, he gave up and moved to another state where a different veterans facility promptly filled his request.

The level and breadth of neglect detailed in the report is almost inconceivable and certainly callous.

The OIG found that some progress certainly has been made, as did we. After a tumultuous two-year period in which the facility was led by five different directors in a two-year period, a new permanent director testifying before the subcommittee has taken the helm, and all senior leadership positions are now occupied, I believe, by permanent staff. In May 2018, the OIG reported that the availability of supplies had improved and the prosthetics backlog eliminated, and that's genuine progress.

But given the history here, we must be aware of what lies behind the metrics or the ostensible metrics. Leaders must measure and examine customer satisfaction at the end of the day. Are veterans receiving the appropriate care that meets their medical needs and treatment expectations? Are employees empowered to report patient safety incidents, and do they trust that leadership, when reported, will, in fact, address them? How can we ensure that this never happens again whether at this facility or any other that is charged with delivering care to those who served our Nation in uniform?

Previous wake-up calls have come and gone, and veterans in need sometimes continue to suffer. In February of this year, one of

my constituents sought inpatient admission for a drug withdrawal set of symptoms, including anxiety and pain management, at this facility. After the hospital first evaluated him and a second doctor decided to not admit him, the veteran's wife found him dead of a gunshot wound in their home the following week. Just last month, there was a shocking report of a psychiatric patient at this facility who escaped from a locked area and traveled to Virginia with, by the way, the help of one of the employees at the facility. Not that he was complicit, but he apparently was not suspicious of somebody in a hospital gown and called him a cab. He went to Virginia and abducted and assaulted a woman, resulting in his arrest. I'd like to play a clip from that NBC4 report, with the indulgence of my ranking member.

[Video shown.]

Mr. CONNOLLY. I won't even comment.

Incidents like this remind us there's a long road ahead. Putting procedures in place is the easy part. Eradicating the culture of indifference or complacency, that's the hard part, and it will take a significant investment on the part of leadership.

We are here today to insist that our new director, Mr. Heimall, rise to the task, and we'll support him, assuming he does, and that he stay long enough and commit to stay and work hard to hear every patient and employee's concerns to rectify those issues and to communicate needed changes that foster trust within the facility.

We should never have to tell this story. Men and women who put on the uniform to protect our country had every reason to believe they would receive the highest quality healthcare as a statement of our commitment to them. That's our part of the contract. Instead, they encountered mediocrity at best. No one inside or outside of government can possibly accept that standard. For everyone who works at D.C. Veterans Medical Center, from the custodian to the cardiac surgeon, there must be one standard, one standard, and that's one of excellence. We'll settle for nothing less.

With that, I call upon the distinguished ranking member, my friend, Mr. Meadows from North Carolina, for his statement.

Mr. MEADOWS. Thank you, Mr. Chairman. I want to thank you for your leadership and truly for working in a bipartisan way to make sure that our veterans get the care that they deserve, the care that they were promised, and honestly, the care that is the least we could provide in acknowledgment of the service that they provided. And I just want to say thank you.

And to the gentlewoman from the District of Columbia, I want to just say that this is a bipartisan effort. You have my 100 percent commitment to work with you and the gentleman from Virginia whose constituents are served by this. I have the blessing of having one of the best VA centers in the Nation, the Charles George Center, where we actually get quality care, and we don't deal with some of the issues that have just been outlined by the gentleman from Virginia.

It shouldn't take an investigative team from News4 to help us fix the problems. Actually, that investigative team is no stranger to this committee. They've done work before. They've done excellent work. And yet to see the kind of tale that was demonstrated just

a few minutes ago on video is not only shocking, but it's truly not going to be tolerated.

And so with that, I know that we've got a new team. And many of these things were systemic problems that happened before your watch, I get that, and yet we have to make sure that the inefficiencies and the deficiencies are eliminated on your watch, and as the gentleman was talking about, that they never happen again.

I think probably the biggest frustration for us is to have an IG that is doing his work, that has to give, as the gentleman mentioned, an interim report because it is so unbelievably poor in terms of quality of service. Our veterans deserve better. And I just want all three of you to hear, and anybody that's watching, to understand that the commitment is not a 90 percent commitment; it is 100 percent commitment to get it right for our veterans.

And I think, Mr. Chairman, it would probably be appropriate that, you know, in the next 60 days or so, that the three of us make a visit back to this facility to really look at the report card and where we are and have that.

With that being said, I also want to acknowledge, many times medical facilities are very chaotic place. It seems like there was a little bit more—in fact, a lot more chaos at this facility than there should have been. And yet we have veterans—Director Heimall, I believe you are a veteran of what, 30 years, and I want to thank you for your service, because many times, the VA, they have actually veterans that are serving veterans. And yet we need to make sure that there's the urgency in the quality of care that they deserve.

And so with that, I know you're the fifth director. We need to make sure that there is a plan in place, that after all of you are gone, that the next person that comes in, that we're not having another hearing here with a tragedy that has happened because we don't have a system in place.

So what I'm looking forward to today is to hear about those systems, to hear about the corrections that have been made, the number of open items that the IG has identified, how they've been closed, when the rest of them are going to be closed, and how that we make sure that the next IG investigation is on something that is totally unrelated to patient care.

And with that, I yield back.

Mr. CONNOLLY. I thank the distinguished ranking member. And I know he is committed, and especially—I mean, this issue knows no partisan line, and we will work together as one subcommittee and with one committee to try to nudge and support, where appropriate, to make sure that the issues that we have identified and that the IG has identified are fully and comprehensively addressed to everybody's satisfaction, especially the patients.

And with that, I want to welcome our witnesses. And I would ask all three if you wouldn't mind standing and raising your right hand. It is our practice to swear in all of our witnesses.

Do you swear or affirm that the testimony you're about to give is the truth, the whole truth, and nothing but the truth, so help you God?

Let the record show that the witnesses answered in the affirmative. Thank you.

Today, we have with us Ms. Tammy Czarnecki, who is the assistant deputy under secretary for Health for Administrative Operations at the United States Department of Veterans Affairs. We have Michael Heimall, the director of Washington, DC. Veterans Affairs Medical Center, the new director, relatively new, of the medical center. And also with us, we have the Honorable Michael Missal, the Inspector General at the Department of Veterans Affairs, who is, he and his team, the author of the report we have discussed.

Each of you has five minutes to summarize your testimony. Any written statement you have will be entered into the record fully. And in the interest of time, we ask you to try to summarize within five minutes, because we know that votes are probably going to interrupt us at some point in this hearing.

And with that, Ms. Czarnecki, welcome.

STATEMENT OF TAMMY CZARNECKI, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR ADMINISTRATIVE OPERATIONS, VETERANS HEALTH ADMINISTRATION, ON BEHALF OF DEPARTMENT OF VETERANS AFFAIRS

Ms. CZARNECKI. Good afternoon, Chairman Connolly, Ranking Member Meadows, and members of the committee. As of 2017, I am the executive over Administrative Operations, and I have oversight of procurement and logistics. I thank you for the opportunity to discuss Washington, DC. VA Medical Center, and I am accompanied today by Michael Heimall, the director of the VA Medical Center.

The veterans healthcare facilities are designed to be safe havens for our women and men who have served our Nation. We are constantly working to improve the standards for our veterans as they deserve that. The D.C. VA and the extended VA Hospital network take provided in providing care to our veterans in an environment that fosters compassion, commitment, and service.

Hospitals, though, by their very nature, are intrinsic risk to patients as personnel contend with unpredictable situations, infection control, significant care needs, and changing demands on a daily basis. The D.C. VA, though, is no exception, and it is actively pursuing high reliability organizational principles. The HRO core pillars are leadership, commitment, patient safety, and continuous process improvement.

Additionally, we are instituting the Just Culture training focused on improving care to our veterans by providing a safe environment for our employees to report and speak up when they see or anticipate a problem.

In March 2018, the inspector general issued its final report on critical deficiencies at the Washington, DC. VA Medical Center from April 2017. The report included 40 recommendations for the medical center, VISN 5, and VHA. Collectively, VA has been working hard to address these deficiencies and to improve our administrative processes and environment of care at the medical center.

Today, 28 of the 40 recommendations have been fully addressed and closed by the OIG. The remaining recommendations involve longer term monitoring of processes to ensure the corrective actions are sustainable. These involve monitoring the availability of supply

stockage levels, periodic equipment inventories, and auditing of financial records for supplies and equipment purchases. We expect that all of these deficiencies will be closed by October 31 of 2019.

Despite the issues raised by the OIG and events reported in the media, the D.C. VA is comparable to other medical facilities in the Washington, DC. metropolitan. According to the Center for Medicare and Medicaid Hospital Compare data, the D.C. VA recorded some of the lowest hospital mortality rates. The D.C. VA has realized a 50 percent reduction in hospital-acquired infections this year compared to the first six months of 2018. This progress attributed to the SAIL rating increasing from one star to two.

As leadership continues to build a culture of high reliability centered on employee engagement, we expect these rates to continue to drop with the goal of zero preventable harm.

The OIG report also raised concerns about the sterilization processes resulting in unnecessary delays and risk to surgical patients. Tremendous progress has been made rebuilding the staff of sterile processing.

During the period of April 2017 to May 2018, the D.C. VA canceled 20 surgical cases due to the availability of reusable medical equipment. Over the same period ending May 1 of 2019, the D.C. VA reported 5 case cancellations, the last occurring in December 2018. At no time during the 2018 to 2019 timeframe was a patient placed under anesthesia before the care team recognized that appropriate medical equipment was not available.

For the first time since April 2017, the D.C. VA has a permanent medical center director. This stability allows the D.C. VA to commit to a long-term plan for improvements in a consistent, programmatic fashion. Currently, there are only four key leadership vacancies among 57 department heads to be filled. The permanent staff has grown by approximately 130 employees in critical areas such as nursing, sterile processing, supply chain, social work, and community care. The medical center plans to add an additional 300 employees between now and October 2020 to support expanded primary care, mental health, and surgical services across the markets.

The chairman and ranking member have shared the committee's concern regarding three unfortunate incidents that happened at the D.C. VA. We share your concern about these incidents and are conducting thorough reviews in each case. And where appropriate, we have changed policies and procedures and retrained or disciplined staff to ensure that these do not occur in the future. Director Heimall can speak to these in detail.

We look forward to the opportunity to share our progress and discuss our continued efforts to restore the trust of our veterans. We appreciate the OIG for their report and the subcommittee for their assistance. My colleague and I are prepared to respond to any questions you may have.

Mr. CONNOLLY. Thank you. Right on time.

Mr. HEIMALL.

STATEMENT OF MICHAEL HEIMALL, DIRECTOR, VETERANS AFFAIRS MEDICAL CENTER

Mr. HEIMALL. Good afternoon, Mr. Chairman, Ranking Member Meadows, and members of the committee. Thank you for the oppor-

tunity to discuss the D.C. VA Medical Center and the work we are doing to restore our veterans and your confidence in our medical center.

Mr. Chairman, I want to begin by thanking you and your staff, especially Sharon and Billy, for the warm welcome that I received in October and the strong relationship that we have built. Sharon has my cell phone number, and she knows that she or you can call me at any time if you have a concern that you would like to discuss. And I extend that offer to all members who represent districts in the Washington, DC. VA Medical Center's market. Please know that you or your staff can contact me at any time to help resolve a concern of one of our veterans.

Ms. Holmes Norton, we are building an equally strong partnership with your team. I am looking forward to discussing our community-based outpatient clinic in southeast D.C. with Karen and your staff tomorrow morning. I appreciate your collaboration on how we can work with the city and community partners to improve and expand the services for veterans in this underserved community.

I am privileged to lead a dedicated team of medical professionals at the medical center. The OIG critical deficiencies report highlights glaring failures in the basic procedures of a medical center that are symptoms of a systemic leadership failure. That team has been working hard to improve our processes and ensure safe care for our veterans.

Over the past two years, we have eliminated the backlog of more than 10,000 prosthetic consults. We have written and reviewed more than 200 standard operating procedures for sterile processing. We have hired 17 additional sterile processing technicians and new leadership in both sterile processing and the operating rooms, all while undertaking a major renovation of the sterile processing workspace.

We have hired new leadership in supply chain, entered more than 12,000 items of medical supply into the generic inventory package, hired 29 additional supply technicians, and conducted a wall-to-wall inventory of all medical equipment in the facility and our six outlying clinics.

In the last eight months, we have hired 149 new staff, and we expect to finish the year with a net gain of more than 200 new employees. All of this is to ensure that we never repeat the failures highlighted in the OIG report.

When I accepted this position, I promised our staff and the veterans that we are privileged to care for that I was in this for the long haul, and I would not leave until I could truly say that this medical center is once again the flagship of veterans healthcare, and I fully intend to fulfill that promise.

Thank you again for this opportunity to discuss our progress and our challenges, and I look forward to answering your questions.

Mr. CONNOLLY. Thank you, Mr. Heimall.

Mr. MISSAL.

STATEMENT OF MICHAEL MISSAL, INSPECTOR GENERAL, OFFICE OF INSPECTOR GENERAL, ON BEHALF OF U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. MISSAL. Thank you.

Chairman Connolly, Ranking Member Meadows, and members of the subcommittee, I appreciate the opportunity to discuss the Office of Inspector General's recent oversight of the Washington, DC. VA Medical Center.

Inspections like those performed by OIG staff at the D.C. medical center are a vital part of our overall efforts to ensure that the Nation's veterans receive high quality and timely healthcare services. They also promote the most effective use of VA resources and taxpayer dollars.

Our March 2018 report, Critical Deficiencies at the Washington, DC. VA Medical Center, made troubling findings at the facility of systemic and programmatic failures. The issues we identified were complex and affected multiple patient care and administrative services. We did not find evidence of adverse clinical outcomes, meaning death, a change in diagnosis, a change in course of treatment, or significant change in a patient's level of care. This was due in large part to the efforts of many dedicated healthcare professionals who worked around these challenges to ensure veterans received the best quality services under the circumstances.

Of the 40 recommendations made in the critical deficiency report, 28 have been implemented, and 12 remain open. The OIG Comprehensive Healthcare Inspection Program report published in January 2019 provided 18 additional recommendations, one of which is closed. Significantly, all senior leadership positions have now been assumed by permanent staff. Key service chief positions have also been filled with permanent managers.

To ensure full implementation of the recommendations, we engage our centralized followup staff to track the implementation of all report recommendations with the responsible VA office. This consolidated function helps ensure specially trained OIG staff provide consistent management of open recommendations. It also facilitates timely and accurate status reporting for our website, the semiannual report to Congress, and other products that promote transparency.

Overall, we found important progress being made at the medical center. We commend the efforts of every staff member, manager, and leader who has worked to make those improvements. Our most recent visit earlier this month showed improvements in patient safety and incident reporting, reprocessing of surgical instruments and trays, sterile processing service personnel training, and staffing plans. While timely hiring actions have helped to address the known deficiencies within logistics and sterile processing services, challenges with human resources management remain in addressing critical core services.

While the deficiencies we identified were at the D.C. facility, they're not isolated to that medical center. We have detected some of the same problems in other facilities where oversight work was being conducted, whether lack of effective inventory management and controls, staffing shortages, challenges with specialty services like sterile processing, or routine cleanliness standards.

Our findings and recommendations should, therefore, alert other VA medical facilities about what red flags to look for regarding how weaknesses in logistics and other key systems can affect patient care. It should then help guide their corrective actions.

OIG recommendations, if fully implemented, should also improve integrated reviews of medical facilities and oversight by VISNs and VHA central office.

Changing the culture that has allowed problems to persist for such long periods of time is never easy. It will take time and require the unrelenting focus and energy of VA employees and leaders. We will continue to monitor the advancements made at the D.C. facility and remain alert to signs that progress is either being stymied or unsustained.

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

Mr. CONNOLLY. Thank you very much.

And before we begin a round of questioning, I'd like to enter into the record a report from the Partnership for Public Service. They did a survey and a prescription for better performance for medical centers. I will say, and we just confirmed this in the last 48 hours, in this report, in their analysis they looked at 150 medical centers. And last year, before Mr. Heimall came on board, this center we're talking about ranked dead last in employee engagement, which obviously has a spillover effect in terms of quality care. And so I want to enter that report for the record. Without objection, so ordered.

Mr. CONNOLLY. I'm going to call on Ms. Eleanor Holmes Norton, and I'll wait my turn a little bit because obviously she and I share jurisdictional interest in this facility. A lot of our constituents, and maybe yours too, Mr. Raskin, okay, avail themselves of the services of the center, so it affects a lot of us.

Ms. Norton, for your five minutes.

Ms. NORTON. I want to thank you, Mr. Chairman, for the visit you and I made to this center so we could see firsthand what the complaints were about. And I appreciate, Mr. Heimall, how we were received and your briefing and the tour we had.

Before I get to my question, please indulge me for, really, an urgent situation that has arisen here in the District of Columbia southeast, and you alluded to this. I'd like to get some information. Your outpatient clinic, the only clinic for our veterans here in the District of Columbia for medical and preventive care, is about to close.

Now, I understand that this facility is, from your point of view, underused. It's open only about three days a week, so you see why it's underused, you know. When you have to keep track of when a facility is open in the first place, that leads to a vicious cycle. And it is, therefore, open on only two or three days, and then only half time, so you see how this plays on itself.

Now, I just have to ask you, where are these veterans from the District of Columbia supposed to receive their care? While I understand that Prince George's has a facility, it's already understaffed, and there is Rockville in Maryland, where my good friend represents. But neither Prince George's nor Rockville are near any subway. Will you provide transportation for these District of Co-

lumbia veterans who don't have any place to go now if you close this facility?

Mr. HEIMALL. Ma'am, thank you very much, and I want to emphasize that no decision has been made as to whether that facility will close or not.

Ms. NORTON. Oh, good to hear that.

Mr. HEIMALL. The lease expires in September, and I do have to make a decision as to whether we renew that lease.

Ms. NORTON. When will you make that decision, Mr. Heimall?

Mr. HEIMALL. Ma'am, I would like to make it by the middle July, with input from both your staff and from the Mayor's staff.

Ms. NORTON. So you're coming to see us and the Mayor?

Mr. HEIMALL. Yes, ma'am. In fact, we have a call scheduled for tomorrow morning with your staff to discuss the issue.

Ms. NORTON. I appreciate that. We just don't want people to be left with no place to go. And these veterans don't exactly have the kind of resources that you and I have.

Mr. HEIMALL. Yes, ma'am. And I understand it's a very underserved community. We do have a physician that is there two half days a week and one full time—one full day a week. And we also have a nurse that is in the clinic five days a week with a technician, and we provide telehealth services from there five days a week back to the medical center.

The clinic has actually been closed for about the last 10 days due to a pipe break that occurred in the building that it is in, and we should reopen——

Ms. NORTON. This clinic is decrepit in more ways than one.

Mr. HEIMALL. Yes, ma'am. And so it's important that we look for a new option.

Ms. NORTON. I want to get on to Mr. Missal before my—I appreciate you coming to see us on that urgent matter.

I'm interested that you issued something that I have never seen from an inspector general. It was—I'm sure it happens from time to time—an interim report. That was in 2017, in which you noted sufficient, quote—and I'm quoting here, sufficient to potentially compromise—problems to potentially compromise patient safety. I mean, those were the words.

Is it common to come forward with interim reports like this? What were you trying to say before there was a full report when you issued this interim report?

Mr. MISSAL. I do not believe it's common to do it. I'm not sure our office has ever done it. Certainly, in the three years I've been the inspector general, we've never issued anything like that.

We got information about issues at the medical center. We immediately sent up a rapid response team, and within hours, they reported back to me of significant problems at the facility. We then contacted VA to let them know of these problems, and I didn't get the kind of response I was hoping for in terms of trying to make sure these issues which impacted patient safety——

Ms. NORTON. When you got that kind—Ms. Czarnecki, when you get that kind of unusual—you heard Mr. Missal say unusual warning, why wouldn't the VA get on it instantly to try to essentially, perhaps, save lives for the veterans who were using the facility?

Ms. CZARNECKI. I'm not sure, Ms. Norton, that I have the full answer to that. I do know that we did have VA central office staff immediately deploy to that area with specifics in logistics and sterile processing. But I believe that the issues that Mr. Missal is discussing went well beyond both logistics and sterile processing. And so the interim report was really helpful in identifying everything that we needed to do to support the medical center.

Ms. NORTON. It was like an emergency report——

Ms. CZARNECKI. Yes.

Ms. NORTON [continuing]. Ms. Czarnecki. And I appreciate, Mr. Missal, that you were willing to depart from your usual processes in order to alert the VA. And I must say that I would hope in the future to receive what Mr. Missal said was not immediate corrective action.

Thank you very much, Mr. Chairman.

Mr. CONNOLLY. Thank you. And thank you for your leadership on this matter, Ms. Norton. And I look forward to continuing to work with you on an issue that affects so many of our constituents.

Mr. Massie.

Mr. MASSIE. Thank you, Mr. Chairman, for calling this hearing on such an important topic.

Mr. Missal, you said that many of the deficiencies that you identified as the IG at the D.C. facility weren't isolated to that facility, that there are some of those deficiencies at other facilities and that that could inform their improvement. Can you expound on that a little bit?

Mr. MISSAL. Yes. We have a very active healthcare inspection program. We inspect 50 some-odd facilities every year. Every medical center is inspected on about a three-year cycle. In addition, we do what we call hotlines, which are if get allegations of specific issues, we'll do an inspection there as well.

So my comment on that was really related to other findings we've made both in inspections and in some of the hotlines, and we publish all of our work product. And so just last week, we published one on the Loma Linda facility in California in which we identified environment of care issues. So we regularly put out reports which have similar issues. Not the same extent, but similar type issues.

Mr. MASSIE. So some of the issues that you found at the D.C. facility, like specialty services for sterile processing, you found those at other facilities, and they should be looking into those?

Mr. MISSAL. Yes. And that's why the D.C. report is a great roadmap for other facilities because they had significant sterile processing issues. And when we write the reports, our goal is for all the medical centers to be reviewing them to see if they have any kind of similar issues and to address them before we get there.

Mr. MASSIE. I want to thank you very much.

And I'm going to yield the balance of my time to Mr. Meadows.

Mr. MEADOWS. I thank the gentleman from Mr. Kentucky.

Mr. Missal, let me come back to that, because you say you expect other VA centers to follow the IG's report. What's your degree of confidence that that's actually happening? I mean, because I can tell you that it's even Members of Congress that a lot of times, we don't see the IG's report. And so to suggest that somehow the ad-

ministration of every VA center is going to look at his problems and associate that they have the same problem, I don't know that that will really happen. What's your degree of confidence?

Mr. MISSAL. We try to work hard to make sure that the information we have in the reports is disseminated as broadly as possible. So, for example, I sometimes meet with VISN directors and talk about recent cases we have, again, to highlight our work. We also try to talk about trends we're seeing in areas. Obviously, it's up to the medical center directors and the leadership at VHA to ensure that they're following what we do.

Mr. MEADOWS. So you mentioned about another facility in California as an example, but how would any of us up here know whether our VA center is having that same problem? I mean, so you've got Kentucky, and that's the reason why the gentleman from Kentucky was asking you. Is it his VA center, or Georgia or, you know, Kentucky, Florida, or—you know, we can go all the way down the line. I mean, are you informing that Member of Congress that their particular VA center might have an issue?

Mr. MISSAL. Absolutely.

Mr. MEADOWS. All right.

Mr. MISSAL. When we do an inspection and we're ready to publish it on a particular facility, we notify the Members of Congress whose jurisdiction it's under, and we always offer to come in and talk about it.

Mr. CONNOLLY. So in that case, no news is good news?

Mr. MISSAL. It could be good news, but again, whenever we publish a report, we will always notify, whether it's a good report or a bad report, just to talk it over with Members of Congress.

Mr. MEADOWS. All right. Because one of the things that we talked about in my opening remarks is about making sure that this problem doesn't happen again. And I heard the number of standard operating procedures that have been put in place as a response, and I would assume that that's meeting with applause from your team. Is that correct?

Mr. MISSAL. That's partially a good development. But what we found, particularly in this situation, is there was such a lack of leadership and governance issues. So no matter how many procedures and processes you have in place, if you don't have strong leadership, if you don't hold people accountable, if you don't have an effective governance structure, it's going to be very difficult to have an effective organization.

Mr. MEADOWS. I'm going to yield back to the gentleman.

Mr. MASSIE. Just very quickly. If you found any issues at the Cincinnati VA, the Lexington, Kentucky VA, the Huntington, West Virginia VA, or the Louisville, Kentucky VA, would you let me know after the hearing?

Mr. MISSAL. Absolutely.

Mr. MASSIE. Thank you very much.

Mr. CONNOLLY. I thank the gentleman.

I now call on the gentleman from Massachusetts, Mr. Lynch, where there is a VA facility five minutes from my family's home in west Roxbury, a very big one.

Mr. Lynch.

Mr. LYNCH. Thank you, Mr. Chairman and the ranking member, for all your work together on this issue in bringing it forward. I've got three VA facilities in my district; one in Brockton, one in west Roxbury near the chairman's family home, and also Jamaica Plain.

I want to speak directly about the veterans and active military suicide issue. Mr. Hice, the gentleman from Georgia, and I, in the National Security Subcommittee, had a hearing specifically on veteran suicide and active military suicides, and I see the elevated numbers here at the D.C. VA center. There's no indication, in my briefing, about the connection among those suicides.

Would you classify it as a cluster, or were those connections, or was there was cross-knowledge among the victims here or no?

Mr. HEIMALL. Sir, the two that have been reported in the media, there was no relation between those two. They were separated by quite a bit of time.

Mr. LYNCH. Yes.

Mr. HEIMALL. I have no knowledge that either veteran knew each other. The veteran that the chairman spoke about, his constituent, actually had not been seen in the VA for about five years before he had that encounter with us.

Mr. LYNCH. All right. So I'm just trying to figure, you know. We've got a lot of these suicides going on. We've got a lot of active military attempts, and unfortunately, successful suicides, and I'm just trying to figure out a way to get at that.

Now, we have REACH VET, a program that was initiated by the VA back in 2017, that tries to do this analysis on those who might be at risk of suicide. Have you adopted that program?

Mr. HEIMALL. Yes, sir, and our suicide prevention coordinators are informed by that information. I think one of the major challenges that we have within the VA, and I certainly experienced it in my leadership roles in DOD, is many times, suicide or suicide attempts are driven by socioeconomic factors that we may not have visibility on. We've got visibility on the healthcare issues but not all the other things that are going on. And a more comprehensive system that includes that data would lead to a much better predictive model.

Mr. LYNCH. Yes, yes. And that's exactly what I'm trying to get at. So at the Brockton VA, we have a program. We actually do sort of a brain scan on our military—our recruits as they're going into—before they deploy. And we have like 250,000 of these brain scans, and we try to compare them with returning veterans to make sure there's not some TBI issue or something like that.

In your experience, is there any connection between the high number of deployments? So members of this committee were in Afghanistan not a long time ago, and we typically ask who's here on their first tour of duty, and we met with a small rifle platoon of Marines, and there were Marines there that were on their seventh tour of duty. That's unbelievable, and I don't think that's ever happened in the history of our country. And I'm trying to figure out, is there a connection between these multiple tours of duty and the psychiatric stress that some of these young men and women are experiencing? You know, because if that's the case, then we're going to have some trouble going forward here as those burdens present.

Ms. Czarnecki?

Ms. CZARNECKI. Yes. I'd like to comment on that. I know that our mental health department is actually doing what we call behavioral autopsies on every suicide that we become aware of.

Mr. LYNCH. Okay.

Ms. CZARNECKI. And we're really trying to look for those key indicators that would help us prevent them from committing suicide in the future.

Mr. LYNCH. Yes. Have you come up with any commonalities or are you still in the process of developing these profiles?

Ms. CZARNECKI. The profile development is ongoing.

Mr. LYNCH. Yes.

Ms. CZARNECKI. I think that there are some key indicators, as Mr. Heimall talked about, a lot of the socioeconomics.

Mr. LYNCH. Yes.

Ms. CZARNECKI. So we have actually partnered with the Law Enforcement Training Center to develop education for the community on how to help us as the VA identify those veterans that are out in the community who are not being seen by us that have risk factors for suicide and try to get them engaged with us at the VA. So we've been doing a lot of outreach to first responders to provide education and training.

Mr. LYNCH. That's great.

Mr. Chairman, I just want to make sure we don't see this suicide issue as just a D.C. VA Medical Center issue. It's much wider than that. And also, you know, I've dealt with some families who have struggled with this. And so, you know, our prayers and thoughts are with those veterans and with their families.

Thank you. I yield back.

Mr. CONNOLLY. The gentleman makes a great point. This is hardly an issue limited only to this facility or this region, no question about it.

And your point about seven tours is right on. I mean, during the Vietnam war, two terms would raise an eyebrow; three would be almost unprecedented; seven did not exist. And so the fact that we have multiple, multiple tours obviously puts more and more men and women at risk of PTSD and other depressive effects, and it needs to be paid attention to.

Mr. Meadows, did you want to comment?

Mr. MEADOWS. Yes. I want to make one real quick comment to the gentleman from Massachusetts, Mr. Lynch.

I want to say thank you for your leadership on this particular issue. As you know, it's very critical to me. It's something that I've had constituents that have lost sons, and it becomes very personal when you have the tears of a mom or a dad, you know, that have lost their loved ones, and so I just want to thank you for your leadership. And thank you for reminding us this is not just a D.C. problem; this is a United States problem, and it's something that we've got to come together on.

And I yield back. I thank the chairman for his courtesy.

Mr. CONNOLLY. I thank the gentleman.

And I do want to give Mr. Lynch one more—he puts his money where—how many times, Mr. Lynch, have you been to Afghanistan and Iraq?

Mr. LYNCH. About 45 times now.

Mr. CONNOLLY. Forty. That's a Member of Congress committed to making sure that the men and women we ask to serve have support from the Congress.

The gentleman from Kentucky, Mr. Comer.

Mr. COMER. Thank you, Mr. Chairman.

And my questions will be for the inspector general. Sir, do you believe the Washington, DC. VA is moving swiftly enough to address the issues that you outlined in your report?

Mr. HEIMALL. They're moving at a very good pace, and we're very glad to see it happening.

Mr. COMER. What are the most significant remaining issues that the D.C. VA still has to address to ensure that our veterans receive the best medical care possible?

Mr. MISSAL. I think it would be the H.R. function, because so many of the issues revolve around having proper staffing. So if you do not have the proper staffing, it's really hard to be able to provide all of the services in a timely manner, and they're still working through some of the H.R. issues.

Mr. COMER. What are some actions that this committee can do to address some of the serious issues reported, not just at the D.C. VA, but other VAs that have received similar media attention for poor performance over the last few years? What are some things that we can do in Congress to address that?

Mr. MISSAL. We have found staffing to be an issue across VA. Every year, due to a congressional request, we put out a staffing report which identifies major gaps in staffing in a number of different areas. So one of the things could be to see whether or not there are hurdles for VA not to be filling these positions. For example, a medical center director to determine whether or not there are any hurdles, such as compensation or otherwise, that prevent some of them from being filled on a permanent basis.

Mr. COMER. I'm very close friends with a constituent, Mr. Dakota Meyer, a Medal of Honor recipient from my district, very close to my hometown in southern Kentucky, and he gives a lot of speeches across the Nation on veterans' issues, and he talks about the VA a lot. And one of the suggestions that he bounces around that I'm beginning to hear more of my veterans suggest is that perhaps we would be better off eliminating the VA and providing our veterans with a gold card, to where if they need medical attention and they can get that medical attention at home, then that would allow them to do it at home, and it would be paid for. And perhaps the savings from not having the VA would somewhere, somehow, come close to paying for that. I don't know if that theory is accurate or not.

I was wondering your opinion on that, because like my colleague, Mr. Massie, my district is spread out. It's five hours from the eastern part of my district to the western part of my district, so my caseworkers are constantly handling VA cases, probably more VA cases than anything our caseworkers do. And in my district, part of my constituents go to Louisville, Kentucky VA; Lexington, Kentucky; Nashville; Evansville, Indiana; and Marion, Illinois. So they're served by five different VAs in four different states.

So I was just wondering what you thought about that proposition that Mr. Meyer and other veterans have brought up before.

Mr. MISSAL. I have not done a comparison of the quality of the healthcare between the private sector and what VA provides. However, I would say, in my time as inspector general, I've seen a lot of very high-quality healthcare that veterans receive and that VA is preeminent in a number of different areas such as mental health and spinal injuries. And when you look at some of the surveys done of veterans, many veterans really value and enjoy the services they get at VA. However, there's issues that come up, and that's why our office, when we see them, is going to report on them fairly and accurately.

Mr. COMER. Right. And I don't think that that bold proposal would happen any time soon, but one thing I would like to see is more choice for our veterans. Obviously, if a veteran received a serious specialized wound, like missing an limb or something like that, the VA is certainly more qualified than most of the rural healthcare systems in my state to handle that. But there are a lot of issues that I think that we deal with from a caseworker standpoint that our constituents are having to travel two hours to a VA when they could be better served from the local hospitals. I have 28 hospitals in my congressional district.

So that's something that gets mentioned a lot. I just wanted to hear your thoughts on that, and look forward to hearing from you in the future. Hopefully, we can get this serious issue solved with the VA. And again, if there are things that we can do in Congress, please let us know.

Mr. Chairman, I yield back.

Mr. CONNOLLY. I thank the gentleman.

The gentleman from Maryland, Mr. Raskin.

Mr. RASKIN. Mr. Chairman, thank you very much. Thanks to all of our witnesses.

Mr. Heimall, you have not been on the job that long, less than a year still, I think. Is that right?

Mr. HEIMALL. Yes, sir. Eight months.

Mr. RASKIN. I wanted to commend you, because I know you came from being the director of the Walter Reed National Military Medical Center in Bethesda, but you've definitely brought a lot of focus and purpose to the task here.

And I have a number of constituents, a whole lot of constituents who go down to the D.C. VA, and they continue to have problems, but we are aware that you are trying to respond, and you've certainly been working well with our staff when we call up. I understand you're still—you're doing these monthly meetings with congressional staff members.

Mr. HEIMALL. Yes, sir.

Mr. RASKIN. And also with, you know, other interested stakeholders, and so I want to thank you. I want to thank Ms. Wimberly from your staff who I know has been very helpful to us as well.

But the morale situation is very tough with a lot of employees there, and I wonder what is it you're trying to do to address that and to what do you attribute it? What is your sense of the situation there?

Mr. HEIMALL. Thank you, sir. I think it's probably one of the top two challenges that we have at the D.C. VA is employee engage-

ment, morale, and commitment. The chairman referenced the survey that we're in the process of retaking for 2019.

And to put some things in perspective, in 2018, 2017, we had 33, 34 percent participation rate in that survey. This morning, we had more than 65 percent of our employees who took the all-employee survey. That is going to give us some very powerful feedback on the pain points of their everyday work environment that we can put action plans in place with them and actually have employee-led groups to improve them.

I think the biggest challenge our employees have had has been psychological safety and fear of retribution should they report a medical error or should they report a mistake that they made, and that is a culture that we are trying hard to break and encourage people to speak up. And I'm encouraged by the data that we're seeing. In 2018, there were about 780 patient safety reports filed by our staff. Now, that may include a patient incident. It may include a near-miss. Like a patient—there was a question about a patient getting the right medication delivered the right way, and a staff member did the right thing and asked the question. And we asked those to be put in our patient safety system so we can trend what is happening and we can look where we need to make process improvements.

Mr. RASKIN. Is it the kind of fear that whistleblowers experience, a fear of retribution?

Mr. HEIMALL. I believe that's part of it. And so what we've seen this year so far is we have about 870 patient—we have more patient safety reports now than we had all of Fiscal Year 2018, and 80 percent of those reports have a person's name on it so we can followup with them. We can ask them what they've done, what the issue was, and we can give them feedback on what we're going to do to prevent it from happening again.

Mr. RASKIN. You're trying to dispel this culture of fear which is a hangover from, what, prior leadership, prior——

Mr. HEIMALL. Yes, sir. I believe so.

Mr. RASKIN. Okay. Well, thank you for that.

I have received a couple of complaints from constituents about the IT situation and the huge backlog in requests for IT assistance. And obviously, today, you really can't run a functional organization if you don't have effective IT. Can you explain what is behind that and what you're doing to address that problem?

Mr. HEIMALL. Yes, sir. There is a significant backlog. As of this morning, I talked to the area manager who reports up to the assistant secretary for OI&T, and there are about 4,000 open work order tickets within the D.C. VA and our six outlying clinics. They have had a significant problem with staffing in the past. They are almost fully staffed now. They're authorized 25 people, and they have 22 on board with two more being recruited and one person who just left that they've got to process the action on.

The team is very engaged. Mr. Gfrerer, the assistant secretary for OI&T, visited the hospital about two months ago and spent an hour with the area manager talking about the issues and challenges. And these concern me a great deal because, as we get ready for the electronic health record deployment at some point in the fu-

ture, I need the IT team really working on upgrading the infrastructure of the facility, not working on a backlog of IT tickets.

Mr. RASKIN. Okay. Finally, would you be willing to compare your experience at Walter Reed with your experience at the VA? Walter Reed really now is a hyperefficient, up-to-date, state-of-the-art kind of facility. And can you compare that to where you are now and to what you would attribute the difference?

Mr. HEIMALL. Sir, it really gets to leadership, and it's a very different patient population. At Walter Reed, primarily retirees, Active Duty servicemembers and their family members. At the D.C. VA, we do have a large portion of our population that is economically challenged and financially challenged—or financially insecure would be the best term for it. Their healthcare status and their engagement in their healthcare is different than it was at Walter Reed.

I think the other piece of it is Walter Reed was an incredibly highly functional organization when I got there. Routine things happen routinely, regardless of who the leader is, and I followed two very talented leaders in Admiral Mike Stocks and Major General Jeff Clark.

At the D.C. VA, the struggle has been and was routine things happening routinely and how we build that into our culture and empower employees to just make those things function every day regardless of who the leader is.

Mr. CONNOLLY. I thank the gentleman.

Mr. CONNOLLY. Before I call on the gentleman from Florida, Mr. Steube, without objection, I'd like to enter into the record the organizational alignment showing the vacancy rate for all of the positions at this facility. And it goes from a high of human resources, which, Mr. Missal, we're going to return to that, 68 percent vacancy rate to prosthetics, zero. So we've made progress in some, but there's still a lot of room for improvement in the top five or six categories here.

And so I'll enter that into the record, without objection, as a document for our perusal.

Mr. CONNOLLY. Mr. Steube.

Mr. STEUBE. Thank you, Mr. Chair.

My question is for Ms. Czarnecki? Am I pronouncing that correctly?

Ms. CZARNECKI. Yes.

Mr. STEUBE. And I know you probably won't have the answer to this question, so I would just ask that you get back with me or my office the information.

I represent southwest central Florida, so most of my district, the nearest veterans center or veterans hospital is Bay Pines. It's been reported to me that Bay Pines has stopped referring patients in need of in-patient mental health and substance abuse service to approved non-VA community care providers. Instead, these veterans are being added to a waiting list that already includes over 70 patients and will take one to three months before receiving treatment.

It appears there is significant confusion in VISN 8 about how to appropriately implement the MISSION Act. My understanding is the purpose of the MISSION Act is to increase veterans' access to

healthcare, yet veterans in VISN 8 are experiencing much greater delays in mental health and substance abuse treatment. Can you explain why this is happening and what can be done in the near term to ensure that these veterans are getting the mental health and substance abuse treatment that they need?

Ms. CZARNECKI. I will be glad to take that for the record and get that response back to you.

Mr. STEUBE. All right. Thank you.

Mr. CONNOLLY. Does the gentleman yield back?

Mr. STEUBE. I'll yield back to Mr. Meadows.

Mr. MEADOWS. Thank you.

And so since you're going to take that back, I'm a big one on timeframes. When can we expect a response? Because literally, these can be life or death kind of—so within the next 30 days can you get back to this committee and Mr. Steube on that request?

Ms. CZARNECKI. Absolutely.

Mr. MEADOWS. All right. Thank you so much.

I thank the gentleman from Florida.

Let me followup real quickly. When you mention your IG report and sharing it, one of the things that just came to me is—I mentioned in my opening statement, I have the luxury of having a five-star quality VA center. And yet every VA center is not without its challenges and difficulties and delays. And yet there are some good practices that I know have been implemented at that particular facility.

What mechanism is out there to share those good practices with perhaps the director here in D.C.? Is there a mechanism to do that?

Mr. MISSAL. Well, that's why what we try to do in our reports is we try to really get into the root cause of any issue that we find. Because when we find an issue, it's not good enough for us just to say we found a problem. We really want to get into why it happened, and we see themes. And that's why in our reports we're going——

Mr. MEADOWS. Yes. But that's more on problems than good practices. And so while I appreciate that, it's the good practices.

Ms. Czarnecki, is there any way to do that?

Ms. CZARNECKI. Yes. VA actually has a number of mechanisms to share good practices. We have an innovation program where employees can submit good practices and they can be shared across the system.

Mr. MEADOWS. So how do they get rewarded for that?

Your pause concerns me.

Here's the thing, is you get more of what you reinforce. And what I'm saying is if there's a great practice that they come up with, and let's say someone comes up and saves the VA hospital a million dollars, how do we make sure that that is rewarded, or do they just get a pat on the back and say, ata boy, ata girl, and go on?

Ms. CZARNECKI. I believe that it's a mix, sir. I do believe that in some cases there are team awards. Generally, a best practice is not just an individual; it's generally team based.

Mr. MEADOWS. Here's what I would like. And I didn't mean to cut you off. And here's what I'd like, is the best practices—listen, you've had just an unbelievably terrible track record that we've got to fix. And the problem is each little thing that you do wrong now

will be judged based on the bad track record. It won't be judged—you know, you may be in your honeymoon phase right now, but because of the systemic problems that have been outlined in the IG's report, if you even mess up a little bit, they're going to say nothing's changed.

So I guess what I would like from the two of you, if you would, is to get back to this committee in the next 60 days, how do we best share best practices and reinforce those? Because part of the survey problem that you're having with employee engagement is they don't feel like their input is being valued. Would you agree with that, Director?

Mr. HEIMALL. Yes, sir, I would. And from a best practice standpoint, we've brought a number of best practices from around the VA to the Washington, DC. medical center, and we have exported some. The work that was done in prosthetics specifically, our chief of prosthetics actually went through the VA shark tank process at a previous facility. He brought best practices to us. And some of the things that he put in place at our facility are now being spiraled out across the VA as best practices.

Mr. MEADOWS. That's what I wanted to hear.

I'll yield back. I thank the chairman.

Mr. CONNOLLY. I thank the gentleman.

The gentlelady from Michigan, Mrs. Lawrence.

Mrs. LAWRENCE. I want to thank the chair for acknowledging me.

I want to say for the record I have four VA facilities in my district. And this is something that I hear and I know that the best practices—and I think the line of questioning that my colleague just entered into is extremely important.

But I hear consistently from the user, from the veterans, from those who are using the facility, their discontent, the lack of followup and the long waits. And so are we including a way to get the voice of the patient? Because so often they feel discounted. So it's one thing to talk to all of the employees and get those best practices. But at the end of the day, if you still have veterans piling into their office of—the Members of Congress telling them that they're not being respected, they're not getting timely response, and that they need services that they cannot get, you may try to put stars on your wall, but are we really achieving the goal?

I would really love to hear a comment on that.

Ms. CZARNECKI. I'll talk a little bit about the national level, and then I'll ask Mr. Heimall to comment on what happens at the medical center.

A couple of years ago, we started a veterans experience office at the department level. And we're collecting real feedback, real time from veterans so that we can trend and track those, and do service recovery in real time as opposed to waiting for survey results.

Mr. Heimall.

Mr. HEIMALL. I think the survey results are great, but they're not—they lag the process. The Veterans Signals, VSignals, is a much more real-time system where we can see how veterans are reporting. I look at that on—a couple of times a week. And it also has a very robust written comments section.

What I find interesting in that is the positive comments outweigh the negative about two to one as I go through that. And then

I spend a lot of time talking with our patient advocates and with veterans across the medical center in our various clinics. You have to deal with their issues up front when they walk into your office with them. And unfortunately, a lot of times a veteran will come into my office demanding to see me and I'm not in the building because I'm out visiting an outlying clinic or I'm in a meeting, but if I'm available, I want to come out and I want to try to resolve that myself.

One of the things that does is it role models—it sets the example for the rest of our staff that if you have an unhappy veteran in your clinic today, don't send them down to the patient advocate. Do everything that you can to resolve their issue in the clinic and let them——

Mrs. LAWRENCE. It's about empowering the staff that you have the ability to address that issue.

One other thing, and please help me because I'm having one of those moments. The facilities that's not a medical hospital that's in the community, what do we call that?

Mr. HEIMALL. Community-based outpatient clinic, CBOC.

Mrs. LAWRENCE. That's it, CBOC. Those work very well.

So I'm hearing about this disconnect of the long traffic. And I actually got involved because the veteran services were trying to close it. And when I visit that facility, the veterans who are there, they love it. It's a smaller environment. You're using telemedicine, which you're going to have to use more of to be more responsive.

And one of the things that was impressive for me was the mental health; that they could, through telemedicine, talk to a therapist. And they go in, and it's not all this long walk, it's not crowded. The staff there were probably the most engaged that I've seen. They took such personal pride in it. And I really want you to know that those work and that we—I feel there's a place for that. Even if we look at closing a facility, you must increase those CBOCs, as they say. Yes.

Mr. HEIMALL. Yes, ma'am. And I think the MISSION Act drives us to doing that. The access—the drive time access standards that the department has put in place really encourage us to take the care out closer to where veterans live and work. And especially in the D.C. market, I'm very concerned, because we have patients that it may take them an hour and a half, two hours to get to the medical center.

In Northern Virginia, the chairman knows, we have a clinic at Fort Belvoir, Virginia, but for a veteran living in Loudoun County, that could be an hour and a half commute during rush hour. And we're going to lose that patient to the community. So we are working with it. There's a vet center extension center in Loudoun County that we are putting a telemedicine system into. And in the next couple of years, we're going to look hard at putting a much more larger CBOC in Northern Virginia.

Mrs. LAWRENCE. The last thing. I would love for you to engage with the chairman, I would love to talk about how we, when we get complaints from veterans, to be able to fill out a form about the customer satisfaction so that we can help you, because we're gathering that data, because we—that's—my veteran is my largest caseload.

Thank you.

Mr. CONNOLLY. I thank the gentlelady. And she makes a really good point. I mean, in a perverse way, Mr. Heimall, being at the bottom of the pile means, presumably, you can only go up. But establishing a baseline of performance and satisfaction is something I think we have to have so we can measure real progress and celebrate it when it occurs.

I also want to ask unanimous consent that my colleague, the gentlelady from Virginia, Ms. Wexton, be recognized for the purpose of participating in this hearing as a full member of the committee. Without objection, so ordered.

I'm going to take my five minutes and then call upon you Ms. Wexton.

You?

Mr. MEADOWS. Yes. They've just been yielding to me. I haven't had my turn.

Mr. CONNOLLY. Oh, I'm so sorry. I thought——

Mr. MEADOWS. I had plenty to say and not enough time to say it.

Mr. CONNOLLY. Yes. All right.

Do you want to go now?

Mr. MEADOWS. Yes, that'd be great.

Mr. CONNOLLY. Okay. Sure. I recognize not myself but the gentleman from North Carolina.

Mr. MEADOWS. Thank you, Mr. Chairman. And again, I want to say thank you for your leadership.

Director, let me just come to you. We have a number of hearings where we get people that come in and make excuses. And I want to say thank you for not making an excuse for what we saw in the video where the I-Team did their investigation. Thank you for taking it seriously. I know we've had discussions. I appreciate the fact that you not only have a concern for our veterans, but you want to get it right.

Here's what I would ask you. And Mrs. Lawrence just made a comment about that. Every year, we have what we call a veterans seminar where we actually go to three different parts of my district where we bring all the people together and we talk about serving the veteran as a whole. So it's not just the VA. It's the eligibility. It's everything that we have in that and bring it together. Sometimes it's adjudication.

What we find in those are the weak spots that we have in our delivery system. And I don't suggest that we can do that across the board. But I do think it's important for us as Members of Congress to understand where the weakness is.

Do you think it would be helpful if we actually get a random survey of veterans that are served across the entire VA system, not just D.C. but across the entire—that it comes back and lets us know, you know, what the scorecard is? The chairman has a scorecard, which is called FITARA, that actually gives a rating, and we're able to follow that on IT.

What if we had a rating system that we were able to do that for veterans? Do you think that that would be helpful in holding people accountable?

Mr. HEIMALL. Sir, I think that one of the challenges with that is there are a lot of surveys out there. There are at least two surveys that our veterans get. If you're an inpatient, you get the HCAHP survey that CMS uses. If you're an outpatient, you get the VA's outpatient survey, and you get pinged for the VSignals on an occasional basis. And so those are statistically designed surveys that have statistically set sample sizes. There may be something that's missing from that and feedback from Members of Congress or from the committee as to how to improve that survey may we very useful. But I'd encourage you to look at the development of that survey.

Mr. MEADOWS. All right. So let's assume we've got two surveys. Obviously, they're not working. Wouldn't you agree with that? I mean, you know, if the surveys would have stopped the poor healthcare results—and maybe I use healthcare more broadly, but the problems that we had at your facility where you are, if we had just the survey and it was an action item, we wouldn't be having this hearing. Would you agree?

Mr. HEIMALL. Sir, I think the question is what was leadership doing with those survey results and how were they trying to address those.

Mr. MEADOWS. All right. And that's exactly where I was trying to get.

How do we make sure that the information that we gather is not just important to you—because I can tell, you're taking it serious. How do we make sure that when you're gone, that the next person that takes the directorship of this particular facility, how do we make sure that he or she is taking it serious?

Mr. HEIMALL. Sir, I think that needs to be on the report card that Congress looks at.

Mr. MEADOWS. But even on the report card—I mean, I guess at what point do we start holding people accountable?

Here's the problem I've got. I've got veterans that enjoy great service in my district. And when they tell the stories to other veterans in other states, all of a sudden the other states, they go, well, we don't have anything like that. And I want to give a shout-out to Ms. Breyfogle. Who's no longer in my district. In fact, I weeped tears. And, actually, we got a good replacement. The director there now is great. But Ms. Breyfogle did what you just mentioned that you had done with the chairman, is gave me her cell phone number so that when I had a problem and it came and was elevated, I could take make a phone call and it was taken care of in minutes. And you know what happened? They ended up empowering their staff to take care of the problems where they didn't need to contact me.

And so how can we do that? Can you get to this committee some recommendations on how we can make sure that this D.C. debacle does not continue to happen here, but also, that it doesn't happen in Arizona or California or Minnesota or anywhere in between? Can you get some recommendations to us on those good practices that you were talking about sharing?

Mr. HEIMALL. Yes, sir. And I would love to do that when we submit back on our questions for the record. I'll take that one for the record, because I would like to put some thought into it.

Mr. MEADOWS. Thank you so much.

I yield back.

Mr. CONNOLLY. Well, thank you, Mr. Meadows.

And just following up on that, I think—and we talked about this when we met at the facility a couple of months ago. I think because of the unique nature of this facility and the problems that have plagued it in the past, we've got to create a matrix for setting goals that have been set certainly by the IG's office and meeting them and institutionalizing them, so that, God forbid, but, you know, if you're hit by a bus tomorrow, your successor has to follow through and has that in front of them.

Remember, we're doing all this for our veterans to make sure they are best served. So I'd like you to give some thought about that, because I think we want to institutionalize following your progress. This is not going to be a one-time hearing. And we have a model we've created for IT in Federal Government with, you know, seven factors, and we grade. And we're going to have a hearing on that next week, if you want to see what it looks like.

But we'd welcome your suggestion on that. And yours as well, Mr. Missal.

Let me ask you. You're the IG, and you talked about a culture of complacency. Could you tell us what you meant by that? What led you to characterize activities at the—this facility as a—constituting a culture of complacency?

Mr. MISSAL. What we found is that the problems that we identified were pretty well known throughout the facility, that a number of staff raised those issues, did not get them resolved, did not get them worked out to their satisfaction. And rather than working harder to get them raised either to our office or others who could do something about it, that they just decided they were going to live with them and have work-arounds so that they could make sure that the patients got the best quality care under the circumstances. So they just were satisfied because they felt they had no other route other than try to get the best quality care for the patients.

Mr. CONNOLLY. So what you've just described are sort of institutional barriers to providing quality service, and they did work-arounds to try to give that quality service the barriers within the system notwithstanding?

Mr. MISSAL. They felt leadership was either not listening to them or not taking appropriate action, and so they felt that there were no other avenues to pursue.

Mr. CONNOLLY. In some cases, however—I mean, for example, we had a case where I think, if I recall, the blood supply had to be destroyed because it had not properly been stored. Is that correct?

Mr. MISSAL. I believe that's correct, yes.

Mr. CONNOLLY. Is that a function of management or a function of maintenance and making sure things kind of work properly?

Mr. MISSAL. It has to do with the leadership at the facility across all departments and all levels. And they have to understand what they're supposed to do, be properly trained. But then if there's an issue, to raise their hand. Not be afraid to raise an issue. That if they do, that they'll in some way be retaliated against. And that's one thing we found at the facility. A number of people who didn't

raise their hand felt that if they did, there would be retaliation against them.

Mr. CONNOLLY. Mr. Heimall, would you agree that that was a problem when you took over, that raise your hand and be empowered and there's no retaliation based on what you report? And what have you done to change that and encourage it?

Mr. HEIMALL. Sir, it was a problem when I arrived at the facility. And, quite honestly, there are still pockets of that fear across the organization today. And the only way that we can really overcome that is by demonstrating that leadership takes those concerns seriously, we're going to address them, and we actually say thank you to people who bring them to our attention, and recognize them publicly. Reward the type of behavior from our employees that we want to see.

Mr. CONNOLLY. Well, both the ranking member and I spent a lot of time in the private sector. And one thing I think both of us would observe is—and you had a line of questioning that got to that. But it's what's rewarded. You can say all you want, but if people notice, that's not what's rewarded. And, in fact, it could be punished. It's not going to change behavior.

So presumably, you're looking for some high profile opportunities to show you are committed to what you just said you are committed to.

Mr. HEIMALL. Yes, sir. I try a couple times a week to send out a tell-me-something-good story to all the staff where either a veteran has thanked somebody for doing the right thing or going above and beyond, or a staff member discovered an issue that they raised and they prevented a problem from happening. I would like to be able to do those every single day. And I would like to have a weekly good-catch award where we could recognize somebody.

Unfortunately, the challenge I have right now is we still tend to focus on the negative event and not finding those positive events where we should be recognizing those behaviors.

Mr. CONNOLLY. Right. Presumably, there's an in-between where we reward someone who takes the initiative to avoid the negative happening, and that's a positive.

Mr. HEIMALL. And that's exactly what we have to have in healthcare if we're going to become high reliability organizations.

Mr. CONNOLLY. Let me explore the issue of HR. H.R. is the one—the No. 1 office still with a 68 percent vacancy rate. So out of 78 designated positions, only 25 are on board, 53 are vacant. What can go wrong with that, Mr. Missal, that high vacancy rate in an H.R. office?

Mr. MISSAL. What could go wrong is you're not going to be able to hire the people in the other departments and divisions that you're going to need. And that was what we found when we came onsite at D.C. is their H.R. department was so broken that they had outsourced it to the Baltimore medical center. So the Baltimore medical center H.R. department was not only trying to staff Baltimore, but D.C. as well. And without effective HR, it is extremely challenging to make sure you have the resources and the staff necessary to do the job necessary.

Mr. CONNOLLY. So H.R. is kind of key to an enterprise. If you want to—you want to have new hires, they've got to be processed.

Mr. MISSAL. Absolutely.

Mr. CONNOLLY. H.R. does that.

Mr. MISSAL. Absolutely.

Mr. CONNOLLY. If certain things have to—personnel actions have to be adjudicated: termination, promotion, demotion, demerits, whatever. All of that has to, in some fashion, go through HR. Is that correct?

Mr. MISSAL. I think the administrative part, but you may have employee relations as well that deals with some of those issues. But they should be working very closely with HR.

Mr. CONNOLLY. Well, if I'm terminating someone, I got—the paperwork at least is done by HR?

Mr. MISSAL. Correct. Administratively, you have to go through HR.

Mr. CONNOLLY. Right. And I got—let me see—how many people—2,564 people. And you're going to have some turnover. And some of it generated by performance, some just generated naturally: retirement attrition, move on. That could keep an H.R. office pretty busy.

Mr. MISSAL. Yes.

Mr. CONNOLLY. And I still have 964 positions vacant. Is that correct, Mr. Heimall?

Mr. HEIMALL. Yes, sir.

Mr. CONNOLLY. So I got 25 people to do all of that. I need 78. So I'm—if I'm running HR, I'm under a lot of pressure. And, frankly, it may be almost an impossible task, given the numbers. I don't know.

Mr. Heimall, what are you finding as the relatively new director is—what's the impediment to filling these critical positions in HR, and what do you propose to do to try to resolve it?

Mr. HEIMALL. Yes, sir. And I would like to—you know, beyond some of the examples you said, the 965 number of vacancies, I'm trying to hire back 425 of those. In our data system that we pulled that data from for your staff, those remainder positions that we are not going to hire back, we should inactivate in the system so it doesn't look like there's a vacancy there. That would be the proper way to do it. And one of the challenges with the shortage that we have in H.R. is we're not able to do that properly, which means we create a false picture of what our vacancies are.

Mr. CONNOLLY. I'm sorry. When you say inactivated, it just sounds so Nixonian. So if you were inoperative, inactive——

Mr. MEADOWS. Can you find a different word?

Mr. HEIMALL. The term we used when I—my year in the private sector was funded head count. All right? This is head count that I am not going to fund, I am not going to hire back. And so there's a way to code that in the system so it does not look like a vacancy.

Mr. CONNOLLY. And I take that point. And we'll—that's fine. But you've still got a vacancy problem in HR, which is kind of critical to your being able to manage the enterprise and do everything you want to do. Improve morale, improve productivity, have a more empowered staff that feels they can actually make decisions, as Mr. Meadows said.

Mr. HEIMALL. So we have an arrangement with work force management consultants from the VHA's human resources division

that provides 17 full-time equivalent staff to help us process hiring actions. And, quite honestly, that is—the way we are surviving on a day-to-day basis right now is that two-year arrangement that we have with work force management consultants.

We have prioritized, in our hiring strategy, filling those H.R. vacancies. Within the VHA, we are also going to an H.R. consolidation at the VISN level. So we have already consolidated the classification of position descriptions which determines the pay grade we bring someone on at the VISN level. We are in the process of now working through consolidating, across the six facilities, the other human resource functions. And on a national level, we are going to begin consolidating our retirement processing.

Every time the central office comes up with a—for example, a retirement processing, I'm happy to take advantage of the centralization of that, because it means I can get better service for my employees who are retiring and free up my internal H.R. staff to be working staffing, recruitment, disciplinary actions.

Mr. CONNOLLY. But just to be clear, I want to make—you can—however you answer, but I want to make sure I don't misunderstand you. You are not saying outsourcing H.R. is the long-term solution?

Mr. HEIMALL. No, I am not.

Mr. CONNOLLY. It's just a short-term solution because of the dire need for functioning and to buy yourself some time to fill these vacancies in HR?

Mr. HEIMALL. Yes, sir.

Mr. CONNOLLY. Mr. Missal, and then I'm going to call on Ms. Wexton.

Mr. MISSAL. Mr. Chairman, I just would also like to add that a staffing model is so critical to ensure you have the proper staff. We've been talking about numbers here and vacancies. I don't know if those are the right numbers, because until you have a good staffing model which tells you what you need and where you need it, it's really hard to know whether or not it's effective.

And we put out a staffing report every year across VA. And it's been very frustrating, because, for years, we've been saying VA needs to have staffing models across all the disciplines. They've done a pretty good job on primary care, but there's a number of other specialty areas which they haven't done it. And I don't want that to be missed. And that was one of our recommendations. It's still open with respect to staffing models.

Mr. CONNOLLY. Thank you.

The gentlelady from Virginia is now recognized for her five minutes, Ms. Wexton.

Ms. WEXTON. Thank you, Mr. Chairman, for yielding and for inviting me to participate in today's hearing. And thank you to the witnesses for coming to testify before the committee today.

So my district, I represent the top triangle of Northern Virginia, far Northern Virginia. My district starts just outside of Washington, DC, and goes all the way out to the west to the Shenandoah Valley. So somebody at the midpoint of my district could go to either the D.C. VA or to Martinsburg, West Virginia. And it would be a little bit more than an hour in each direction for those folks.

Now, most of the folks live on the eastern side of my district, though, who need those services. But what we have encountered in terms of a constituent service standpoint is that more and more of our veterans want to go to Martinsburg because they are not getting the satisfying care that they need at the D.C. VA.

And I'm glad that you guys have made progress. It looks like you're really digging in and doing what you can in the short time you've had thus far. But there obviously are still some ongoing issues that the patients there are having to face. I think understaffing has been a lot of the cause of that. It seems that everybody agrees. It's resulted in longer than usual wait times and unresponsive departments. And a lot of our constituents are reaching out to our office in assistance of transferring their cases from D.C. to Martinsburg, despite the fact that it's going to take them longer to get there.

Now, Chairman Connolly talked a little bit about the staffing issues. And I know that you have had pervasive staffing issues across multiple departments. Have you hired yet or is there a plan to prioritize hiring a new H.R. director, Mr. Heimall?

Mr. HEIMALL. Yes, ma'am. Our new H.R. director came on board, I believe, in September 2018.

Ms. WEXTON. Okay. And is there a staffing plan to fill the vacancies that you have?

Mr. HEIMALL. Yes, ma'am, there is.

Ms. WEXTON. How are you prioritizing which positions you're trying to fill first?

Mr. HEIMALL. We looked at where our greatest pain points were. When I first came on board, we had prioritized 45 housekeepers as one of our top priorities, but we had a very functional housekeeping contract that was supporting the facility and actually doing a wonderful job. I reprioritized those positions lower on our priority list, and I moved up positions like human resources, our patient safety manager, and our infection control nurses so that we could provide better care and we could also hire them on board the staff that we need to support the medical center.

Ms. WEXTON. So you moved up the positions that have direct patient contact care, those kinds of——

Mr. HEIMALL. Yes, ma'am. Or ones that were absolutely critical for us bringing on board the people that we needed to bring on. We also prioritized some of our logistics in SPS positions a little higher on the list so that we could fill those critical gaps as well.

Ms. WEXTON. Okay. Very good.

And one of the things that Mr. Missal brought up in his remarks at the end of the chairman's questioning was that a lot of your data from 2017 and 2018 were unavailable when it came to staffing vacancies in the H.R. system because it was not properly maintained as the system of record for a position management. So basically, you didn't know what you didn't know, right?

Mr. HEIMALL. Exactly, ma'am.

Ms. WEXTON. Okay. What changes has the facility implemented to ensure that you have accurate tracking about vacancies and what——

Mr. HEIMALL. We have validated an organization chart for every single one of our departments. And technically, under H.R. mod-

ernization, H.R. belongs to the VISN, but I validated their staffing chart as well so I could make sure I have the local staff that I need to support the medical center. That information now needs to be corrected in the H.R. system so that we have a position management system that allows us to function and prioritize our needs. And that is the last piece that needs to be completed from the two recommendations on H.R. in the IG report.

Ms. WEXTON. And do you have a timeline for that to take place?

Mr. HEIMALL. We expect that will be completed by 30 September of this year.

Ms. WEXTON. Okay. Very good.

And what steps is the facility taking to retain top talent, especially medical talent? Nurses. I know that there's been a lot of turnover and a lot of them working a whole lot of overtime, which has cost them in terms of their satisfaction.

Mr. HEIMALL. Yes, ma'am. We're looking very hard at the salary rates among our competitors. Somebody sent me a flyer last night that one of our local competitors is offering a $20,000 recruitment bonus for nurses. That means we've got to put recruitment bonus in all of our job announcements for nurses and try to match that. And if any of our nurses tell us that they're going to leave for that $20,000 recruitment bonus, I would like the opportunity to match that with a retention bonus before they make a decision.

Ms. WEXTON. Thank you very much.

I see my time has expired, so I will yield back.

Mr. CONNOLLY. Wouldn't it be nice if there were a retention bonus for Members of—no. No. Just talking crazy here.

Mr. MEADOWS. You're going to regret that question.

Mr. CONNOLLY. Let the record show I didn't approve of that. I just asked.

Mr. MEADOWS. You're against it, I'm sure, right?

Mr. CONNOLLY. I'm against it, as is——

Mr. MEADOWS. As I am, yes.

Mr. CONNOLLY. Go ahead.

Mr. MEADOWS. I want to make just two requests and a closing comment. And the chairman has afforded me that luxury, and I thank him.

Director, whenever you have a hearing like this, there's two things that come out of it, is either a good action plan—and it sounds like you're well on your way to addressing the outstanding issues. And I understand by October, you're going to have those outstanding issues on the IG's report done. Is that correct?

Mr. HEIMALL. Yes, sir. We expect everything to be completed by 30 September.

Mr. MEADOWS. But there is a tidal wave of complaints that will come in for people that have been watching this hearing. And I just—they're going to call the I-Team investigator and say, yes, but. They're going to call our staffs. And the chairman and the gentlewoman from Virginia and the gentlewoman from the District of Columbia will get a number of complaints.

And so here is my ask of you, is when those come in, if—will you remain committed to address all of those as expeditiously as you have testified here today? Are you committed to do that and give rapid response on those complaints that come in?

Mr. HEIMALL. Yes, sir, I absolutely am.

Mr. MEADOWS. All right. And I'll close with this. I can tell that you're sincere. And I came into this hearing so angry and so upset that our veterans had not been served, partly by the investigative team work that's done, partly by the numbers that we've seen. We know that you didn't create this problem. In fact, this is a systemic problem that has been there, it appears, for a number of years. And so I want to say thank you for having a sobering response and not pretending like everything is fixed. I appreciate that.

One of the telling things is when you talked about how teams were afraid—the IG pointed out teams were afraid to come to management. And you admitted there are still pockets of that now. Very transparent. I don't know that most witnesses would do that. I want to thank you for doing that.

We would also like a good health report over the next 60 to 90 days on where you're coming. And if you would be willing to commit to do that, I think the chairman and I would love to look at this very closely. Are you willing to do that?

Mr. HEIMALL. Yes, sir, I am. And I would love to have both of you visit the facility.

Mr. MEADOWS. I thank you.

And I thank, again, the chairman for his leadership, and I yield back.

Mr. CONNOLLY. I thank my friend.

So in conclusion, we're going to develop a matrix for monitoring progress, and it's got to be a workable matrix to you and for us. And we welcome your involvement and that of your office, Mr. Missal, so that it meets your concerns as well.

So if all of us sign off on, yes, that's the way we're going to measure, then we can look at how well we're doing. But we got to first agree on what are the metrics. We need to see to be satisfied that all the people we're accountable to can see or not see the progress we're making.

You've made a commitment, Mr. Heimall, to stick around. You've made a professional and, I think, moral commitment to the men and women we serve to get this right. You're not leaving until we do. And we want to hold you to that. But we also want you to know we understand the nature of that professional commitment. And for God's sake, please keep it.

Mr. HEIMALL. Sir, that is one I—I love the team that I work with. I love the veterans that we are privileged to care for. And if something were to arise that would cause me to question that commitment, it would be an incredibly painful day for me, so I am here for the long haul.

Mr. CONNOLLY. But I also think, when you have the kind of turnover in leadership that your facility has had, it's—it has a huge toll on productivity and morale with the work force. And it adds to that culture of complacency or indifference that we talked about, because I know I can wait you out. Average life spans of one of you people is three months, or whatever it is. And I think that's had a hugely deleterious impact on the quality of care at this facility and the commitment to the veteran.

Having stable leadership that exacts standards of performance, rewards good performance but also holds people accountable for

bad performance can have a very salutary effect. And the beneficiaries of that salutary effect are the men and women who wore that uniform who are counting on us to deliver quality care for them and their families.

I thank you for coming here today. This hearing is adjourned.

[Whereupon, at 3:44 p.m., the subcommittee was adjourned.]