A MATTER OF LIFE AND DEATH: EXAMINING PREVENTABLE DEATHS, PATIENT SAFETY ISSUES, AND BONUSES FOR VA EXECS WHO OVERSAW THEM

FIELD HEARING

BEFORE THE

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

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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A MATTER OF LIFE AND DEATH: EXAMINING PREVENTABLE DEATHS, PATIENT SAFETY ISSUES, AND BONUSES FOR VA EXECS WHO OVERSAW THEM

Monday, September 9, 2013

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

The Committee met, pursuant to notice, at 9:00 a.m., in Room 410 of the Gold Room, Allegheny County Courthouse, 436 Grant Street, Pittsburgh, Pennsylvania, Hon. Jeff Miller [Chairman of the Committee] presiding.

Members present: Representatives Miller and Michaud.

Also present: Representatives Doyle, Murphy, and Rothfus.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. Good morning and welcome to today's Full Committee hearing entitled, "A Matter of Life and Death: Examining Preventable Deaths, Patient Safety Issues, and Bonuses for VA Executives Who Oversaw Them."

Before we begin, I would like to ask unanimous consent that our colleagues from Pennsylvania, Mr. Doyle, Mr. Murphy, and Mr. Rothfus be allowed to sit at the dais and participate in today's proceedings.

Without objection, so ordered.

And I would also like to thank the good people of Allegheny County for hosting us today here.

As most of you are aware, the Department of Veterans Affairs, Veterans Health Administration provides health care services for millions of American veterans, but recently a rash of preventable veteran deaths, suicides, and infectious disease outbreaks at several VHA facilities throughout the country has put this organization under intense scrutiny.

Despite the fact that multiple VA Inspector General reports have linked a number of these incidents to widespread mismanagement at VHA facilities, the Department has consistently given executives who presided over these events glowing performance reviews and cash bonuses of up to $63,000.

Many Americans have watched in disbelief as these events have unfolded on their television screens and in the pages of their local newspapers.

For some, however, this tragic incident has hit much closer to home.

So I would like to take a moment to recognize all the family members of those who have suffered preventable deaths at VA

medical centers, as well as any veterans who have endured VA patient-safety incidents that are here in attendance today.

Additionally, I want to recognize former American Legion National Commander Ron Conley, for whom the Pittsburgh Legionnaires Disease outbreak is very personal because he was at the 1976 American Legion convention and in the hotel during the original Legionnaires Disease outbreak in Philadelphia.

To the families of those who have passed away, I know I speak for every Member of Congress here today and every Member of our Committee when I say that we are deeply sorry for your loss, and we will simply not tolerate substandard care for our veterans under any circumstance.

When we hear about it, we will investigate it and keep the pressure on VA until the problems are resolved and those responsible for letting patients fall through the cracks are held accountable, and that is precisely why we are here today.

The purpose of this hearing is to examine whether VA has the proper management and accountability structures in place to stop the emerging pattern of preventable veteran deaths and serious patient safety issues at VA medical centers across the country.

In doing so, we will specifically look at VA's handling of recent events in Pittsburgh, Atlanta, Buffalo, New York, Dallas, and Jackson, Mississippi.

For the folks we just recognized, the good people of Pittsburgh, and all those watching this hearing over the Internet, what you are about to hear is going to be disturbing, but just so everyone understands the significance of the five locations I just named, I want to offer a brief rundown of why these incidents are so troubling to the Members of our Committee and, indeed, to other Members of the United States Congress.

In Pittsburgh, VA officials knew they had a Legionnaires Disease outbreak on their hands, but kept it secret for more than a year. Five veterans are now dead.

Despite all of that, VA Pittsburgh Director, Terry Gerigk Wolf, received a perfect performance review during a period that covered the bulk of the outbreak and Regional Director Michael Moreland, who oversees VA Pittsburgh, accepted a $63,000 bonus just three days after VA's Inspector General reported VA Pittsburgh's response to the outbreak was plagued by persistent mismanagement.

In Atlanta, two VA Inspector General reports identified serious instances of mismanagement that led to the drug overdose death of one patient and the suicides of two others.

True to form, VA doled out nearly $65,000 in performance bonuses to the medical center director who presided over the negligence.

During a visit to the hospital in early May, hospital officials told me that although they had identified specific employees whose actions had contributed to patient deaths, no one had been fired. When I asked a roomful of Atlanta VAMC leaders if there were any other serious patient-care incidents that Congress needed to know about, they said, no, failing to reveal a previously unreported suicide that the media would expose just four days later.

At the Buffalo, New York, VAMC, hundreds of veterans were potentially exposed to Hepatitis and HIV after facility staff had been

reusing multi-use, disposable insulin pens. At least 18 veteran patients have tested positive for Hepatitis so far.

In addition, officials at hospitals in Buffalo and Battavia failed to properly maintain medical records, leading to the damage of thousands of patient files. Despite all of this, David West, the man tasked with overseeing the Buffalo facility, pocketed nearly $26,000 in bonuses.

The Dallas VA Medical Center has been the subject of a series of serious allegations from VA workers, patients, and family members regarding poor care at the facility, as well as more than 30 certification agency complaints in the last three years alone. The fact that there have been so many allegations of poor care at this facility is troubling enough.

What is also troubling is that Congresswoman Eddie Bernice Johnson of Dallas worked for more than a year behind the scenes to get VA officials in Washington to seriously investigate the matter.

Amidst these accusations, two top VA health administrators in Texas have collected a combined $50,000 in bonuses since 2011.

The situation in Dallas mirrors another instance of VA's apparent failure to take multiple allegations of poor patient care seriously, this time in Jackson, Mississippi. At the VA Medical Center, there a series of whistleblower complaints from medical center employees to an independent Federal watchdog called the Office of Special Counsel or OSC, raised concerns about poor sterilization procedures, understaffing, and misdiagnoses. Based on OSC's recommendations, VA was required to investigate the complaints, but VA Under Secretary for Health, Dr. Robert Petzel, downplayed the problems by referring to them as "kerfuffles."

So is it any wonder that the OSC wrote to the President in March of this year to voice serious concerns with the outcome of VA's investigation and the manner in which it was conducted?

In her letter to the President, U.S. Special Counsel Carolyn Lerner said, "It does not appear that the agency has taken significant steps in improving the quality of management, staff, training, or work product," and that the whistleblower complaints, "raise serious questions about the ability of this facility to care for the veterans it serves."

To me, that is about as far away from a kerfuffle as it can get.

There are two sides to every story, of course, and later we will hear from VA officials who will likely tell you that these problems are all in the past, but just last Friday, VA's Inspector General released another report that will challenge that assertion.

After an investigation into the VAMC in Columbia, South Carolina, the IG found that mismanagement at the facility helped create a backlog of thousands of gastrointestinal consultations, leading to 19 instances of serious injury, harm or veteran patient deaths.

We have a photo on display on this side of the dais that I took myself during a recent visit to a medical facility in Albuquerque, New Mexico, and it depicts a quote from Dr. Petzel that was emblazoned on the wall of the facility. It reads, "Improving our work is our work."

Well, it appears that the work is not improving, and the question VA officials must now answer is, "Where is the accountability?"

We are not here as part of a witch hunt, to make VA look bad, or to score political points. We simply want to ensure that veterans across this Nation are receiving the care and benefits that they have earned.

No one is questioning whether VA officials are sorry for these incidents or if VA officials are committed to providing the best possible care because we know that they are. We also know that the vast majority of the Department's more than 300,000 employees are dedicated and hardworking, and many veterans are satisfied with the medical care they receive from VA.

What we are questioning today is whether VA has the proper organizational culture, accountability, and management structures to minimize the future occurrence of heart-breaking situations like the ones that I have just described.

Considering that the VA executives who presided over the incidents I just described are more likely to have received a bonus or a glowing performance review than any sort of punishment, the question we are asking here today is entirely valid.

By now, it is abundantly clear to most that a culture change at VA is in order, and it is imperative. Today, we will find out if VA leaders agree.

I now yield to our Ranking Member, Mr. Mike Michaud, the gentleman from Maine, for an opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. MICHAEL H. MICHAUD

Mr. MICHAUD. Thank you very much, Mr. Chairman. I would like to thank all of you for coming here today.

Patient care issues are a continuing concern of this Committee. I want to thank Chairman Miller for his aggressive oversight hearings, not only field hearings, but also Washington, DC, to address a lot of the issues affecting the VA. I also want to thank my colleagues as well from Pennsylvania who will be here today also.

Patient care is a top priority for me. In my own State of Maine, I keep a vigilant watch to ensure that veterans receive timely, quality, and effective health care. While we are here to discuss the problems within the VHA Care System, I would be remiss if I do not recognize the Veterans Health Administration. It is a very large organization, and the majority of employees throughout VHA are hardworking and very dedicated to serving veterans and their families. For those hard-dedicated employees, I want to thank them for their efforts.

Unfortunately, we are here in Pittsburgh today to talk about some of the very serious problems within VA Healthcare System. This hearing is focusing on five VA Medical Centers. However, patient care issues at 13 different locations have been brought to our attention just this year. It is clear that there is much that we have to do, and the systematic issues that plague the Veterans Health Administration is concerning to a lot of us on this Committee.

These issues include failing to hold employees responsible and accountable for their actions, widespread non-compliance with established policy and procedures, inadequate training of employees

and personnel, and what comes across in reports as a general disregard to provide effective oversight of programs.

My concern remains the big picture. I am hoping that today's testimony will not fall upon deaf ears and that VHA will listen to the veterans and their families to whom they are responsible for taking care of. I lay the responsibility of the patient care directly at the feet of VA and VHA management at every level.

Today's hearing will shed light on what these five facilities are doing to correct the wrongs and put action plans in place to ensure these egregious actions are not repeated throughout the VA System, and I look forward to hearing from them on the progress that they have made to ensure that the veterans receive the quality care that they have earned and deserve, the attention and good health care that we have got to make sure that every veteran receives throughout the VA System.

And with that, Mr. Chairman, I want to thank you very much for having this hearing in Pittsburgh, and I want to thank the panelists on both panels for coming today as well. I look forward to hearing your testimony.

The CHAIRMAN. Thank you very much. I would like to recognize a gentleman who has the VA Medical Center within the confines of his Congressional District, the gentleman from Pennsylvania, Mr. Doyle.

OPENING STATEMENT OF HON. MICHAEL F. DOYLE

Mr. DOYLE. Thank you, Mr. Chairman. I appreciate you and the Ranking Member being in Pittsburgh today. I wish you weren't in my city. You are here because something has gone terribly wrong in Pittsburgh.

Before us, we have the family members who lost loved ones, and I want to say to each and every one of you that you have our deepest sympathy and condolences, and you deserve answers, and we are here today to try to get you some answers and to make sure that there is accountability and to make sure that this doesn't happen ever again. We can never guarantee perfection in any system, but every day that the men and women, and I want to say the vast majority of men and women who serve our veterans in VA hospitals are good people who care for our veterans, who love our veterans, and try to provide them the best care possible, but something clearly went amiss in these cities, and we need to get to the bottom of it to make sure that it never happens again.

Mr. Chairman, I want to thank you. When Congressmen Murphy and Rothfus and I came to you when we first learned of this and asked for this Committee to provide its oversight function, you acted swiftly, and I want you to know that we appreciate the hearings that you held in Washington, DC, and the fact that you are here today to continue to make sure that we get answers for these family members and for other families, so that they can feel secure that when they bring their loved ones to VA hospitals anywhere in this country, they are going to receive the best care.

So, Mr. Chairman, thank you for being here today. I appreciate it.

The CHAIRMAN. Thank you very much, Mike, and Mr. Murphy from Pennsylvania also has been in the forefront of bringing this

issue to the Committee's recognition, and I recognize you for an opening statement.

OPENING STATEMENT OF HON. TIM MURPHY

Mr. MURPHY. Thank you, Mr. Chairman.

Proud to serve his country during World War II, William Nicholas told his family to always take him to the VA for his medical care. He, like thousands of other veterans, was loyal to the VA because of his steadfast belief that the government would honor its commitment to veterans and deliver the best possible care.

But the faith and trust placed in the VA by our Nation's veterans has eroded because of the heartbreaking stories told by our witnesses due to appear at today's hearing.

These tragedies in many cases could have been avoided had those responsible for operating the VA hospitals followed their own internal guidelines and acted decisively when confronted with problems. We wouldn't be here today if they did that.

As the renowned Institute of Medicine reported on patient safety states, "To err is human." Mistakes will happen which is why a rigorous system of safety and accountability must be in place at hospitals. When issues are identified, errors must be corrected immediately so that lives are saved. Instead, what the Inspector General and this Committee have documented at the Pittsburgh VA Healthcare System was a management beset with an attitude of arrogance and indifference that led to at least six veterans to die from a Legionnaires Disease outbreak.

The arrogance led to the destruction of the world-class special pathogens lab, which kept the VA Pittsburgh free of Legionnaires cases for nearly a decade. If the SPL still had been operational, the evidence shows there likely would not have been a two-year struggle to control Legionella bacteria in the hospital's water system.

The indifference was that the VA Pittsburgh leadership failed to maintain water quality equipment, coordinate infection control efforts, or communicate with medical staff about the Legionella problems so vulnerable patients would immediately receive diagnostic testing, and appropriate treatment when the difference between life and death was measured in hours.

Even when the Legionella problem was discovered in Pittsburgh, the VA failed to follow its own protocols in flushing its plumbing system properly to eliminate the risk of infection and then during a Congressional hearing, VA personnel told us the cleaning and testing were thorough. They were not.

And yet for this record of failure, tens of thousands of dollars in bonuses were given to top executives at the VA Pittsburgh. Last month, I wrote to the VA Secretary asking whether there had been any suspensions, sanctions, or firings of individuals who contributed to the failures that led to the November 2012 outbreak. I have yet to receive an answer.

The VA let these families down and then took their tax dollars and gave to those who were in leadership positions when these tragedies occurred. It is unconscionable, and I hope we will see a change in culture at the VA, so we can begin to rebuild the trust that men and women who wear the uniform have in the VA and the stability to fulfill the words of Abraham Lincoln to, "Care for

him who shall have borne the battle and for his widow and his orphan."

I yield back.

The CHAIRMAN. Mr. Rothfus, do you have any opening comments you would like to make?

OPENING STATEMENT OF HON. KEITH J. ROTHFUS

Mr. ROTHFUS. I would like to thank the Chairman and the Ranking Member for allowing me to participate in this hearing today, and thank you for arranging for this hearing here in Pittsburgh.

I want to first thank all the witnesses for sharing your stories here today. The debt we owe your loved ones and all our veterans can never be repaid, and we must do all we can to ensure that they receive the best quality health care that they have earned and rightly deserve.

Transparency and accountability are important parts of making that happen, and I am hopeful that the testimony that you give today and the testimony we hear from the VA is going to be a step in that direction.

I thank the Chairman, and I yield back.

The CHAIRMAN. Thank you very much, and thank you to the witnesses for patiently listening to the opening statements of the Members here. I want to welcome each of you to the witness table.

I would like to introduce everybody to the witnesses. They are veterans, family members, and whistleblowers from across the country who have personally been impacted by patient safety violations and management failures at VA Medical Centers, again, in Atlanta, Buffalo, Dallas, Jackson, and here in Pittsburgh. We are joined by Brandie Petit from McDonough, Georgia. Ms. Petit is the sister of Joseph Petit. Last fall, Joseph went to the Atlanta VA Medical Center seeking mental health services. When VA failed to provide him with the help he was asking for, he committed suicide in a staff bathroom where his body was found the next day. Ma'am, thank you very much for being willing to come here today and to tell your brother's story.

We are also joined by Gerald Rakiecki from Depew, New York. Gerald is an Air Force veteran and VA police officer and whistleblower at the Buffalo VA Medical Center. Sir, thank you for your service and, again, thank you for being with us today.

Also with us is Sydney Schoellman from Allen, Texas. Ms. Schoellman is the daughter of Gary Willingham, a veteran, who passed away as a result of serious complications resulting from a medical error he experienced while undergoing surgery at the Dallas VA Medical Center. Thank you for being here today and representing your father.

Also joining us is Dr. Phyllis Hollenbeck. Dr. Hollenbeck has worked at the VA Medical Center in Jackson, Mississippi, for five years and is a protected witness by OSC. Dr. Hollenbeck, thank you for being here.

And we are also joined by Robert Nicklas from Butler County, Pennsylvania. Mr. Nicklas is the son of William Nicklas, a Navy veteran, who died from Legionnaires Disease he contracted from the Pittsburgh VA Medical Center. He is accompanied by his wife

Judy. Thank you both for being here and telling us about your father, and we are grateful for his service as well.

And finally, we are joined by Maureen Ciarolla from Monroeville, Pennsylvania, or Monroeville, depending, I guess, on which side of the mountain you come from. Ms. Ciarolla is the eldest child of Joseph Ciarolla, a Navy veteran, who died from Legionnaires Disease he contracted from the Pittsburgh VA Medical Center. Thank you for being here, too, and sharing your father's story with us. We are truly grateful for his service as well.

It is an honor to have each of you here with us today. I understand how difficult and emotional your testimony today will be, and I appreciate each of you, again, for joining us to tell the stories.

Ms. Petit, you may now proceed with your testimony.

STATEMENTS OF BRANDIE PETIT, VETERAN FAMILY MEMBER, ATLANTA, GEORGIA; GERALD J. RAKIECKI, VETERAN AND VA POLICE OFFICER, BUFFALO, NEW YORK; SYDNEY N.W. SCHOELLMAN, VETERAN FAMILY MEMBER, DALLAS, TEXAS; PHYLLIS A.M. HOLLENBECK, M.D., FAAFP, VA PRIMARY CARE PHYSICIAN, JACKSON, MISSISSIPPI; ROBERT E. NICKLAS, VETERAN FAMILY MEMBER, PITTSBURGH, PENNSYLVANIA, ACCOMPANIED BY JUDY NICKLAS, VETERAN FAMILY MEMBER, PITTSBURGH, PENNSYLVANIA; AND MAUREEN A. CIAROLLA, VETERAN FAMILY MEMBER, PITTSBURGH, PENNSYLVANIA

STATEMENT OF BRANDIE PETIT

Ms. PETIT. I am Brandie Petit, sister——

The CHAIRMAN. You are probably going to have to pull the mike real close to you.

Ms. PETIT. Okay. Hold on. I am Brandie Petit, sister of Joseph Petit. Thank you for allowing me to speak about my brother. Joseph didn't have a lot as a child, but he wanted more. Joseph showed me information he had about the Army. He told me, "I want to be the best of the best." He believed he could make a difference as an Airborne Ranger.

Growing up, Joseph was very active. He ran, weightlifted, and seemed to eat everything in sight. I can't ever recall him taking any medications, even over-the-counter meds for something as simple as a headache.

Joseph was determined to be a ranger. He passed all his physical flawlessly at the Atlanta Military Enlistment Processing Station, but in March of '91, while on airborne training, he injured both his knees performing parachute landing falls. Dr. Greer Busbee did not examine him for more than six months after his injury and would not allow him a second opinion or other treatment.

Joseph wanted his knees fixed because he still was aspired to be an airborne ranger, but he received an honorable medical discharge instead.

With almost two decades of begging for help with no results, persistence paid off. The VA finally agreed to help him. He was very happy to have them look at his knees after all that time. He was in a great deal of pain. The VA saw Joseph and said the problem was in his head, and sent him home with meds for his head, not

his knees. They said that if he took those meds and did specific exercises, his knees would quit hurting. Joseph was willing to try and was hopeful it would ease his pain, but it never did.

In February of 2012, I took him to an appointment at the VA set up at QTC Medical Group where he had to do several movements with his knees. I heard one of his knees pop. It sounded like a chicken bone snapping. The other one sounded like bone-on-bone grinding. Those sounds gave me chills. If his knees were okay, then please explain how I heard those sounds. Why did my brother break his teeth gritting from the pain of trying to walk?

One day Joseph went to the VA seeking help, and they told him that he needed to leave because he didn't have an appointment. The VA police physically and forcibly removed him and put a standing order in place to arrest him if he showed up again without an appointment.

I am outraged at his treatment that day. My brother deserved respect if nothing else. If your job involves people, it doesn't matter how many credentials you have, without compassion, credentials mean absolutely nothing. The Bible says in Luke to treat others as you would have them treat you. My brother treated everyone with respect.

Joseph told me if he did what the VA said, they would finally fix his knees. So he took over 20 pills a day as prescribed, and just about every time he went to an appointment, they looked him up for being unstable or suicidal, and they changed his meds and sent him home. Joseph was afraid that if he stopped following the VA's treatment, they would stop helping him.

Due to the side effects, Joseph literally chained himself around his ankle and used a master lock so that he would not wake up hallucinating and harm someone. He told the VA he was suicidal, but they ignored him, so he went to the bathroom, put a zip tie around his neck, and someone walked in and found him on the floor unconscious.

Again, they changed some meds and sent him home about a week later. He begged them to put him on some meds that wouldn't give him those thoughts. He stated he wasn't thinking clear. Please lock him up. He didn't want to hurt anyone. He begged the VA to fix the medication problem they had created. He wanted to walk without pain.

Many of his medications caused hallucinations. He went to the VA on November the 8th hearing voices and hallucinating and asking for help. My brother was a prisoner in his own body. He couldn't even stand up alone. My 12-year-old son watched his uncle Joseph fall down the stairs. My brother, who was so selfless and compassionate to others, was dying in front of me.

Joseph sent me texts, hallucinating. It was very sad to read those. That was not my brother anymore. My brother was hiding in there somewhere, trying to get help. He did not commit suicide because he felt sorry for himself. He committed suicide to protect others from his hallucinations.

Joseph was given information about homeless shelters. My brother would have never been homeless. The words homeless and veteran should not be used together. Veterans fight for our freedoms. I do believe they should be treated with more respect. If you go to

a VA and look around, you will see a lot of men and women being neglected, forgotten, and shamed by the actions of the American people.

The VA also disrespected my mom and I after his death. We didn't know where to go to pick up his belongings. My mom was on the phone asking the VA's police where to go. Their reply was, how did he die? Was it suicide? Now, you tell me why they had to ask my mother that right then.

We need to make sure that compassion is not forgotten when dealing with a person, a brother, a son, an uncle, a friend, a solider. Joseph was gracious and generous to the bitter end. Seeing no way to a cure in the care provided, he took himself out of the long, long line to make way for someone else to try to get help from the VA. It was typical of my brother to bring much attention in his quiet way to another lack of ethics in government.

I don't believe my brother was perfect, nor do I believe anyone else in this world is. I do believe when someone says they need help, they should be taken more seriously. How dare anyone try to hide my brother's death. Why didn't someone make sure he got on the transportation bus home? Ten months ago today, they found him several, several hours later in a bathroom where he had committed suicide.

This could have been avoided. He was a good soldier, a good man, a good son, a good friend, and a damn good brother. What would you do if Joseph was your brother or your son or your friend?

Thank you.

[THE PREPARED STATEMENT OF BRANDI PETIT APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Mr. Rakiecki, you may now proceed with your testimony.

STATEMENT OF GERALD J. RAKIECKI

Mr. RAKIECKI. I, Gerald Rakiecki, have been invited by Congress to testify in regards to all the knowledge I have about veterans' health care at the Buffalo VA. This written document contains information about events which occurred from December 2011, through the present period of time. Some of the information was directly relayed to me by VA Buffalo HIMS employee, Mr. Leon Davis, VA Buffalo LPN employee, Patricia Morrison, VA Buffalo EMS employee, James E. Carney. The following is my statement and affidavit on this matter.

I served over two years consecutive active duty with the United States Air Force. I am a service-connected veteran, and I was honorably discharged from my military service. I am employed by the facility as a police officer. I have also served as a steward and a chief union steward with the Service Employees International Union, Local 200 United, which is the exclusive representative of the VA employees within the particular bargaining unit.

In the course of my collateral duties as chief steward, I represented Mr. Tracy Harrison, a VA Health Information Management Systems employee, who was, in fact, a whistleblower concerning the mismanagement of veterans' medical records. Mr. Har-

rison made a protected disclosure of damaged and mishandled records and was subsequently threatened by Associate Director, Mr. Jason Petti.

In December of 2011, I became aware of these allegations of mismanaged records by Mr. James E. Carney, who was also a union steward under my charge. Mr. Carney explained to me the four HIMS employees' allegations. Over the next month and a half, I had several conversations with Mr. Carney about these allegations, and at first it was hard for me to digest the magnitude of what I was being informed of. According to Mr. Carney, approximately 240 boxes containing hundreds of patient records were wet, moldy, stuck together, out of sequence, out of order, inaccessible, and unattainable.

Eventually, I informed Patricia Morrison, who is also the current SEIU Divisional Chairperson for the Buffalo Division. I relayed this information directly to her in January of 2012. In term, Ms. Morrison warned me to keep out of it. Ms. Morrison explained that Associate Director Jason Petti confided in her with his plans to take administrative action against the reporting HIMS employees in the form of reclassification, downgrading, and possible removal from government service. It became clear to me, Ms. Morrison was placing her support as the SEIU Divisional Chairperson behind Jason Petti and the HIMS Manager, Liz Kane, instead of the membership she was elected to represent.

I was aware of a subsequent meeting held between labor and management on this matter, which took place on February 8, 2012, which proved ineffective. In fact, Associate Director Jason Petti made a clear, written threat against the four HIMS employees; Mr. Leon Davis, Cathleen Manna, Pamela Hess-Wellspeak, and Tracy Harrison. Associate Director Jason Petti sent a Microsoft Outlook email in which he singled out the whistleblowers by writing, you four. Assistant Director Jason Petti also wrote that he expected the four to correct the problem during their work hours in addition to their regular duties. Associate Director Jason Petti attached the Union Chairperson, Ms. Patricia Morrison, to this email, and this information is documented in the Agency investigation and OSC findings.

The four HIMS employees followed up by making a formal disclosure to the Office of Special Counsel. In turn, their disclosure resulted in an Agency investigation. As a result of that investigation, a majority of the charges were sustained in September of 2012. An OSC report of the Agency Investigation was released to the public in the spring of 2013.

I represented Mr. Tracy Harrison in January of 2013 through March 6 of 2013 on a proposed discipline. Mr. Harrison was charged with being AWOL and a reprimand, two forms of discipline for one incident. The fact is, Mr. Harrison requested annual leave in the VA's computer leave system. Mr. Harrison's leave was, in fact, approved, and he took his approved leave. Ms. Kane, however, performed a corrected timecard, reversing Mr. Harrison's approved leave so she could impose discipline.

The evidence proved the discipline Mr. Harrison experienced was a direct result of retaliation from HIMS Manager, Ms. Liz Kane. I successfully represented Mr. Harrison by proving to Assistant Di-

rector, Mr. Royce Calhoun, the discipline was completely unwarranted based on the facts in my investigation. I disclosed my proof of retaliation against Mr. Harrison in writing to Assistant Director, Mr. Royce Calhoun. Mr. Calhoun had assumed Ms. Kane's managerial duties for the VA Release of Information HIMS on or about February 25 of 2013.

What I have learned throughout this entire ordeal is that there are two completely different standards of employee conduct at my facility. The average employee is held completely accountable for his or her behavior and or misconduct, however, this standard does not apply to the high-level management employees and senior executives' service. Evidence of this exists in the Agency's investigation of mishandled records and the subsequent report filed by the OSC.

The Agency's investigation and OSC findings clearly proved Associate Director Jason Petti was found to have made four separate threats against four whistleblowers that did their job by reporting wrongdoing. The investigation also proved that Associate Director Jason Petti's investigation of the moldy records was not accurate. I believe it is plain to see that Associate Director Jason Petti's investigation was, in fact, false.

However, Associate Director Jason Petti was not disciplined. Associate Director Jason Petti was recognized for acting quickly. Associate Director Jason Petti was, in fact, commended for doing the exact opposite of what he should have done and what he is compensated with GS15 pay to do. Liz Kane received only a counseling for her part. A verbal or written counseling is not even considered discipline.

VA employees in Senior Executive Service and high-level management employees are supposed to be the pillars of integrity, morals, and ethics. This entire ordeal has shown me they are, in fact, just the opposite. If an average employee were to be suspected of displaying a lack of candor, that employee would be harshly disciplined based on a preponderance of the evidence, which means the employee would be suspended or removed if management just believed that they were not being completely truthful.

Our system of accountability to our veterans cannot work unless every employee is held equally accountable. The fact that veterans' medical records were sent out to the retirement center wet, moldy, inaccessible, and unattainable, shows a clear disregard for duty and serious ethical violations on the part of the managers who were, in fact, well aware.

The managers involved displayed a total disregard for veterans' health. These veterans depend on the VA to maintain and keep safe their records. Management failed to do so, management attempted to cover it up, and management congratulated itself for a job well done. Despicable is the word I see fit to describe management's conduct and how it affected our veterans.

Veterans gave their lives in every war we fought. Veterans place their lives on the line for this country every day. We, the VA, are supposed to help them, treat them, and keep them safe. Our veterans should not have to put their lives on the line twice for their country by seeking assistance or care from a VA Medical Center.

Veterans should feel safe and most important, be safe, while being serviced and cared for at their local VA Medical Centers.

In closing, I will answer the questions put forth to me prior to my invitation to this hearing. I will state for the record that due to the aforementioned medical records and the recent report of misuse of insulin pens, no, I will not seek treatment at the Buffalo VA. I will not reconsider seeking treatment at the Buffalo VA until this Agency takes appropriate action concerning the responsible management officials. And, no, I do not trust the VA System. It is a system in which managers commit wrongdoing, cover it up, and get rewarded for doing so. The end result is an inability for this Agency to identify serious issues and correct them quickly in order to properly serve our veteran heroes.

Please feel free to ask me any questions, and I will do my best to answer. Thank you.

Thank you.

[THE PREPARED STATEMENT OF GERALD RAKIECKI APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Ms. Schoellman, you are recognized.

STATEMENT OF SYDNEY W. SCHOELLMAN

Ms. SCHOELLMAN. Hello. Good morning. I would first like to thank all of you for inviting me here today. I feel honored and greatly appreciate the opportunity to testify on behalf of veterans and their families.

Before I begin, I want to introduce myself and the gentleman sitting behind me. My name is Sydney Willingham Schoellman. I live in Allen, Texas, with my husband and two children near both my mother and one of my sisters, Sarah Bell, who is here in attendance today. The gentleman sitting behind me, Larry Taylor, is an attorney for Johnny Cochran's firm in Dallas and previously served as both an Assistant District Attorney for Dallas County and as the Director of Outreach for Congresswoman Eddie Bernice Johnson. Larry and our family became dear friends due to our matching principles concerning faith and our United States veterans.

I come to you all today on behalf of not only my dad, deceased Korean War veteran Gary Willingham, but also on behalf of all veterans and their families. My dad was a vibrant, God-fearing patriot who, at the age of 80, lived a full and active life completely independently. He was a great man of faith who lived his life based on strong principles. My dad loved the United States and never passed on exercising his right to vote and never missed a birthday party for one of his very own grandchildren. He was the model of what a dad, grandfather, and citizen should be. He was not a man that took handouts, not even as he struggled to raise three daughters on his own.

Because he believed in earning everything he received, he felt it was only appropriate to rely on the VA Health System for his health care needs. He did, after all, earn it. It was his pride and his belief that made him continue to use the Dallas VA for his health care for many years.

In 2009, he noticed a lump forming in his neck, so he went to the Dallas VA to have it looked it. After over a year of the VA's doctors unsuccessfully trying to find out what was thought to be cancer, they recommended surgery to remove the lump. After removing the lump, they guessed that the problem must be his tonsils, so they removed them. They discovered after the tonsillectomy that they had guessed wrong.

By 2010, the lump in his neck had returned, and the surgeons at the VA, again, recommended to my dad that they should operate to remove it. On the morning of November 18, 2010, my sister, my dad, and I arrived at the Dallas VA at approximately 5:45 in the morning. He was not taken back to begin surgery until 2:25 p.m. After waiting for more than six hours, two surgeons emerged and began telling us about the surgery. During their explanation, we were told that multiple tears had been made into his jugular vein, which caused a massive blood loss. To stop the blood loss, they began clamping everything. The next statement is a direct quote from the surgeon. "We realized six minutes later that we had clamped his carotid artery."

We found out later when we obtained the medical records that his carotid artery was actually clamped for 15 minutes, not the six minutes that we were initially told. Due to the 15 minutes that my dad's brain was not getting oxygen, he suffered a massive stroke. He would undergo three more surgeries to stop the internal hemorrhage that kept forming in his neck. His fifth surgery to place a feeding tube would occur a mere three days after the first.

My dad would spend approximately three weeks in ICU and would later spend a week on the patient floor. After the week on the patient floor, we were told that he needed to be discharged because, had he not suffered a stroke, he would have already been discharged.

At that time, we were also told that due to the tracheotomy in his neck, he could not continue his care at the VA's rehab facility because they were not equipped to handle patients with tracheotomies. We were urged by an employee at the Dallas VA to get our dad out of that hospital because it was not safe for him. We were also told to obtain his records as quickly as possible before they disappeared.

We used private health insurance to place him in other rehabilitation facilities. I want to stress that our family made important, life-changing decisions on behalf of my dad because we thought he had a chance at recovery based on the thought that he had only suffered a stroke with six minutes of oxygen lost to the brain. Had we known the truth, that he had such a massive stroke of 15 minutes of oxygen loss to the brain, we would have never made some of the decisions we did to aggressively rehabilitate him.

We know now that someone who has such a massive stroke has been given a death sentence. It is only a matter of when, not if, they will die from the complications of the stroke. My dad spent the last six months of his life in a skilled nursing facility at the VA. Every day, his dignity was stripped away as he defecated in a diaper and then dug his own feces out because he was being neglected.

Despite promises that these issues would be addressed, my dad died on December 24, 2011, due to bacterial sepsis and aspiration pneumonia. E-coli bacteria, like those found in feces, were found in his body and around his heart. He also drowned in the tube feedings that had been improperly administered.

Since his death, our family has filed a Federal Tort Claim against the VA. After filing the claim, we were shocked to find out that the attending surgeon could not be held liable for his medical negligence because contrary to the surgical notes, he was not a Dallas VA employee. As a result, the VA is refusing to claim full responsibility for an act committed in their facility.

I am here relaying our graphic, horrific experience, so that no other veteran or their family will experience what we did. In my time working for a large health care system in Texas, I learned quite a bit, and I have been able to take what I learned and apply it to the experience we had and can tell you without any doubt that this system is severely broken.

Again, I want to thank you all for asking me to testify today, and I would like to leave you with one last statement my dad made to me. On his deathbed he said to me, "VA murderers. Get them, Syd." While I am not getting anyone, I will spend the rest of my life fighting for these national treasures and their families with the hope that no one will ever go through or lose what we did.

At this time I am happy to answer any questions.

Thank you.

[THE PREPARED STATEMENT OF SYDNEY W. SCHOELLMAN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Dr. Hollenbeck.

STATEMENT OF PHYLLIS A.M. HOLLENBECK, M.D., FAAFP

Dr. HOLLENBECK. Thank you. Ladies and gentlemen, good morning. Thank you for the opportunity to bear witness to the state of veterans affairs at the G.V. Sonny Montgomery Medical Center in Jackson, Mississippi. I did not have the honor of meeting Sonny Montgomery, but I have met people who have and who knew him well, and I know he served as Chairman of the United States House of Representatives Veterans' Affairs Committee from 1980, to 1994, and I know his answer to the political question of, are you red or blue was always, I am red, white, and blue.

And I want us all to remember, and I think it has already been brought up so eloquently by the people who preceded me, in two days we celebrate—not celebrate, but remember the 12th anniversary of 9/11. This hearing is about the human treasure that we sent and that we lost in those wars.

Our medical center in Jackson is named after Sonny Montgomery because he was a combat veteran who came back from war and became a champion for the lives of all veterans. He understood what it means to serve in the United States military, and he did not want veterans to have to fight more battles at home.

The current state of affairs and deliberate mismanagement by leadership at the VA Medical Center that bears his name would sicken him. It dishonors all those who signed up to put their lives

on the line for others, and it shows contemptuous disrespect for the VA motto taken from Lincoln's second inaugural address, and I am going to paraphrase, to care for he and now she who had borne the burden.

Terrible, illegal, and unethical things have happened and still happen at the Jackson VA Medical Center, matters of life and death. This is an American tragedy. As playwright Arthur Miller wrote in Death of a Salesman about another time of heartache in this company, "Attention must be paid," and consequence for those responsible must ensue. For too long, the leadership responsible for the G.V. Sonny Montgomery VA Medical Center has eluded all consequences and accountability.

Yes, attention must be paid, and this time heads must roll, or nothing will ever change.

I became a whistleblower with the Office of Special Counsel, United States Department of Justice, for the same reason I wrote a book called, "Sacred Trust—The Ten Rules of Life, Death, and Medicine." The practice of medicine is a sacred trust between two human beings, doctor and patient. Medicine is a service profession. As a medical school professor told me, we work for the patient, and I, and the multitude of dedicated, committed, and excellent members of patient care teams at the Jackson VA Medical Center signed up to work for the veteran. It is a humbling honor to be asked for help from another human being and to have he or she put their life in your hands.

But the leadership at the Jackson VA Medical Center caused the primary care service to disintegrate because they did not truly care about the mission.

My expensive written testimony details the specific and serious violations of Federal and individual state laws and VA regulations and rules occurring in primary care at the Jackson VA. OSC charged the VA with investigation of my whistleblower complaint, and I know that the team substantiated my concerns.

The findings include not enough physicians in primary care. A ratio of three nurse practitioners to one doctor, the inverse of comparable institutions. Nurse practitioners improperly credentialed as independent practitioners, when their state licensing guidelines require collaborative agreements signed by physicians. Collaborative agreements signed but legal licensing requirements violated. Still no policy in place for any oversight of nurse practitioners and their clinical care. Multiple-patient scheduling problems, multiple, "problematic behaviors," indicating a high likelihood of quality of care and patient safety issues. Illegal signing of Medicare home health certifications and illegal prescribing of narcotics by unsupervised nurse practitioners.

Essentially, everything that happens in primary care at the Jackson VA, can be included under the umbrella of being unethical, illegal, heartbreaking, and life threatening for the veterans, and everything in the care of the veteran starts in primary care.

A casual and careless disregard for the law and the veterans and dedicated employees is the management mode of leadership at the Jackson VA. The names of the regional and local administrative and medical leadership are included in my written testimony. I will

name them now as others have certainly named specific people at their institutions.

Rica Lewis-Payton, Joe Battle, Dot Taylor, and Drs. Kent Kirchner, James Lockyer, Jessie Spencer, and Greg Parker. I have included the details of their illegal and unethical acts and attitudes and specifics on nurse practitioners.

I promised my Iraq War Army veteran son I would let the Committee know veterans have lost faith in the VA System and thus government, and so I charge you not to fail the veterans this time. As a character in Arthur Miller's play, "All My Sons," cries out when realizes his unethical acts have caused the deaths of servicemen, they are all my sons, all the veterans are the sons and daughters of all of us. They deserve only our best.

Thank you.

[THE PREPARED STATEMENT OF PHYLLIS A.M. HOLLENBECK APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Doctor.

Mr. Nicklas.

STATEMENT OF ROBERT E. NICKLAS

Mr. NICKLAS. Thank you. Good morning. My name is Bob Nicklas. I am the oldest son of William Nicklas, who died on November 23, 2012, from the Legionella bacteria which he contracted while a patient at the VA Hospital in Pittsburgh. Before I would begin, I would like to thank the Committee for arranging this field hearing in Pittsburgh. Without the support of the Chairman of the House Veterans' Affair Committee, Congressman Jeff Miller, our local congressmen Tim Murphy, Keith Rothfus, and Mike Doyle, and Senator Bob Casey, as well as the members of the press such as Shawn Hamill of the Pittsburgh Post-Gazette and Adam Smeltz of the Pittsburgh Tribune and Review, and all of you who are here today and were here with us at the Congressional hearing in February, we may never know the truth.

My father, William Nicklas, was not only a devoted husband, father, and grandfather, but also a proud, loyal veteran who served his country in time of war. In 2008 at the age of 83, he helped my brother construct a memorial to the World War II veterans in his community, and every day at our home, the American flag would be seen flying in our front yard as a symbol of his belief in his country.

On November 1, 2012, my father entered the VA Pittsburgh Hospital. He and my mother had private health insurance, however, he opted to go to the VA because he believed that is where a veteran would get the best care. For the first 16 days of November, my father was allowed to shower and drink the hospital water without any warning from the VAPHS that a CDC A–Team was already on site working on an ongoing problem with the deadly Legionella bacteria outbreak, and that the CDC had already linked the cases of two VA patients who contracted Legionnaires to the hospital.

My father came down with a fever and elevated potassium levels and was moved to the ICU. Hospital staff advised us that he had an infection, and we were assured that they were running the proper tests to determine the cause. You cannot imagine the shock

and anxiety we experienced on Friday, November 16, 2012, when we learned that the VA had announced a Legionella outbreak.

The next day during our visit, we noticed that signs had appeared which read, "Due to waterline problems, this fountain is out of order," or "Due to waterline problems, do not use." Still there was no mention of Legionella or Legionnaires.

Over the next several days, it was heart wrenching to watch my father's slow, painful decline. He was obsessed with trying to get the poison off of himself. He was scared and concerned that they were going to poison us, too. As I sat there the night of November 23, 2012, holding his hand, he drew blood as he pinched my skin over and over again, in an attempt to pick the poison off the back of my hand. We told him that we loved him and that we would see him the next day. That would never be. He passed away that night at the VA.

We are left with many questions. Why were we not warned that the CDC was onsite? Why wasn't something done after the first person died, the second, the third, the fourth? Why was the testing not done sooner on my father when they knew there was a Legionella problem? Why did the VA not accept the help that they were offered by consultants such as Enrich or Liquitech? The questions go on and on and on.

More than nine months ago, we began to ask questions about this situation, which has devastated our family. Those questions have led us on a journey. We were raised to respect our government and its institutions, but with all we have learned through your investigations and press reports, we are very disappointed that no one has been held accountable.

While we know that we do not have the power to get the answers, you do. In February, we attended the Congressional hearing in Washington, DC. No one from the Pittsburgh VA Hospital administration attended, and those VA representatives who did were unable or unwilling to answer specific questions. Since then, countless reports have appeared in the press and on local and national television, yet still no accountability.

In April, the U.S. Office of the Inspector General released a report that detailed many systemic problems that allowed Legionella bacteria to flourish in the system, and the Director of the VA responded to this report by saying, "They validated what we already knew," yet no one has said who is responsible.

Imagine what my family has been through. Do not forget the veterans who senselessly lost their lives through a long, painful process full of anxiety and struggle. I am asking everyone who is present today to reflect on this one question. What would happen if you had performed your job in the same manner as the Administration at the VAPHS? Would you still be employed? Would you still have your benefits? Would you be receiving bonuses?

We urge Congress and all veterans to join us to demand answers and accountability. The same tax dollars paid by every citizen, including family members affected by this travesty, are the same tax dollars used to pay the salaries, benefits, bonuses, and budgets of the employees of the VAPHS. We beg you to please help us get the answers and accountability which the following veterans deserve.

My dad, William Nicklas, John Ciarolla, Clark Compston, John McChesney, Lloyd Wanstreet.

Thank you for this opportunity to testify, and I would be happy to answer your questions at this time.

[THE PREPARED STATEMENT OF ROBERT E. NICKLAS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Nicklas. Ms. Nicklas, thank you for being with us as well.

Ms. Ciarolla.

STATEMENT OF MAUREEN A. CIAROLLA

Ms. CIAROLLA. Good morning. I want to thank you for the opportunity for us to testify here today on behalf of my family regarding the VA Pittsburgh Legionnaires outbreak. My name is Maureen Ciarolla, and I am the eldest daughter of John J. Ciarolla, a United States Navy veteran, who died from Legionella while residing in the Pittsburgh VA Healthcare System.

Our father entered the VA Healthcare System on January 22, 2011, became a resident of the H.J. Heinz Facility here in Aspinwall and died six months later on July 18, 2011, and as of present time, he is the first veteran to die of the Legionnaires. While our father was in the Pittsburgh VA, we were actively involved in his life and his medical care. In fact, there is a notation in his medical records warning of just that.

First, my testimony today has nothing to do with the people who worked directly with the veterans. We would like to thank all of the employees and staff at the Aspinwall Facility who were very kind and professional while our father was there, and we would like all of them to know our appreciation.

We are here today as family members who lost a loved one and to take part in the continuous effort to find out how and why this Legionella problem got so out of hand here in Pittsburgh, causing our father and other veterans to die prematurely, obviously.

There can be no more tolerance for the tactical usage of stonewalling, and we should reject any evasive responses to questions and compel a lucid answer by all means necessary, and we demand clear answers to questions, and that those responsible are held accountable. All the victims and all the families who lost loved ones and all veterans are at least owed that much.

This micro pandemic, if you will, in the Pittsburgh VA was predictable. In fact, in 2008, top-ranking VA officials, some who are here today, were informed that this very situation was going to happen. If for whatever reason they weren't aware prior to 2008, they should have known what was going to happen in the future. At one time, the Pittsburgh VA had the leading Legionnaires' research facility in the world called the Special Pathogens Laboratory. In 2006, an administrative decision was made to close this research department and destroy decades of research in the process. This decision was deemed so bizarre and irresponsible that Congress had a hearing over that very matter.

Five years ago to this day on September 9, 2008, a hearing was held by a Subcommittee on Science and Technology. The subject was about how a lack of a coherent policy allowed the Pittsburgh

VA administration to destroy an irreplaceable collection of Legionella samples. This report is public record and took place three years before our father contracted this fatal pathogen at the Pittsburgh VA. The information and discussions in that hearing record is the very reason why we say this Legionella mess was, indeed, predicable.

Mr. Michael Moreland, I believe, was the incoming Director of the Pittsburgh VA. The record goes on to say that he and Associated Chief of Staff for Clinical Services, Dr. Mona Melhem, oversaw the decision to close down the nationally-acclaimed laboratory and order the acrimonious destruction of the Legionella isolates and water samples containing the Legionella bacteria that had been accumulated by Dr. Janet Stout and Dr. Victor Yu over the decades of their research of this disease.

The Subcommittee investigative report points out that after months of investigation, the Subcommittee have not revealed any credible reason for the destruction of this collection. What was also relevant, evident was that administrators at a major VA hospital had allowed personal animosities and goals to overcome its own processes.

Mr. Moreland and other witnesses from the VA should remember that their testimony today is under oath, and it is simply not credible, that important technical decisions were made entirely based on conversations with no documentation.

Well, here is an important question if we are all seeking the truth. If Mr. Moreland's testimony wasn't deemed credible back then before deaths ensued as a consequence of his decision, how credible can his testimony be after this disaster? The record continues. I cannot imagine the circumstances under which a Federal health agency official would unilaterally order the destruction of human tissue collection without receiving the approval of agencies research office, and the Research Compliance Committee and why that official would apparently make false statements during the destruction to keep the Associate Director for the research at the center in the dark until the destruction was complete.

When Dr. Stout was questioned about the need for ongoing research because the bacteria kept changing, so as to stay ahead of it, she states, we have been, for many years, trying to put the tools in the toolbox to prevent the disease, which includes treatment of water distribution systems with various methods to control the presence of the bacteria in the water, and just like with antibiotics, there is no perfect solution, so we continuously do research to perfect the techniques. And she attached a report of the September issue of "Clinical Infectious Diseases," demonstrating that there is an increase in the number of cases of Legionnaires that have been noted.

Dr. Yu testified that microbes are evolving and antibiotic resistance is now a major problem, and two days prior to the sample destruction they had received a commentary from one of their colleagues in France regarding just that concern.

And finally, one Subcommittee Member finally commented that, "All of us may pay a price for this conduct, veterans most of all, because the Nation lost one of its leading research labs on hospital infectious diseases."

Well, veterans did pay a price. On February 13, 2013, the CDC Report to the U.S. House Committee on Oversight and Investigations states, in fact, that 32 cases of Legionnaires Disease was diagnosed at the Pittsburgh VA between January 1, 2011, and October 21, 2012. Prior to the release of that CDC report, the VA vehemently had claimed that there was only one death. Well, after that report they were compelled to come clean. There were at least five, and now a possible sixth death is linked.

We don't know, nor do I think we will ever know how many victims there were in the past or that exist today. They definitely chose to be careful and quiet about this. In our case during the week of July 11, 2011, we were adamantly told by our father's clinical care nurse practitioner and the doctor who ultimately signed his death certificate and I quote, "Legionella had nothing to do with your father's condition. We treated and cleared that with antibiotics before we put on the ventilator."

Additionally, there were two different water system representatives that gave testimony in February of this year. Mr. Aaron Marshall, Operations Manager for Enrich Products, which supplies copper-silver ionization systems for the control of Legionella, testified that in June, 2012, the VA contracted them to perform a review of their copper-silver ionization system and its operation at the University Drive facility. However, the VA withheld critical data from them and requests to access, to view the Legionella test results were denied. They were denied that information.

He also stated that he first learned of the Legionella problem at the VA through the media that some deaths had already occurred. He stated there, copper-silver ionization is an effective method of controlling Legionella bacteria. However, it needs to be properly maintained and regularly monitored. And if they had been aware of the situation, we would have recommended implementing the reactive course immediately.

And Mr. Steve Schira, Chairman and CEO of Liquitech, the company that manufactured the Pittsburgh system, in his prepared statement says, it was simply a matter of maintenance and if Liquitech were notified, we would be able to correct the problem and eliminate the Legionella bacteria within 24 to 48 hours once action was taken. And he goes on to say that the outbreak at Oakland Pittsburgh VA could have been prevented with standard maintenance and open communication.

Think about this for a minute. You eliminate the world's renowned Legionella experts whose life's work is all about preventing, eliminating, and treating those that contract the deadly bacteria, and by all reasonable accounts, they would have been the first responders the moment before this deadly bacteria reached this critical stage. Ignored the procedures and the advice of the product manufacturer that helps to keep the bacteria in check and withholding critical information from the water treatment professionals while knowing that the deadly bacteria, Legionella, was lurking in the water systems at the Pittsburgh facilities.

If he eliminated the advice and the work of all these people when the disaster is predictable, who was Mr. Moreland getting advice and counsel from? And if you read the records of those 2008 hear-

ings and 2013 hearings and all that was discussed there, it should be criminal.

Under Mr. Moreland's watch, adequate policies and procedures were either disregarded or non-existent. Warning signs and recommendations were either ignored or considered insignificant, and there was certainly a complete lack of communication and request for help according to the water systems experts.

At the February 5 hearing of this year in Washington, DC, Mr. Moreland had no prepared statement and testified to that Subcommittee that he didn't know too much about the issue or that it is complicated. In fact, he testified he first became aware that there was a concern of Legionella, Legionnaires at the Pittsburgh VA in the fall of 2011. Apparently, Mr. Moreland was clueless in 2006 about the Legionella bacteria generally, attending the 2008 hearings over that decision that led to those hearings, and he didn't learn a thing, and he is still clueless about the Legionella issues in his own facilities in 2011, 2012, and now we find out 2013.

Additionally, the Veterans Affairs Office of the Inspector General issued two reports this year, one in April and one in July, finding that the Pittsburgh VA had, in fact, inadequate maintenance at all times of the copper-silver ionization system, failure to conduct routine flushing, failure to test patients with hospital-acquired pneumonia for Legionella, inadequate testing requirements, and utilized loopholes in reporting Legionella to the CDC, state, and county health agencies.

Like I said, this situation was predictable, and if, indeed, predictable, then casualties were imminent. If deaths were imminent, then that had to be acceptable to those knowingly responsible. Mr. Moreland and his administration regime knew that the water system at these facilities had a Legionella problem, eliminating a diligent water monitoring scheme, obstruction of investigations, and the misleading of families and agencies was no less than gross negligence and gross misconduct or complete incompetency. Either way, a deliberate gamble, and veterans paid the price and lost their lives over it, and all while collecting five-figure bonuses. And there is no other way for us to look at it.

Thank you.

[THE PREPARED STATEMENT OF MAUREEN A. CIAROLLA APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you to each of the witnesses. Let me lay out to you what we are going to do. We will rotate back and forth between the Members on questions. We are going to go into a five-minute round of questioning, and then when the last Member asks a question, we will rotate back to the Chair.

We may also have some questions that the Committee may want to send you after this. We hope that you will be willing to answer those questions for us to make the record complete because obviously there may be other testimony that comes up after yours and we may want to ask you follow-up questions about that testimony.

So with that, I will recognize myself for five minutes and go back to you, Ms. Petit.

Thank you for your compelling testimony. I cannot tell you how angry I was when I got a frantic call from VA telling me that they basically forgot to tell me about a suicide that had occurred prior to our visit.

But what I am additionally angry about is that in your testimony you talked about a friend of your brother's, I think, saying that your brother had told him that he was feeling suicidal when he went to the VA——

Ms. PETIT. Yes, sir.

The CHAIRMAN. —and my question is, please expound on that a little bit, and how did the VA respond to the fact that they had a veteran on their campus that they knew had expressed suicidal tendencies.

Ms. PETIT. It seemed like they just basically ignored him. They turned him away several times. Any time they did—they did commit him also to try to help some, but they would change his medication and basically release him again. His medications, he was on so many different medications that, I mean, you shouldn't, there is no reason to have that many medications going into one body. It is just crazy to me.

The CHAIRMAN. Do you know if there was any documentation of the incident in your brother's medical record?

Ms. PETIT. I do not know. I have not seen his medical records. The police report we got when me and my mother went up there, we requested it, it took quite a bit of time to get a police report.

The CHAIRMAN. This was the VA's police report. Correct?

Ms. PETIT. Yes, sir. It took quite a bit of time to get it, although we had written a statement and requested it when we picked up his belongings. Somehow it fell through the cracks, and then one of the VA representatives actually helped us obtain it. When we got it, there was black. So many places had been marked out. It was—I don't know if that is standard procedure, but, I mean, it is my brother. I should be able to read what actually happened, all of it, not just bits and pieces of it.

The CHAIRMAN. And you have yet to see an unredacted version of that.

Ms. PETIT. Exactly.

The CHAIRMAN. To the Nicklas family and Ms. Ciarolla, the testimony after you from VA, we had an advanced copy so we have had a chance to read it, it talks about the medical center here in Pittsburgh conducting information sessions which the Department is using to relate timely information and updates about Legionella surveillance and treatment efforts to local community partners. Are you aware of these, and if so, have you attended any of them?

Mr. NICKLAS. I did not attend any.

Ms. CIAROLLA. Not at all.

The CHAIRMAN. Is anybody in the room aware of any of these taking place?

Thank you. Mr. Michaud.

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

Mr. Nicklas, this question is for you, and first of all, I am sorry for your loss. Aside from the signage indicated not to use the waterlines, was there any guidance given to the veterans and their families by staff regarding the Legionella outbreak?

Mr. NICKLAS. No. When we heard the Legionella outbreak on the news on the 16th of November, I believe, we went in to see my dad the following day, and that is when we did notice the signs on the water fountains and on the sinks in every room, especially do not use due to water pipe problems, do not use, but there was no other mention on Legionella or Legionnaires while we were there.

Mr. MICHAUD. So no staff told you anything about it at the time.

Mr. NICKLAS. No.

Mr. MICHAUD. Okay. Ms. Petit, this question is for you, and I am also sorry for your loss as well.

Ms. PETIT. Thank you.

Mr. MICHAUD. As a family member, what do you believe would have been more helpful to you from the VA as far as understanding what your brother was going through?

Ms. PETIT. I think they need to reach out to other family members, friends. A death doesn't just affect the next of kin. They need to reach out to more people and find out what is going on.

Mr. MICHAUD. This one here is for Dr. Hollenbeck. In your testimony, you mentioned that doctors were leaving and you were one of only three care physicians. What do you think should be done to improve the recruitment and retention for medical staff, you know, system-wide?

Dr. HOLLENBECK. Well, I will tell you that there have been a total of eight providers in my prior—I worked four years in primary care and for the last year, I worked in compensation and pension. Taking care of my panel of patients, which is roughly 1,000 people, eight different, seven physicians and one nurse practitioner who rotated through. They finally got a fourth physician, and he quit recently after two months. He was pressured again with an overload, the same kinds of patient scheduling things I got when I was working. He was also pressured about prescribing narcotics on patients that he didn't take care of, and the only way you are going to keep, be able to recruit and keep physicians which the OSC or the VA Investigative Committee is very clear we don't have enough of, is, you can't overload them, you can't ask them to be double-booked, with no control, then see every walk-in that comes in.

Again, your hairdresser doesn't work like this. Certainly no decent medical facility does, and you could offer more money, but you will keep people if you treat them as decent human professionals taking care of other human beings.

Mr. MICHAUD. Thank you. This question is also for you. The testimony from Buffalo, New York, facility points out the discrepancy between how staff and management are held accountable. Can you comment how that pertains to Jackson?

Dr. HOLLENBECK. Well, I think there is no accountability for administrative or medical leadership. I have extensive documentation of emails, the whole series of events, physicians told by other physicians to break the law, including physicians in training from the University of Mississippi Medical Center. To my knowledge, no medical licensing board has been allowed to discipline any of the physicians or even investigate it. I know that nurse practitioners who have broken the law have not been investigated or disciplined, however, I do know that if you are a regular employee, I would

wager that if I did anything even possibly wrong, people have warned me that they would probably try to change the documented, the computer system, I believe, that has been mentioned.

So I think that the average employee, and I know people are called in for all kinds of things. Any time you speak up as a regular employee you are called on the carpet, but you can break Federal, state laws, Federal regulations and rules and nothing happens. In fact, Dr. James Lockyer, who was our chief of primary care through most of the events I outlined, he stepped down as chief of primary care in March when the first "New York Times" article came out. He wasn't asked to leave before that, then all of the sudden he was reassigned, but he got another job as a chief of primary care at Mountain Home Health Systems in Tennessee.

Now, somebody, several people had to give him recommendations to get another job to go do, I would say, the same problematic behaviors at another VA, and those people have to be our VA, obviously medical——

Mr. MICHAUD. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

Ms. Ciarolla, I just have a question. When you were at the hospital, was there any mention of Legionella in the water systems that had been detected there during that time?

Ms. CIAROLLA. No, sir. No, sir. We found out when my father was rushed from—my father was in the hospital for—he was taken from the Heinz Facility over to the Oakland Facility in the emergency room.

Mr. MURPHY. Was there any signs or warnings that you shouldn't use any of the water systems within the hospital?

Ms. CIAROLLA. No, none at all.

Mr. MURPHY. And the VA said you should test your water at home for Legionella. Am I correct?

Ms. CIAROLLA. Yes.

Mr. MURPHY. Do they tell you how to do that?

Ms. CIAROLLA. They said they would send a sample.

Mr. MURPHY. Just send a sample of the water from your house?

Ms. CIAROLLA. They said they would send a sample packet.

Mr. MURPHY. Okay, and did you follow that instruction?

Ms. CIAROLLA. No, we did not.

Mr. MURPHY. Okay. Ms. Nicklas or Nicklas, when you were at the hospital, did you see or hear of any warnings or signs regarding use of water or restrictions of water on the hospital room?

Ms. NICKLAS. Just the signs that we had seen when we went on November 16, is when it was announced in the news. We had seen it on the news, and we went.

Mr. MURPHY. Prior to that no signs at all, no warnings at all?

Ms. NICKLAS. The 17th when we went in they had signs.

Mr. MURPHY. The 17th of 2012?

Ms. NICKLAS. It didn't say anything about Legionnaires. It just said waterline problems.

Mr. MURPHY. That was in 2012?

Ms. NICKLAS. Yes.

Mr. MURPHY. And what did—can you recall what those signs said? Either one of you? Can you tell us?

Ms. NICKLAS. One said due to waterline problems, this fountain is out of order, and then other signs said, due to waterline problems, do not use.

Mr. MURPHY. But no mention at all of an infections?

Ms. NICKLAS. No mention about Legionnaires or Legionella.

Mr. MURPHY. Just curious. When you were at the hospital, did you see any other signs that said such things, you should wash your hands?

Ms. NICKLAS. I do not recall.

Mr. MURPHY. Do you recall, Ms. Ciarolla? There is usually signs——

Ms. CIAROLLA. No, I don't——

Mr. MURPHY. —around the hospital that recommends one washes their hands. Subsequent to that did anybody at the hospital, Mr. Nicklas or Ms. Ciarolla, tell you of any other concerns about using water later on, perhaps after the death? No one ever mentioned anything about the water systems there?

Ms. NICKLAS. When we went in on the 17th, that is when they had started using the bottled water. In fact, it was out in the public because it was announced on the news the night before.

Mr. MURPHY. Okay.

Ms. CIAROLLA. I would like to say that when they called my home about—my father, we had my father at a facility for two afternoon visits on the weekend of Father's Day of 2011, so they called up my home and they wanted to test my water at home and my sister's water at home. My knowledge of Legionella at that time was air conditioning units. I mean, that is what it was, and my first response was, I don't have central air, and they said that you can catch it anywhere.

Mr. MURPHY. When they offered to test your water or other elements like that, do they ever suggest that it might be hospital-based water that might be part of this?

Ms. CIAROLLA. No. What they said to me was, when I questioned them that if I had Legionella bacteria in my water, would not somebody in my home be sick? Would I not feel ill? And their response to me was, if we had other cases, and I quote this, "If we had had other cases here at the hospital," if he had contracted it here——

Mr. MURPHY. Wait. I think—let me rephrase the sentence. They were saying if they had other cases, the hospital, were they—were you——

Ms. CIAROLLA. No. They——

Mr. MURPHY. Did you conclude from that, they did not have other cases?

Ms. CIAROLLA. Yeah. Let me rephrase that.

Mr. MURPHY. You just have a few seconds.

Ms. CIAROLLA. They said to me, if he had contracted it here at the VA, we would have other cases, and that statement made sense to me.

Mr. MURPHY. Because at that time did you know they had other cases?

Ms. CIAROLLA. No.

Mr. MURPHY. Mr. Nicklas, when—Ms. Nicklas, when you were handed bottled water and the news came out that Legionella was

found in the water system, at that time, did anyone brief you about precautions to use with the water in the system?

Ms. NICKLAS. No.

Mr. MURPHY. And did they look back with you and ask you in the past had he been exposed to water in the system, the showerheads, water fountains, or anything like that?

Ms. NICKLAS. Absolutely. He was in the hospital from November 1 to November 16. He was showering, he was drinking water, he was eating ice cubes. He had a fever, so, yes, absolutely he was exposed.

Mr. MURPHY. One last question. Ms. Ciarolla, what was your reaction when you found Mr. Moreland received a bonus, and part of that bonus was recognition for his infection control efforts at the VA Pittsburgh?

Ms. CIAROLLA. Well, I always—my question from the time—because we did not know about this, the ongoing——

Mr. MURPHY. What was your reaction?

Ms. CIAROLLA. My reaction was there is the smoking gun.

Mr. MURPHY. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman. I really don't have questions for this panel. My questions are for the VA, and the questions I am going to ask are the questions that you have asked in your testimony. I think Mr. Murphy has clarified the situation. I was going to ask whether they were actually told there was Legionella outbreak when those signs were put up, but I think you have answered that question.

So I will reserve my time for the VA panel.

The CHAIRMAN. Thank you. Mr. Rothfus.

Mr. ROTHFUS. Yes. I would like to ask several questions here.

I would like to go down the line with the family members and hear from each of you on this question. Do you know of anyone at the VA who has been held accountable in any form for the failures that you have identified this morning? For example, have there been any suspensions, sanctions, or terminations?

Ms. Ciarolla, we will start with you and go down.

Ms. CIAROLLA. No, none at all.

Mr. ROTHFUS. Mr. and Mrs. Nicklas?

Ms. NICKLAS. No, none that we know of, but they have gotten bonuses.

Mr. ROTHFUS. Dr. Hollenbeck?

Dr. HOLLENBECK. No, absolutely not, and like I said, someone else got another job to do the same thing at another thing at another VA.

Mr. ROTHFUS. Ms. Schoellman?

Ms. SCHOELLMAN. No.

Mr. ROTHFUS. Mr. Rakiecki?

Mr. RAKIECKI. No.

Mr. ROTHFUS. Ms. Petit?

Ms. PETIT. No.

Mr. ROTHFUS. You know, we have another anniversary coming up in our country, a very sad one and one of the most tragic ones, November 22. I was only one year old at the time, but everything I hear was about President Kennedy's call to public service. "Let

the public service be a proud and lively career," he said, "and let every man and woman who works in any area of our national government in any branch, at any level, be able to say with pride and with honor in future years, I served the U.S. government in that hour of need."

I would like to ask a question of our whistleblowers here. Do you think there is a, you know, you look at President Kennedy's call to public service. I am hearing from your testimony, do you think there is a double standard at play here with folks at the rank and file and the senior executives?

Mr. RAKIECKI. Yes, sir.

Mr. ROTHFUS. Dr. Hollenbeck?

Dr. HOLLENBECK. There is an absolute double standard. It is obscene. As I said, I have been warned as a whistleblower. I am glad you said protecting witness, Chairman Miller, when you introduced me. I have been warned they might go into the system, say I was AWOL, things like that, try to say I, you know, didn't do my job, there have been complaints about me, that all the sudden they found things like that, so I think they definitely punish anyone who speaks out, but even when there is a huge amount of evidence as I think we all have, the egregious misconduct and callous disrespect, callous disregard for the rules and the veterans, in particular the veterans, always first, the veterans, there is no consequences, and in fact, there are rewards, financial and promotions.

Mr. ROTHFUS. I know one of the ongoing complaints of the families that were affected by the Legionella outbreak here in Pittsburgh is the VA's failure to communicate and provide information and answers. I share that frustration, particularly with respect to the VA's blatant disregard of requests made by this Committee dating back to January to turn over key documents and emails related to Legionella outbreak. For all these reasons, I joined my colleague, Congressman Murphy in calling for Secretary Shinseki to come to Pittsburgh to meet with the impacted families as soon as possible to provide answers. He has yet to do this.

I am interested in your experiences. Has the VA been forthcoming and responsive in disclosing information pertaining to the events that have affected your family, Ms. Ciarolla?

Ms. CIAROLLA. No, and the medical records that were received are an absolute mess.

Mr. ROTHFUS. Have they been accessible and responsive to your questions?

Ms. CIAROLLA. No.

Mr. ROTHFUS. Mr. and Mrs. Nicklas, have they been responsive in disclosing information to you?

Ms. NICKLAS. No, they have not.

Mr. ROTHFUS. Have they been accessible and responsive to your questions?

Ms. NICKLAS. No, they have not.

Mr. ROTHFUS. I thank the Chairman and yield back.

The CHAIRMAN. Thank you very much.

Dr. Hollenbeck, let's continue with some questions about Jackson. In VA's written testimony it states this, "The Jackson VA Medical Center Director and other facility leaders maintain an open-door policy for veterans to speak with them about their con-

cerns, and the Director has personally addressed the comments provided by them on comment cards at the town hall meeting."

Could you respond to that and explain what you think that means?

Dr. HOLLENBECK. Well, what it means in real life is that you can respond to something, you can answer a question, you can come to a town hall meeting and stay and let someone talk and say, I am very concerned. I will get back to you, or I will look into it, and that is the end of that. To me that means they think it is a joke. I know that I have veterans who are patients of mine and say they have waited and waited hours outside Mr. Battle's office, and they have been told they won't get to see him that day. Then they have been told they will get a call. An 88-year-old veteran said he waited by his phone all day because he don't have a cell phone, so he didn't leave his assisted living apartment, waiting for the call.

I also know the veterans didn't say this. They are afraid to speak up, so they don't ask the tough questions. They don't go with the terrible sad stories, because they are afraid they will be retaliated against, and their care will be affected, and that to me is beyond sadder than I can put into words.

The CHAIRMAN. Mr. Rakiecki.

Mr. RAKIECKI. Yes, sir.

The CHAIRMAN. Would you elaborate on the reference that you made in your testimony to the Department having two different codes of conduct and means of accountability; one for what you call the average employee and one for high-level management members and senior executive service?

Mr. RAKIECKI. Well, I am in kind of a unique situation as a police officer. I probably wouldn't be privileged to this, but in, because, you know, acting as a steward and a chief union steward you kind of see what goes on behind the scenes, and what I have become aware of, especially if you look at the example which I cited with the records, since I have been involved with the union as a steward in 2007, I have been involved in many disciplinaries, and I have had the unfortunate dealings with, again, Associate Director, Mr. Petti. I have known of prohibitive personnel practices where managers in the Buffalo VA asked for a discipline. They may counsel an employee on a wrongdoing, a misuse of a computer issue, and he has come in and insisted upon more punishment, 14-days suspensions, 15-day suspensions.

So I have actually battled with him on it. I have gotten statements from the managers and said, wait a minute. If you go after this employee twice, I am going to file an unfair labor practice charge against the Agency. So it happens all the time. They do as they please, and who do they answer to?

In reference to this issue with the records, upon the Agency completing its investigation and OSC determining its outcome into a report that went to the President, those two individuals who I mentioned, Liz Kane and Jason Petti, are still employed, and up until now, I believe the Agency or the Director was getting his information about whether or not these records were straightened out. Now, a plan was supposed to be put into place to fix this problem. It is to my understanding, by speaking recently with Mr. Leon

Davis, that the Director, approximately 11 days ago, was made aware that he was being misinformed by Mr. Petti and Liz Kane.

So these people collected a year's worth of salaries and continued with doing harm. Our records are still in a mess, and I believe now the Director is aware, and he is doing something about it, but for a year, we listened to these people? A year after they have done harm and proven themselves to be non-trustworthy we are listening to these people? An employee would be put immediately on administrative leave pending serious disciplinary action, but yet he is still in that office making decisions. And I don't understand it.

The CHAIRMAN. To the Nicklas family, real quickly because I am running out of time, you received contradictory reports per your testimony from the ICU nurses and the physicians when you would phone in to check on your dad's condition. Could you talk about the confidence that you had when you started receiving those contradictory reports, and how did you proceed at that point with getting further information?

Ms. NICKLAS. That happened over a course of a couple days. When my mother-in-law would call, she would get one report, and I would call every morning. I would get another report. My husband would call around lunchtime. He would get something different, so that is why we asked to have the meeting with the doctor so that we could all be on the same page and hear the same thing from her. And that was the day, that was the 21st of November, I believe. It was that Tuesday, Wednesday that we had asked for the meeting. It was Wednesday before Thanksgiving, and shortly before we left our home to go to the hospital, I just called to see if my father-in-law had gotten any rest that day, and that is when they had told me that the test had just come back, and he had tested positive for Legionella. I asked them if that meant that he had Legionnaires, and they said they couldn't tell me that right now.

So that evening, we had the meeting with the doctor. My brother-in-law was on via a conference call, and they had told us that he had acquired the Legionnaires, and she also had told us that prior to that, she was sure that he would have been home and made a full recovery.

The CHAIRMAN. Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman.

Ms. Schoellman, while your father was in the facility for six months, did family bring the care that he was getting or the lack of care to the management at the facility, and if so, what was their response?

Ms. SCHOELLMAN. We, you know, prior to him being put into their facility, the only response we got was because they had an Acting Director, Mr. Milligan wasn't there yet, and they were actually having a meeting, and I went into the hospital meeting, interrupted, and told him he had to come speak to me. I finally told him all the story. He was being abused at the nursing facility that we had put him in, and they made room for him at the rehab facility.

I had almost weekly meetings with most of the administration and addressed some of the, you know, the different concerns and things, and we were promised all the time that they were going to move him closer to the nurse's station because he was completely paralyzed. That never happened.

And I addressed every, there was always someone from our family up there with him, and I addressed every time that we came to visit, there was fecal matter around his mouth and under his fingernails, and he could not process the mucus in body any longer. I guess because he wasn't walking around or, you know, different reasons, but there was always a coating of thick mucus in the back of his throat to where he couldn't really breathe. And after repeated, you know, addressing this issue and being called to the ER and different things, I mean, it never got any better.

Mr. MICHAUD. Thank you. My second question for you is you expressed some key issues that you felt needed to be addressed such as accountability, customer service, and risk management and family services. Could you elaborate a little bit more what you mean by risk management and family services?

Ms. SCHOELLMAN. In the public health system that I worked in, we obviously had a risk management department, and if there is a risk management department within the Dallas VA or maybe an EVA giving their testimony, you are not aware of it. It is appalling to me that something of this magnitude can happen to someone, and no one ever comes to address you. The administration didn't even know what had happened in their own hospital until I walked in their office and demanded that they meet with me. That is appalling.

I think it is the VA's, like she said, you know, when the veteran is being treated, their family is being treated, and when there is an issue that occurs or they are injured or something happens, it is all hands on deck, and luckily our family is very resourceful and somewhat pushy. So we were successful in, you know, addressing some of the issues. However, not everyone has that, and there needs to be something in place that brings the administration or you know, the risk management department over to address these issues.

And as far as the accountability goes, it is a shame to me that an attending surgeon can work in a government facility such as the VA and represent themselves as an employee and be referred to as staff in every medical record, but once you call them on the carpet for it, the VA's response is, he is not our employee. That is appalling to me. That is ridiculous, and with the customer service that you asked about, I feel like the customer service and the accountability go hand in hand. The patients at the VA System are a captive audience. Some of them don't have private health insurance.

I feel like the best way to fix that would be to bring in an outside surveying agency like private hospitals use, Prescani, you know, Stuper Group, any of them, and actually survey the veterans and ask how their care is going because that is one way that they can address issues without fear of retaliation. We shouldn't have people attending, you know, going to hospitals as a captive patient, and you know, feeling like they can't discuss their concerns.

Mr. MICHAUD. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Murphy.

Mr. MURPHY. I just wanted to finish asking my last question of reactions to bonuses since that is part of the title of this hearing.

Ms. Petit, do you know if anybody at the VA where your brother was treated received a bonus?

Ms. PETIT. I am pretty sure they did.

Mr. MURPHY. Okay. Do you know how much or——

Ms. PETIT. No, but they didn't deserve it if they did.

Mr. MURPHY. Okay. Mr. Rakiecki, at the Buffalo VA was there any bonuses?

Mr. RAKIECKI. I heard the number through Mr. Carney also sitting in the office, something around $64,000 for the Division Director and possibly $28,000 for the Facility Director, but I don't have that information in front of me. There were bonuses paid, I believe.

Mr. MURPHY. Thank you. Ms. Schoellman?

Ms. SCHOELLMAN. I am not aware as I said. Mr. Milligan was not in place at the time of the surgery. He came in at the latter part, but I would, you know, read in the news reports, yes, they received bonuses, and there hasn't been, you know, an established improvement in care.

Mr. MURPHY. Dr. Hollenbeck.

Dr. HOLLENBECK. I don't have specific information. I will just say that all the physicians, certain other whistleblowers feel that administrative people do receive bonuses, both medical leaders and administrative leaders based on metrics that are not related to the quality of patient care and such as how many patients are going through primary care even if the frontline reality is that the walk-ins are waiting eight hours to get seen, that people are double-booked, or what is happening with the turnover in my, you know, the people taking care of my old patients, you have eight different people rotating through. There is no continuity even though it looks like they have not been seen.

Mr. MURPHY. Thank you. Mr. Nicklas, what was your reaction when you heard that administrators at Pittsburgh received bonuses? Both of you, please.

Ms. NICKLAS. Mine was—I can't even put into words my reaction. I was stunned, I was outraged. It was on top of everything else that we had found out, it was a huge slap in the face to all of us, to every family member, and to every veteran.

Mr. MURPHY. Mr. Nicklas, could you pull the mic close to you and give your reaction to it?

Mr. NICKLAS. Yes. I was very horrified. When we heard the news on that, again, I was just shocked they would even announce something like that with this ongoing investigation.

Mr. MURPHY. And did Mr. Moreland, the Division Director at Pittsburgh, or Ms. Wolf who runs the VA ever call you and offer you sympathy, apologies, anything?

Ms. NICKLAS. No. They have never called. When we had our meeting with them afterwards——

Mr. MURPHY. I apologize. Could you pull the mic just——

The CHAIRMAN. You have to point the microphone towards you.

Ms. NICKLAS. I am sorry. When we had our meeting several months later with them, they apologized. They said they were sorry. Still no responsibility, no accountability. We never, ever received a call ever, but Ms. Wolf got a $13,000 bonus and a glowing review, and Mr. Moreland got a $15,000 bonus and several days later it was announced that he got the $63,000 bonus on top of the Presidential Distinguished Rank Award, which I think only 1, less

than 1 percent of veteran executives get a year. Something like 54 people got it this year. He was one of them.

Mr. MURPHY. And what was your reaction when you heard that?

Ms. NICKLAS. I was outraged, outraged. And I think Mr. Rothfus alluded to this before, that we had asked for Shinseki to come in and meet with the families. He has not said one word to the families. Not one. And the only thing that he has come out so far and said is that he defended the bonus given to Mr. Moreland.

Mr. MURPHY. Ms. Ciarolla, have you heard from Secretary Shinseki?

Ms. CIAROLLA. No, not at all.

Mr. MURPHY. Thank you very much. I yield back.

The CHAIRMAN. Thank you.

Mr. Doyle passes.

Mr. Rothfus, do you have any questions?

Mr. ROTHFUS. Mr. Murphy has taken care of my questions. Thank you.

The CHAIRMAN. Okay. I have no further questions.

Mr. Michaud?

Mr. MICHAUD. No further questions.

The CHAIRMAN. Mr. Murphy.

Mr. MURPHY. We want to, again, thank the witnesses very much, and remember, we may be asking for further clarification or asking other questions, but we do appreciate your testimony, and we hope that you will hang around the next battle. Thank you.

[Applause.]

The CHAIRMAN. I would like to call the second panel of witnesses to the table, please. All right, ladies and gentlemen. I would like to ask if everybody could please take their seats. We are not going to take a break. We are going to continue right on with the testimony and questioning this morning. We appreciate it.

We would, again, ask all witnesses if they could get into the microphone as closely as they possibly can.

Our next panel is Dr. Robert Petzel, the Under Secretary for Health at the U.S. Department of Veterans Affairs. We appreciate you, each of you being here today. Dr. Petzel, you are recognized for your opening statement.

STATEMENT OF ROBERT A. PETZEL, UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR CLINICAL OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; MICHAEL E. MORELAND, FACHE, NETWORK DIRECTOR, VA HEALTHCARE (VISN 4) VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; LESLIE B. WIGGINS, MEDICAL CENTER DIRECTOR, ATLANTA VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; BRIAN G. STILLER, MEDICAL CENTER DIRECTOR, VA WESTERN NEW YORK HEALTHCARE SYSTEM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JEFFERY L. MILLIGAN, MEDICAL CENTER DIRECTOR, VA NORTH TEXAS HEALTHCARE SYSTEM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; JOE D. BATTLE, MEDICAL CENTER DIRECTOR, G.V. (SONNY) MONTGOMERY VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS.

STATEMENT OF ROBERT A. PETZEL

Dr. PETZEL. Chairman Miller, Ranking Member Michaud, Members of the Committee, other Members of Congress in attendance today, ladies and gentlemen. I want to thank you for the opportunity to appear before you and submit my written testimony for the record.

I am accompanied today by Dr. Thomas Lynch, Assistant Deputy Under Secretary for Clinical Operations, Mr. Michael Moreland, Network Director, Pittsburgh, Mr. Brian Stiller, Medical Center Director, Buffalo, Ms. Leslie Wiggins, Medical Center Director, Atlanta, Mr. Joe Battle, Medical Center Director at Jackson, and Mr. Jeffery Milligan, Medical Center Director at Dallas.

First, I want to say the testimonies given by this first panel were deeply compelling and very upsetting. I am saddened by these stories of loss, I am saddened by the incredible journey that these people have had to go through as a result of what had happened in several of our medical centers, and I offer my absolutely sincerest condolences and sympathy and empathy with all of you.

My written testimony discussed in detail what we know and our response to the events in Atlanta, Buffalo, Dallas, Jackson, Pittsburgh.

Briefly, in Jackson, the facility is responding to all of the findings that have been set forth in the VA's report to the Office of Special Counsel. We have new management at that facility, and they are making significant improvements.

In Buffalo, our own staff discovered an inappropriate use of insulin pens. The practice was stopped immediately and has been investigated in a systematic way. The findings associated with that have triggered a national change in how our system manages the use of insulin pens, ultimately positively impacting the care at over 1,800 sites.

In Atlanta, we have responded to all the recommendations made by VA's Inspector General and are extensively monitoring the contracts, the contractors, and the delivery of care on our mental health service. The new director has taken this challenge head on and is committed to restoring the trust of veterans in the Atlanta area.

For Dallas, I have not yet received the taskforce report that we commissioned as a result of Congresswoman Johnson's concerns, and, therefore, I will reserve direct comment until that report has been reviewed.

But the lessons learned from Pittsburgh, and they are extensive, are now being used to ensure water safety at all of our VA Medical Centers throughout the Nation, and we continue to work with Federal, state, and local officials and partners to keep all informed about the situation.

Mr. Chairman, the VA is committed to providing the highest quality of care. Our veterans deserve no less. The patient care issues the Committee has raised are serious, but they are not systemic. VA has a long established record of providing safe health care. While no health care system can be made entirely free from inherent risks, when adverse incidents do occur, VA studies them to fully understand what has happened, how it happened, and how the system allowed it to happen, and how the system can be changed to prevent it happening again.

In this way, we design patient safety systems that reduce the likelihood of errors and lessen the potential harm to patients. The VA has an international reputation for its ability to look at safety issues and problems and change the way it delivers care as a result.

Transparency and honesty are keys to engaging the trust of our veterans. Being public about such events informs the greater health care community about intended risks and failures and helps prevent future harm.

The key to achieving this is an internal, confidential, and nonpunitive reporting system to make sure all VA employees feel protected reporting events and near misses. We ask employees, veterans, families, and visitors at our facility not only to report incidents resulting in harm, but also close calls and solutions to be developed, implemented, and harm eventually avoided.

This systems approach is the same used in high-risk industries like aviation and the nuclear industry. Acts deemed blameworthy have clear accountability and consequences. These include criminal acts, purposely unsafe acts, malfeasants, willful neglect, patient abuse, and events resulting from alcohol and substance abuse. I will assure you that VA works diligently to identify and hold those people that are responsible accountable.

The Veterans Health Administration is a system characterized by quality and safety programs above the industry standard with an outstanding reputation within the VA health care community as an integrated health care delivery system that measures quality, measures outcomes, and responds to what we learn.

What we can and we must do better, this is not a perfect system, and there are many things that need to be improved in the way we do our business. We owe that to each veteran under our care,

we owe it to the people that testified here today, this morning, and we owe it to the American people who have entrusted us with this sacred mission to care for those who have borne the burden.

Regarding VA senior executive awards, as authorized by law, these are based on a stringent and standardized process in which these accomplishments are measured against a pre-established performance contract, their ability to lead, change, and their impact on the overall organizational performance.

Mr. Chairman, the responsibilities of a network director or a medical center director are vast. Peter Drucker has described it as the most complex management task in this country. No matter how well they do their jobs, there will, at some point, most certainly be adverse events in their areas of responsibility. When adverse events do occur, there are many ways to hold people accountable when it is appropriate to do so.

Because this is in an opening hearing, by law, I am not at liberty to provide specific details about what has been done in the individual cases spoken about this morning. However, as requested, we have provided the Chairman with the disciplinary actions that have already been initiated, and they are substantial.

At this time, Mr. Chairman, my colleagues and I are prepared to answer your questions.

[THE PREPARED STATEMENT OF HON. ROBERT A. PETZEL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you. I think for the record, so that everybody is well aware that the Chair did receive the information that Dr. Petzel referred to. We received it yesterday afternoon. So we are still trying to go through that information to try to see exactly what type of disciplinary actions were taken.

Dr. Petzel, it seems to me that your testimony focuses, as a lot of VA testimony does, on discussions of systems, systems failures and systems that reduce the likelihood of preventable error and a systems approach and a system-wide improvement. But what it doesn't discuss is people.

And so my question is or my statement would be that systems are only as good as the people that administer them, and I think what you heard today from many of the folks that were testifying is, in fact, that the systems have failed and those that ran the systems have not been held accountable.

So I think, what the Committee needs to know is, what is the Department doing to ensure that the systems are, in fact, being improved?

Dr. PETZEL. Mr. Chairman, there are multiple ways that we can hold people accountable. Let's just go back and review this for a moment. We do hold each individual employee and each senior leader in this organization responsible for the things that they have been told they must do and are responsible for. They are responsible for seeing that the programs are in place, that they are operating effectively, and they are responsible for the outcomes.

As an example, in Atlanta there were issues with contracting and there were issues with delivery of care on the mental health unit. The individuals that were responsible for those systems have,

indeed, been dealt with effectively and have, indeed, been held accountable for their actions and for what happened in Atlanta.

The CHAIRMAN. Well, and Doctor, I have been asked to hold that information very close. I cannot comment, but I don't believe that the information that was provided to me does, in fact, hold individuals accountable. There may have been action taken, but I don't know necessarily that it holds them accountable.

Let me do this. I have asked, and you are aware of this, for the Secretary to provide a top to bottom review of the bonus system. Do you agree that, yes or no, does it need to be reviewed?

Dr. PETZEL. I would agree that reviewing the performance awards is appropriate.

The CHAIRMAN. Do you think that there is a problem with the system when preventable patient deaths due to mismanagement are apparently not factored in at the highest levels of leadership at the hospital and VISN or networks within that leadership?

Dr. PETZEL. I would disagree that the prevention of, that the incidents of preventable illness is not factored into someone's performance contract.

The CHAIRMAN. How about death?

Dr. PETZEL. Avoidable death?

The CHAIRMAN. Yes, sir.

Dr. PETZEL. It is. It would be factored into——

The CHAIRMAN. How much, what percentage is—I am sure they are all weighted, but is a preventable death more important to the VA, preventing that, than it would be meeting the matrix that the VA has established, which it is apparent that that is the way most of the bonuses are awarded.

Dr. PETZEL. Mr. Chairman, they would both be very important.

The CHAIRMAN. Which is the most important?

Dr. PETZEL. I am not going to make a judgment, sir, as to which is most important.

The CHAIRMAN. I can make it for you. The death is. The death is. It is absolutely unconscionable that we would award bonuses to anybody who had a preventable death occur on their watch, and I think that is what the frustration that you are hearing this morning is, and that you will hear from the other Members that are here on the dais are hearing. It is just unbelievable what has occurred here in Pittsburgh, and the fact that bonuses were awarded, when the people that got the bonuses knew what was going on. I was told, well, we didn't know it, when the bonus was awarded. Has anybody asked for it to come back?

Dr. PETZEL. I beg your pardon, sir?

The CHAIRMAN. Has anybody asked for the bonuses that were awarded here at Pittsburgh to be returned?

Dr. PETZEL. Not that I am aware of. No.

The CHAIRMAN. Did you?

Dr. PETZEL. I did not.

The CHAIRMAN. Why not?

Dr. PETZEL. Because the bonuses were awarded for the performance as we knew it when it was occurring then, and as I understand it, we cannot retract or take back those bonuses.

The CHAIRMAN. Well, and that may be a legal response, but what about the moral, ethical response? I would think a letter to the per-

son that got the bonus that, says hey, why don't you give the bonus back because you weren't truthful to us. I would be furious if I was you, that I was left hanging out like you are today by individuals that join you at the table.

Dr. PETZEL. We have not asked, I have not personally asked for those bonuses——

The CHAIRMAN. Has the Secretary asked?

Dr. PETZEL. I am not aware whether he has or has not.

The CHAIRMAN. Okay. Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman.

The VA OIG reports have repeatedly found noncompliance with published policy and procedures. How is VA addressing the accountability and enforcement of these policies and procedures, because it seems to be constantly that they are not following policy and procedures?

Dr. PETZEL. Well, thank you, Congressman Michaud. I will use the example of Pittsburgh. There were things that were not being done according to the IG report relative to Pittsburgh that caused us to look not only at Pittsburgh, but across the entire system at the way we were preventing, detecting, and managing positive cultures in all of our systems, and there has been a dramatic change in the processes that we use to look for the presence of Legionella in the water supply systems, mitigate that when we do find it, and how we screen our patients clinically for potential Legionella infection. This has changed across the country as a result of what we have seen in Pittsburgh.

Mr. MICHAUD. A follow up on the Chairman's question about bonuses. What restriction or is the Administration, I am not talking about the Department of Veterans Administration because I know you have the Office of Policy and Management that actually sets criteria as well as far as bonuses, is the Administration looking at the overall OPM policies as it relates to bonuses systemwide or government wide?

Dr. PETZEL. I can't speak for the Office of Personnel Management. I don't know. I do know that internally within the VA, we are continuously and right now intensively reviewing our practices in terms of bonuses, how the contracts are set up, how they are evaluated, and our review process.

Mr. MICHAUD. But in that when you are reviewing the VA's issue as it relates to bonuses, are you running into problems as it relates to the Office of Personnel Management guidelines?

Dr. PETZEL. No, we are not. We feel that we have the freedom to administer that programming the way we need to.

Mr. MICHAUD. Okay, because it is my understanding that OPM says that in order to give bonuses, it has to be a bare minimum of 5 percent of whatever that salary is. So you are saying that that 5 percent minimum, you can go below if you——

Dr. PETZEL. We have. Yes, sir.

Mr. MICHAUD. Okay. Great. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

You heard some testimony from the families here, and since it seems no one from the VA has answered their questions, I am going to try and relate some of those.

So in June of 2011, samples were taken at nine sites and found that copper-silver ionization levels were outside accepted levels. On August 31 of 2011, five sites showed copper-silver levels outside of recommended levels. In October of 2011, all four sample levels outside of recommended levels. You also heard that the pathogens lab had been closed in '06, under Mr. Moreland's watch. We also know that when samples were taken from patients to analyze, if they had Legionella, Legionnaires Disease, the VA couldn't do it, they then contacted UPMC Pittsburgh, who said we can't do it. Why don't you take them to Dr. Janet Stout. She is an expert in this. The reaction of staff was, "someone would go ballistic," after they went to her because of the issues of which she left the VA.

Now, the CDC has guidelines that says when you have two cases of Legionnaires Disease that appear within six months, you are supposed to report it. I understand the VA didn't report that, but we know this occurred in 2011. All right. Now, we also know that when Mr. Moreland came and Ms. Wolf came to me with a few Members of Congress to talk about some things after the IG's report was happening, what struck us later on, when we found out, that a day or so later, Mr. Moreland was going to get this award, the Presidential Distinguished Rank Award, and I believe the VA nominated this award. Am I correct?

Dr. PETZEL. That is correct.

Mr. MURPHY. All right. Now, you only have the information to go on at the time as you testified here today, but you also said that there are lessons learned, quite a few lessons, particularly Pittsburgh, and my question here then relates to this, that we also know that as part of your nomination process, you are supposed to see if there is any active Inspector General's investigation taking place. There was none at that time in 2011. Am I correct?

Dr. PETZEL. There was not.

Mr. MURPHY. Now, based upon what you have heard today and based upon what has come out of the Inspector General's report, lack of a documentation of system monitoring for substantial periods of time, inconsistent communication and coordination of the infection action team, that VA Pittsburgh did not conduct routine flushing of hot water faucets and showers, especially in areas that are frequently used as recommended with the systems.

The VA conducted an environmental surveillance in accordance with VHA directives, however, the VA responded to positive cultures in February, 2011, by flushing distal outlets with hot water at normal operating temperatures, a corrective action not consistent with the VA guidelines and CDC guidelines.

And the VA Pittsburgh did not test all health care-associated pneumonia patients for Legionella as expected according to VA guidelines.

Knowing that none of—the Inspector General has reported that in 2011, and 2012, all these problems occurred under Mr. Moreland's watch. Knowing what you know now, would you still recommend that he receive this award?

Dr. PETZEL. Mr. Moreland's Presidential Rank Award——

Mr. MURPHY. It is based on the VA recommendation, and where there is an active Inspector General's investigation taking place, you are supposed to report that. If you knew then what you know

now about how these things were not followed, the guidelines of the VA were not followed, I am asking where the buck stops. It either stops at him, or it stops at you. But he was recommended for this award.

Now, on behalf of these families, I am trying to get to the heart and soul of this matter. If you knew then what you know now, would you recommend him for this award?

Dr. PETZEL. I would.

Mr. MURPHY. Even though people died?

Dr. PETZEL. I would.

Mr. MURPHY. Even though he did not follow VA guidelines, even though he did not follow CDC guidelines?

Dr. PETZEL. Mr. Moreland's Presidential Rank Award is based upon a lifetime of service——

Mr. MURPHY. And part of——

Dr. PETZEL. —to America's veterans, Congressman.

Mr. MURPHY. I understand, and he has been recognized in the past, and I have been to the hospital to congratulate him as well for the work that that hospital has done, and he has told me the doctors have done this work, for reducing MRSA in the hospital. We see VAs all over the country have done it. I understand that, but I am saying in this case, in this case, because of the multiple deaths, because of the multiple cases of Legionella, in this case, don't you think that if you knew then what you know now, that it would not be appropriate to give this award?

Now, let me put it in other terms. You know, Lance Armstrong won all of these Tour de Frances. When they found out later he had broken the rules, they said even though you have had these great achievements, you shouldn't get the medals. And there has been multiple people who could have been in the Hall of Fame, maybe were in the Hall of Fame, they found out later they broke the rules of baseball or football or something else, they don't get it.

So it sounds to me from what you are saying that of all things professional sports has a higher standard than the VA. They have lifetimes of achievements in those sports, but still, when it was found out that something was wrong, they had stricter rules.

I ask you again to answer for the sake of these families, knowing now all this information, if you knew then what you know now, would you still recommend he keep his bonus?

Dr. PETZEL. Very difficult question to respond to. I am not in that circumstance. I am not there now.

Mr. MURPHY. I am asking you——

Dr. PETZEL. I can tell you, Congressman, that fact of what happened at Pittsburgh would be taken into account in terms a nomination coming out of——

Mr. MURPHY. Doctor, Doctor, Doctor.

Dr. PETZEL. —the Department, but you are asking me would I not do it. I cannot tell you that.

Mr. MURPHY. I am asking you now, you are a doctor, Hippocratic oath. Based upon the question of the Chairman, it is easy enough for you to turn to your left and look Mr. Moreland in the eye or look at the families here who have lost someone, look them in the eye. It is easy enough to say, you know, I can't make you do this,

there is no law that says I can, but somewhere along the line isn't it just the right thing to do, to give this back. What would you do?

Dr. PETZEL. What would I do?

Mr. MURPHY. Yes.

Dr. PETZEL. I cannot ask, I will not ask Mr. Moreland to give this back.

Mr. MURPHY. Well, then who will do this on behalf of the families?

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman.

Could you tell me and the families and the people here today why was the special pathogens lab closed?

Dr. PETZEL. I would have to turn to Mr. Moreland. I was not aware of that at the time in 2006.

Mr. DOYLE. Mr. Moreland, why was the lab closed?

Mr. MORELAND. The lab was closed because the director of the lab decided he would no longer stay in the employment of the government because he had been asked to stop taking samples from across the country, from restaurants and gas stations and being paid to do those samples for those organizations and using that money to supplement the income of the employees of that lab. When he was asked to stop doing that, to continue doing his work at the VA and the special pathogens for VA, he refused to do that, and because he refused to stop that and was insubordinate in following direction, he was no longer required to be an employee of the VA.

Mr. DOYLE. So you say he was taking samples, and he was receiving payment. Where was the payment going to?

Mr. MORELAND. The payment was going into a research foundation and then being paid back out to his staff.

Mr. DOYLE. So it was staying within VA. It wasn't going to him personally.

Mr. MORELAND. Some of it went to him personally through the research foundation.

Mr. DOYLE. Why were these samples, why were these specimens destroyed?

Mr. MORELAND. I have explained this a few times.

The CHAIRMAN. Could you bring the mic a little bit closer, sir?

Mr. MORELAND. I have explained this a few times, and it is difficult sometimes to understand, but a set of samples is required to have a catalog and to have them organized as a set of samples. That was not present in what was left in the special pathogens lab after other researchers had provided their catalog of samples and arranged their samples according to that catalog. Those samples were moved in total to the clinical laboratory where they still continue to exist today and are continued to use by researchers today.

In terms of Dr. Yu's samples——

Mr. DOYLE. Are you saying the specimens weren't destroyed?

Mr. MORELAND. I am saying that, what was left in the lab was a collection of biomaterial that was not labeled, and there was no catalog for, and despite frequent requests of Dr. Yu and Dr. Stout, to provide a catalog that would make those samples understandable and safe, they refused to do that. As a consequence, there

were unlabeled specimens in the laboratory that posed a biological risk, and they were then destroyed.

Mr. DOYLE. So you are saying that these samples would have no practical use because they weren't labeled properly, or I am trying to——

Mr. MORELAND. You couldn't tell what the samples were because they were not labeled, there was no catalog to explain what they were, and so they were basically just a collection of biological specimens that did not have a catalog to explain what they were and what use they were for. Despite repeated requests to have that catalog provided, it was not provided, posing a risk because of those unlabeled samples in the building.

Mr. DOYLE. The IG's report made it quite clear to all of us that the routine maintenance and inspection of the copper-silver ionization system was not taking place. Who was responsible for seeing that that was monitored on a daily, weekly, or however often it needed to be done, who was responsible to make sure that was taking place?

Mr. MORELAND. Yeah. The water system engineers and the plumbers were responsible to do daily checks, adjust the calibration of the system and how it worked, and they were responsible to do that.

Mr. DOYLE. And that obviously didn't occur.

Mr. MORELAND. In looking back over the records, there were clearly times when that was not done as rigorously as it should have been done.

Mr. DOYLE. Who supervises those people?

Mr. MORELAND. There is a supervisor over the water engineers and the water pipe system and then a chief of engineering above that, an associate director above her, and then the hospital director.

Mr. DOYLE. So when this maintenance that should have been taking place wasn't taking place, what action did that supervisor take for those people or the people above him?

Mr. MORELAND. Well, the supervisor, in looking at the individual people responsible to manage, we have been unable to issue any kind of actions at date, because during the hearing last October or November, during the last hearing, one of the vendors indicated that he had evidence that some of the staff had falsified records.

Mr. DOYLE. So——

Mr. MORELAND. When we found out about that, we requested the Criminal IG to come and look. When the Criminal IG starts an investigation, you must step back and allow them to do their investigation and hold further actions until that is complete.

Mr. DOYLE. So what you are saying to these families is that the reason no one has been held accountable up the chain is because there is a pending criminal investigation?

Mr. MORELAND. There is a pending criminal investigation that we have to wait until it is finished and completed and provided. After that is done, other administrative actions that are more administrative can be considered, as well as response to any findings from the Criminal IG.

Mr. DOYLE. What is the status of that criminal investigation, and when do we expect to hear from that?

Dr. PETZEL. I don't know what the status is. We periodically ask them, and all we are told is that the investigation is continuing, and we are as anxious, Congressman Doyle, as you are to see the results of that so we can progress with what we are going to be doing about Pittsburgh.

Mr. DOYLE. Mr. Chairman, I see my time is up, but I hope we have another round of questions.

The CHAIRMAN. Yes, Mr. Doyle, we will.

Mr. Rothfus.

Mr. ROTHFUS. Thank you, Mr. Chairman.

Mr. Moreland, you just testified that the specimens that were destroyed were not labeled. Is it your testimony today that not one of the specimens that were destroyed had a label on it?

Mr. MORELAND. What I said was that they were not labeled and cataloged. They may have had labels that meant nothing to anyone without a catalog, but one must have both a catalog that explains the labeling system, and the specimens must be labeled so that you can be safely understood there is a sample. Without that, they truly represent a hazard to the organization.

Mr. ROTHFUS. So there were specimens that were labeled, but you are saying there was no catalog.

Mr. MORELAND. I am saying that there were specimens, some of them had labels, but there was no catalog to explain what the labels meant.

Mr. ROTHFUS. And did you ask for a catalog? Was there a catalog available?

Mr. MORELAND. There were multiple requests for the catalog. That catalog was not provided.

Mr. ROTHFUS. Dr. Petzel, you began your testimony this morning by stating that the Department of Veterans Affairs is committed to consistently providing the high-quality care to our veterans that they have earned and deserved.

Having heard the testimony this morning from our first panel of witnesses, I don't know anyone who could conclude that the VA in these instances met that commitment.

In your testimony, you state that when misconduct occurs, employees are held accountable through a range of actions and consequences that appropriately address the circumstances, and acts that are deemed blameworthy have clear consequences and accountability.

You also state that you can ensure the Committee, that you are holding the appropriate people accountable as a result of management and oversight issues at the facilities that are the subject of this hearing. It has been known for a long time that there has been a Legionella problem at the Pittsburgh VA. In 2007, we know that 17 out of 19 specimens taken from the ICU proved positive for Legionella. At the Pittsburgh VA, there has been a massive outbreak of Legionella that killed at least five veterans and sickened many more. The Inspector General identified systematic failures that led to this outcome. These were preventable deaths, and I think that we would all agree that someone needs to be held accountable.

Let me walk you through the facts of one of the deaths. On October 29, 2012, the CDC had conclusive and definitive proof that

Legionella bacteria discovered at the VA had, indeed, infected at least two veterans. This was on the University Drive, the VA Hospital. This resulted in the CDC coming to Pittsburgh with a team that arrived on November 6. So hospital officials absolutely knew what was going on.

On November 1, World War II veteran Bill Nicklas was admitted at the VA Pittsburgh Hospital. On November 11, he was moved to the ICU, and on November 12, he had a fever and an infection, yet no one tested him for Legionella at the time. The CDC told the hospital officials that they should test their hospitals for Legionnaires Disease when they left on November 15 and the 16th. And on the 17th, signs went up around the hospital saying don't drink the water, don't use the water.

Mr. Nicklas was finally tested two days later on November 19 for Legionella, but the hospital lost the sample. So they had to retest him again on November 21, and he died on November 24.

Getting to accountability, it appears that even though the VA Pittsburgh officials had actual, clear knowledge no later than November 6, that they did not notify the medical staff, who would be responsible for that? The CDC is there. Who bears responsibility? Is it the Chief of Staff? Is it the Chief of Infectious Diseases?

Dr. PETZEL. I would say that it is the Hospital Director, the Chief of Staff, and perhaps the Chief of Infectious Disease have the responsibility.

Mr. ROTHFUS. Is the VISN Director responsible in any way?

Dr. PETZEL. Not directly, no. He has oversight of that, but the responsibility for those notifications——

Mr. ROTHFUS. Should the——

Dr. PETZEL. —lie with the medical center.

Mr. ROTHFUS. Should the VISN Director know that the CDC is onsite on November 2?

Dr. PETZEL. Yes, he should.

Mr. ROTHFUS. When will we see somebody held accountable for this dereliction, because all I have seen, frankly, is bonuses, Presidential awards, and glowing performance reviews, and I think that is an outrage and an insult to the victims here. When are we going to see some accountability?

Dr. PETZEL. We will see accountability when we get the Criminal IG's report, and then, we will be allowed to proceed with whatever actions we are going to take.

Mr. ROTHFUS. Mr. Chairman, I do have another question, but I know I am going to go over time, so if we are going to have a second round, I would like to——

The CHAIRMAN. Yes. We will have a second round.

This is public information that I am asking for, but I think there are at least 12 executives from VA that are here with us today. I would like to ask a show of hands from the 12 that are here, how many of you received a bonus last year. Raise your hand, please.

Who got one in 2011?

Dr. Petzel, did you get one?

Dr. PETZEL. No, sir. I do not receive bonuses.

The CHAIRMAN. Okay. You have agreed to talk to the press after this hearing, I believe.

Dr. PETZEL. I understand that there is going to be a press—a brief press avail after this.

The CHAIRMAN. Is there anything that would prevent any of the other individuals that are here with you today from talking with the press?

Dr. PETZEL. No.

The CHAIRMAN. Okay. Would you all agree if asked to talk to the media?

Mr. Moreland, would you agree to talk to the media?

Mr. MORELAND. Yes.

The CHAIRMAN. Okay. Dr. Petzel, could you expound, there was a lot of testimony in regard to doctors being credentialed and being called staff but they were actually contracted and individuals said there is no recourse for the VA. How does that work? If a physician is a contract doctor within a facility, how does VA not have any responsibility for whether or not that physician performs their job appropriately or not?

Dr. PETZEL. Mr. Chairman, I was as surprised as you were to hear that testimony. We have contract physicians in a number of different circumstances. We have physicians that are part-time university, part-time VA. My understanding is that they are as accountable as any other VA physician, and I intend to talk with the people at Dallas after we finish to find out what those circumstances are, because that does not make sense to me.

The CHAIRMAN. It doesn't to me either, and I appreciate that response.

If you could, in general terms without providing any personally-identifiable information, provide for the Committee any type of disciplinary action that has taken place in the last year where an act occurred in a VA medical center that was deemed blameworthy, which is a word you used in your testimony, and personnel action was taken.

Dr. PETZEL. Well, let's use the example of Atlanta, where we had issues with the contract for mental health care outside the facility, and several people died. The contract was mismanaged. Whether one can draw a connection to those deaths between that mismanagement is difficult to know, but they did, and the Mental Health Inpatient Service, where, again, there were two deaths associated with people in that circumstance, and we have taken disciplinary action in seven different arenas. The Chief of Mental Health Service before we could do anything resigned. The Chief of Staff has resigned from that facility. We have issued three specific actions, and as the document that we have sent to you shows, there are at least four, and I believe five, pending actions that will be taken, a clear, I think, trail of accountability in the cases at Atlanta.

The CHAIRMAN. Can you tell us what happened to the former Medical Center Director?

Dr. PETZEL. He retired.

The CHAIRMAN. Is that a disciplinary action?

Dr. PETZEL. No, it is not, but it does obviate the possibility of us doing any disciplinary action.

The CHAIRMAN. It does?

Dr. PETZEL. Yes.

The CHAIRMAN. So you have no recourse now to find any disciplinary action?

Dr. PETZEL. We do not.

The CHAIRMAN. So if a physician causes somebody's death and then they leave, and I am not saying it was a physician, and leaves your employ, you have no way to go back, no recourse.

Dr. PETZEL. We do not have a recourse, however, in the case of a clinical person such as a physician, we would report that to the State Licensing Boards, and there would be recourse through the State Licensing Board, but in terms of our discipline, an employee who has left our employ, it is not doable.

The CHAIRMAN. Even if they caused a death.

Dr. PETZEL. It is not doable, sir.

The CHAIRMAN. I think we can probably do something to fix that but—Mr. Michaud.

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

Getting back to the lab, you mentioned you closed it down because of, you know, what the Director had done. Why didn't you replace the Director in that lab to keep it running?

Mr. MORELAND. We actually moved the responsibility for the clinical sampling and such to the clinical laboratory at the medical center, and that worked really well, and then in terms of the Legionella samples, the CDC is where we go, and they are a definitive source for CDC lab samples.

Mr. MICHAUD. We heard in the first panel from Brandie Petit about so many medications, you know, for a family member, and it is not the first time I have heard it from, actually, I heard it from the general from Maine, when you look at how the Department of Defense and now the VA, the response seems to be give more meds, that will solve the problem versus trying to find other ways to do it without using medications.

I guess, Dr. Petzel, what is the VA doing as far as trying to hold down what they give for meds, or are they just giving meds because it is an easy solution?

Dr. PETZEL. Yes. Thank you, Congressman Michaud. Before I answer the question directly, I did, again, want to express my profound regret to Ms. Petit over the way her brother was treated. This is not the way we want to do our business. This is not the way we want patients to be treated, and I find it as appalling, I believe, as this Committee does.

In terms of medication, it is a problem across the country that people are overmedicated, particularly people that are involved in mental health issues. There is a variety of drugs that can be used, and we need to be very careful, very vigilant that they are being used appropriately. VA has started a program where we first are able to provide data about how many drugs and what doses a patient is receiving, how many drugs and what doses a physician is prescribing or another provider, and that material then is used as someone from pharmacy visits those physicians and discusses their prescribing practices with the attempt to reduce the number of medications and reduce the doses of some medications. It has been piloted in two networks. It has worked very effectively, 35, 40 percent decreases in the number of medications being distributed and

in the doses, and we have now begun the process of spreading that out to the entire country.

The same thing is being done in a different way with pain medication, which is another serious national problem, and in that case, we have developed a same sort of database, and then we classify providers and patients as outliers, getting unusually large amounts. Those people are contacted by a liaison at each one of the medical centers and specifically counseled about the way that patient's pain medication is being managed.

The goal is to use these drugs only in the doses that are effective, that are recommended, and only in the combinations that are useful, and the idea of piling on one drug after another when one doesn't work is just not the practice that is acceptable any longer.

Mr. MICHAUD. When you look at actually the first panel, a couple talked about when you look at what happened here in Pittsburgh, they were told not to use, you know, drink the water and without any explanation of what was going on.

Is that a common practice or——

Dr. PETZEL. It should not be, Congressman, a common practice. One would like a general alert to the patients, the facility, the staff that this is an issue, this is a problem, and here is what we are doing to ameliorate it. No, it should not be a common practice.

Mr. MICHAUD. I see my time is almost run out. I would encourage you to keep doing what you can to make sure employees are trained appropriately, because we have heard some of the problems of the first panel, and I know it is not systemwide, but there are some employees out there that probably should not be employees of the VA because they do not provide that customer service that they should be providing. I know with a vast organization, Doctor, that is very hard for you to do it personally, but hopefully, you do provide the adequate training that needs to be done and keeping an eye on that as well.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Dr. Murphy.

Mr. MURPHY. Thank you. Doctor, the Inspector General's criminal investigation, my understanding is, that came out of testimony we heard at a VA Committee hearing, whereby there was a claim made that someone involved with some of the copper-silver ionization equipment had said that he had heard from someone that information was falsified on the record. Are you aware that that testimony took place?

Dr. PETZEL. I am. I am aware of the fact that a vendor of the copper-sulfate made the accusation that there had been falsification of data, and that is what engendered the—I don't remember who asked, whether we asked or Congress or asked——

Mr. MURPHY. Right. Right.

Dr. PETZEL. —that there be a criminal investigation.

Mr. MURPHY. Because that would be something worth a criminal investigation.

Dr. PETZEL. Right.

Mr. MURPHY. But that criminal investigation by the IG does not include looking to see if reporting followed CDC guidelines, does not look to see if doctors were properly notified, does not look to see what the impact was of closing the pathogens lab, does not look

at the delays. Those aren't necessarily criminal in the sense of what the Inspector General would be looking at. Am I correct?

Dr. PETZEL. That is correct.

Mr. MURPHY. So how does that keep you from doing any discipline? You had said you were waiting for the Inspector General's criminal investigation, but those aren't criminal issues we are talking about.

Dr. PETZEL. Those aren't criminal issues, but they are a part of the whole look at what is going on in Pittsburgh, and we feel constrained to do anything in terms of——

Mr. MURPHY. Anything?

Dr. PETZEL. —administrative action——

Mr. MURPHY. Anything?

Dr. PETZEL. —until we see all of that material.

Mr. MURPHY. So by anything, you mean, you are not taking any administrative action until that is coming out?

Dr. PETZEL. We are not.

Mr. MURPHY. Okay. Mr. Moreland, you have heard the testimony. I have complimented you in the past for work you have done and some things you have done with MRSA, and the VA has done great work with that.

But as the doctor has pointed out, this is a lifetime award you received, and even a lifetime of good work can sometimes be marred by other issues. You have heard the families say what their reactions are to having a bonus going with this award. Do you have any message for them with regard to that?

Mr. MORELAND. I want to echo Dr. Petzel that I have significant sympathy and empathy for the families. I came to the VA with a mission to help take care of America's veterans about 30 years ago, and every time something bad has happened or a family has suffered, I have felt personally bad about that. So I can't express more sincerely my apology and appreciation for the suffering that the family faces.

The Presidential Rank Award was provided to me for a career of that service. The timing of it was very bad, and I understand the families that would look at that and make the connection and be upset about that. I received the award. I am proud to have received it. I am focusing my efforts every day to looking for, understanding what happened, how it happened, analyzing information to make changes, and putting those changes in place to reduce the risk of anyone else suffering.

Mr. MURPHY. Let me ask about another issue then. On May 2 during—while Greg Bethany was receiving a liver transplant, apparently some construction workers cut a power line, so the O.R. was out of power. Now, my understanding there was a two-hour time period in the middle of this delicate surgery the power is lost. Does that sound correct?

Mr. MORELAND. Yes.

Mr. MURPHY. And my understanding also the liver may have been damaged with freezer burn during this incident. Are you aware of that?

Mr. MORELAND. Well, I really don't want to talk about an individual case, because I really should not be talking about an individual case. What I would say is that during events when power

is lost, we work very carefully with alternate sources of power to make sure that we are able to complete the work that is done. It was a challenging issue.

Mr. MURPHY. So is that something you prepare for in case something like that happens? The OR has a battery back-up system?

Mr. MORELAND. There are multiple lines into the hospital to provide multiple sources of power. The challenge is when a vendor cuts, you know, the main line right into the O.R., but we were able to complete and finish the surgery.

Mr. MURPHY. I understand that, but it is also, my understanding is that unsterile portable air units and also maintenance personnel who had not scrubbed or changed clothes also came to the O.R. at that time and that Mr. Greg's condition deteriorated. He has since passed away from organ failure and infection and was in incredible pain.

So it is another one of those cases of, even though you said that it was back-up systems there, it doesn't sound like it was that good, and I hope that is something, Doctor, you can also take a look at as well. But my understanding also is there was no back-up power. This is all by battery systems, and it unfortunately, led to another life, but I am particularly concerned about the infection issues that occurred at that time.

Thank you, Mr. Chairman.

The CHAIRMAN. If I could follow on with that line of questioning, and, again, it has been open, so I would just like to know since it was an organ donation or transplant, was the death of the veteran who received that transplant reported to UNOS?

Mr. MORELAND. Yes. It is my understanding that it was reported and that the events in the operating room were not part of the cause of the death.

The CHAIRMAN. Okay. Do you know who reported it and when they reported it? Because I don't have direct knowledge, but what happens is, we have an organ transplant coordinator who works with the surgical team, and it is his or her responsibility to collect and report that information to UNOS.

Dr. PETZEL. Well, Mr. Chairman, we will find out and get back to you or your staff quickly.

The CHAIRMAN. Okay. Ms. Wolf is here. Could she answer the question?

Ms. WOLF. Mr. Chairman——

The CHAIRMAN. And could you identify yourself for the record?

Ms. WOLF. Yes.

The CHAIRMAN. And get a little closer to the mic. I apologize. Maybe Mr. Stiller can stand up so you can sit down.

Ms. WOLF. Mr. Chairman, I am Terry Wolf, and I am the Director at VA Pittsburgh.

The CHAIRMAN. Could you answer the question?

Ms. WOLF. I am sorry.

The CHAIRMAN. Was it reported to UNOS?

Ms. WOLF. I don't know that definitively.

The CHAIRMAN. What is your position?

Ms. WOLF. I don't have that information with me right now, but I would be happy to——

The CHAIRMAN. How many patients die in your facility from this type of a surgery that you wouldn't know the answer?

Ms. WOLF. You asked me if UNOS was notified, and I assume that——

The CHAIRMAN. You assume it.

Ms. WOLF. Yes. That is standard operating procedure.

The CHAIRMAN. Okay, but you don't know that.

Ms. WOLF. I am not going to say something that I don't know——

The CHAIRMAN. How long have you prepared for this hearing?

Ms. WOLF. About one month.

The CHAIRMAN. A month? How many trips to Washington did you take to prepare for it?

Ms. WOLF. One.

The CHAIRMAN. And in that trip this didn't come up at all in your preparation?

Ms. WOLF. No, it did not.

The CHAIRMAN. And so you don't know the answer. Can you tell us if it wasn't the loss of power or temporary interruption, what caused the death?

Ms. WOLF. I am not at liberty to discuss that with patient privacy reasons.

The CHAIRMAN. Okay. So when I subpoena that information, you will provide it.

Ms. WOLF. Of course.

The CHAIRMAN. Okay. Dr. Murphy, have you got any questions you want to ask while she is at the table?

Mr. MICHAUD. Thank you, Mr. Chairman. I want to continue to follow up on my first line of questioning and ask some more questions that the families have asked.

At the February 5 hearing Aaron Marshall, who was the Operations Manager for Enrich, was called at the request of Pittsburgh VA to perform a review of the system, but he was denied access to view the Legionella test results. He said had they been aware of those presence of Legionella, that they would have recommended implementing the reactive course immediately.

Steve Schira, Chairman of Liquitech, also whose company manufactured the Pittsburgh VA's Legionella prevention equipment, in his statement said that the system requires regular maintenance, monitoring, and validation. It is not plug and play.

Who was responsible for denying the Enrich to view the Legionella test results, and why was that denied?

Mr. MORELAND. It is my understanding that there are two different companies running two different copper-silver systems that were in place at that time and that the engineering staff had asked one of the other vendors, Enrich, to look at the other system, Liquitech and explain——

Mr. MICHAUD. So they had asked Enrich to look at Liquitech's system?

Mr. MORELAND. Right.

Mr. MICHAUD. Why wouldn't you just call Liquitech?

Mr. MORELAND. Well, they had been talking to Liquitech, too——

Mr. MICHAUD. Okay.

Mr. MORELAND. —and then they thought they would get another opinion and get a feel for that, and some of the recommendations they got really were not consistent with the manufacturer's guidelines for the other system. So it appeared in looking at it, that the engineers were just looking for a consultation and advice from multiple people to take a look at the system.

Mr. MICHAUD. And what about Mr. Schira's statement, that the system requires maintenance, monitoring, and validation, which the IG's report says apparently wasn't being done?

Mr. MORELAND. Yeah. I say that his statement was correct. It required lots of daily look and see, and while the VA Pittsburgh staff did do a lot of maintenance, talked to each of the vendors multiple times, and the copper-silver ionization levels were appropriate much of the time but not all the time. Sometimes they were too high, and sometimes they were too low, and it was most troubling to us when the CDC found copper-silver levels at manufacturer's recommendations and still positive living Legionella in the water.

Mr. MICHAUD. Is that because those were false readings, or they actually were reading at those levels, and there was Legionella?

Mr. MORELAND. They were reading at the correct level, and there was still Legionella. It is a complicated system. The PH of the water is involved and other things as well. That is why we have moved to a new system now, and we are using a chlorine-based system and managing that. We found it easier to manage and more compliant with what we need to do.

Mr. MICHAUD. But isn't it true that during the time that Dr. Yu and the lab was open and they were using the system, that there wasn't outbreaks of Legionella? I mean, the system seemed to be working fine when it was operated the way it was meant to be operated. It just seems to me, and many others, that after they left, somebody dropped the ball here with regards to seeing that the maintenance was being done, and you can't put this just on a couple plumbers. So my——

Mr. MORELAND. This——

Mr. MICHAUD. —question is who is responsible for making sure that the plumbers were doing what they were supposed to be doing, and you know, at what point in the chain of command is somebody responsible for this?

Mr. MORELAND. That is one of the myths about the presence of the special pathogens lab, that there were no hospital-acquired cases during their oversight and that there were no positive water samples of Legionella. That is a myth. In fact, there is a 2003, paper published by the Special Pathogens Director that from '96, to 2003, there were seven hospital-acquired cases during their oversight, and so the article states that we have achieved a level of one hospital-acquired Legionella case per year on average.

So it is not possible to guarantee that there will never be a hospital-acquired Legionella. What you have to do is work very rigorously to reduce the level of Legionella in the water, which reduces the risk, and that is what happened in the early Fall of 2012. After rigorous review to figure out why are we getting Legionella cases that look like they are community acquired because our water samples are looking positive where those patients were.

Mr. MICHAUD. Let me ask you, too, because I don't want to forget. Mr. Murphy had asked about and it was mentioned that there were signs up in the hospital not to use the water fountains or the water because there was a trouble with the line. Whose decision was it not to be more transparent and disclose to visitors and patients and others that there was a Legionella outbreak, not that there was some problem with the waterline?

Mr. MORELAND. Yeah. Contrary to the perception that there was not transparency and that there was a cover-up, I will tell you that the news media was provided a news release, and so when the family talked about seeing something in the newspaper, that was based on the news release that the VA Pittsburgh did. They posted it on their Web site the concern about Legionella and held town hall meetings with employees.

I apologize and it is troubling to me that if individual families were not talked to, that is challenging, but I am glad to hear that they heard about it on the media because that was one of our strategies, to get the word out, was to release the information to the media.

Mr. MICHAUD. Mr. Chairman, I see the red light has been on for quite some time, and I appreciate your indulgence, and if there is a third round, I am interested.

The CHAIRMAN. There will be a third round.

Mr. Rothfus.

Mr. ROTHFUS. Dr. Petzel, in response to the Legionella outbreak at the Pittsburgh VA, there has been legislation that has been introduced in the House of Representatives, which I cosponsored, that requires the VA facilities to follow the same state guidelines for infectious diseases reporting as all other hospitals. I think this is a good, commonsense approach that will serve to better protect the health and wellbeing of our veterans.

But VA officials oppose this legislation, in part because it would subject them to potential fines for violation of the law, and the VA would rather keep those funds for patient care.

Can't the same be said for the bonuses that you paid to the senior staff? Wouldn't the tens of thousands of dollars that you paid to individuals like Mr. Moreland and Ms. Wolf have been better spent on patient care?

Dr. PETZEL. Yeah. First of all, Congressman, I am familiar with the legislation. I am not familiar with the opposition that you just described. We, in fact, have already implemented a policy within the VA that all facilities will report infectious diseases as their states require. That is already being done, and I will go back and see. I was not aware that there was some official opposition to the legislation, but we are already doing this. We think it is a good idea and are doing it already.

Mr. ROTHFUS. I would encourage you to do that because the VA has said if the proposed bill is adopted, the VA wants an exemption from potential fines for——

Dr. PETZEL. The fines. All right.

Mr. ROTHFUS. Said Jane Clara Joyner, Assistant General Counsel for the Department. So I would appreciate you going back and——

Dr. PETZEL. I will find—we certainly don't oppose the idea of reporting. That is fundamentally important, and we are already, in fact, doing it. I will find out about the fines.

Mr. ROTHFUS. Now, your testimony also states that people are not punished for inadvertent errors. Do you have an opinion as to whether what happened at the Pittsburgh VA was simply an accumulation of inadvertent errors?

Dr. PETZEL. I do not believe that what happened at the Pittsburgh VA is an accumulation of inadvertent errors.

Mr. ROTHFUS. I want to go back to what I talked about with the first panel about President Kennedy and his call to public service and that quote, "Let the public service be a proud and lively career, and let every man and woman who works in any area of our national government in any branch, at any level be able to say with pride and with honor in future years that I served the U.S. government in that hour of need." And, of course, when President Kennedy said, "Ask not what your country can do for you but what you can do for your country."

What about you, Dr. Petzel? Say it was you. You have run a VISN before, and let's say that an Inspector General report comes out several days before you are going to get a distinguished award that says there was systemic failures that resulted in the deaths of veterans. Would you have accepted that award?

Dr. PETZEL. Let me first tell you a little Kennedy story. I was in college as opposed to being one year old when John Kennedy was assassinated, and I have served for 43 years in two Department of Veterans Affairs. I am in public service in part because of those words. I consider it to be an incredibly honorable and incredibly fulfilling thing to be doing. And I will be very candid and honest with you. It is incredibly difficult for me to put myself into the circumstances that you just described, but certainly if, I would not expect to be nominated for an award, if those sorts of things were in the process. In fact, the IG at the behest of the VA reviews everybody that is going to get an award, and if there is an IG investigation, it is almost automatically you are not a part of that.

Whether or not I would, first of all, I am not eligible for a President Rank Award, so it is very hard. As a politician, it is very difficult to imagine it. But I would certainly hope that I wouldn't even be in the running if that happened.

Mr. ROTHFUS. Do you think you might say, you know, given what we have seen behind the scenes, given what we have seen, this is not the best time for this. Maybe give me some time to clean this up, make sure that it is all taken care of and then recognize my work.

Dr. PETZEL. I think that at that moment in time, Mr. Moreland didn't have that choice. This was already a done deal, already processed through OPM and wherever else it goes, and it had already been awarded. You were just hearing, we were just hearing about the announcement, but the decision about giving that, about doing that had been made long before that. I would think that if the opportunity were there prior to what happened, that Mike or I, or anybody else, would step up and say, let's wait and see what happens.

Mr. ROTHFUS. Mr. Chairman, I will have some more follow ups. Thank you.

The CHAIRMAN. Dr. Petzel, you said you weren't eligible for a President Rank Award, but are you eligible for any bonus?

Dr. PETZEL. At the present time as a Presidential appointee, no.

The CHAIRMAN. Okay.

Dr. PETZEL. That is my understanding that I am not.

The CHAIRMAN. Okay, and you said that you currently are reporting any incidents similar to, we are talking about the Legionella outbreak, so did we report that? Did VA report that?

Dr. PETZEL. Yes.

The CHAIRMAN. To who?

Dr. PETZEL. To the C—to the state as I understand it. The way this works is that the CDC——

The CHAIRMAN. No, no. I just——

Dr. PETZEL. Let me just quickly.

The CHAIRMAN. Let Mr. Moreland since he shook his head, and I have limited time. No.

Dr. PETZEL. All right.

The CHAIRMAN. Mr. Moreland. Who was it reported to?

Mr. MORELAND. The State Health Department.

The CHAIRMAN. Who in the state?

Mr. MORELAND. The State Health Department.

The CHAIRMAN. Okay, and is that public record when you report it to the state?

Mr. MORELAND. I really don't know if it is public record, but we reported each case. I think the challenge was, is that——

The CHAIRMAN. No, no, no, no, no. Not each case. When you know you had a situation in your water system, was that reported to the state?

Mr. MORELAND. Oh, the water samples were not reported because that is not required.

The CHAIRMAN. Okay. That is what we are talking about. When you know you have got a problem, that is what the bill is intended to do and that is to seek a reporting from the VA to the local or state reporting authority so that they know that there is an issue. The local hospital doesn't have to do it?

Dr. PETZEL. No. They report cases of Legionella.

The CHAIRMAN. Okay.

Dr. PETZEL. They do not report positive water samples.

Mr. MORELAND. They all don't even take samples.

Dr. PETZEL. Most of them don't take samples.

The CHAIRMAN. The local hospital doesn't take samples?

Mr. MORELAND. I don't know what the local hospital does, but I know——

The CHAIRMAN. You just said the local hospital doesn't take samples.

Mr. MORELAND. I know from meetings where I——

The CHAIRMAN. You just told me that they don't take samples.

Mr. MORELAND. I said not every community hospital takes samples.

The CHAIRMAN. No. You said the local hospitals doesn't take samples. Do they or don't they?

Mr. MORELAND. I don't know.

The CHAIRMAN. Okay. Well, you just said they did.

Mr. MORELAND. Based on my understanding of local community hospitals, many don't.

The CHAIRMAN. All right. Dr. Petzel, and this is from something Mr. Moreland just said because you brought in, there are two systems, I guess, and you brought one company in to check out the other system because you weren't quite sure whether that system was doing what it was supposed to do. It kind of fits this question because you conduct a root cause analysis when there is a serious injury or a death that has occurred at a facility, and that analysis is an impartial process according to your testimony.

And my question is, how can it be impartial when it is staffed by a team of experts from throughout the hospital? How is that? Impartial would be to bring in somebody from the outside to look at it, not somebody from the inside, in particular, with the Medical Director being in charge of overseeing that.

Dr. PETZEL. Mr. Chairman, I don't know where the term impartial got into this discussion. We do root cause analyses locally on every kind of an adverse event that has occurred. When we are looking for something that is impartial, we either do it at the network level, or we bring in a central office team. I wouldn't want to——

The CHAIRMAN. So the root cause analysis is not an impartial process?

Dr. PETZEL. It is impartial in that the people involved in it are not, but if you are implying that the whole medical center is contaminated by the fact that they all work there, then——

The CHAIRMAN. No, I didn't imply.

Dr. PETZEL. Well, I would view it as an impartial, sir, if it is coming from people other than those involved in the discussion or in the incident.

The CHAIRMAN. Okay. Your testimony on page 3, "When a root cause analysis is needed, a team of experts from throughout the hospital and elsewhere work with those who are familiar with the situation in an impartial process to identify prevention strategies." So it came from you.

Dr. PETZEL. It came from me.

The CHAIRMAN. Yes.

Dr. PETZEL. Yes and——

The CHAIRMAN. You said you didn't know where it came from.

Dr. PETZEL. —we would view that as impartial. People not involved in the incident and review it from outside the incident.

The CHAIRMAN. Who has the final say within that facility on that root cause analysis?

Dr. PETZEL. The Director would.

The CHAIRMAN. Okay, and would it not make sense that the Director wouldn't necessarily want bad news to get out to somebody?

Dr. PETZEL. I would certainly hope that that is not the case.

The CHAIRMAN. I would hope not.

Dr. PETZEL. —way this is being thought of.

The CHAIRMAN. I would hope not, too.

Mr. Michaud.

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

I see Mr. Battle, Mr. Milligan, and Mr. Stiller. We are concerned about your facilities as well. I know the focus, since we are in Pittsburgh is with Mr. Moreland. I just want to, Mr. Chairman, first of all, thank the first panel for their story, and our sympathies go out to you, the family, and we will do whatever we can to make sure that we continue having these oversight hearings and to hold the VA accountable systemwide to make sure that we have policies and procedures in place, but also that staff in those facilities are implementing those procedures that are placed. That seems to be where problems have been, is within these certain facilities, and I also want to thank this panel as well for coming out.

Mr. Chairman, I have no further questions. I know that Mr. Doyle has a lot of questions, so I would yield the remainder of my time to Mr. Doyle.

Mr. DOYLE. I want to thank the Ranking Member.

Mr. Moreland, we had met with you shortly after the Inspector General issued reports in April and July in which they found the Pittsburgh VA had inadequate maintenance at all times at the copper-silver ionization system, failure to conduct routine flushing, failure to test patients with hospital-acquire pneumonia for Legionella, inadequate testing requirements, and at that time, you told us that you had accepted the findings of the IG's report. Is that correct?

Mr. MORELAND. That is correct.

Mr. DOYLE. Who do you hold responsible for that?

Mr. MORELAND. Well, first the Hospital Director and then the leadership team below the Hospital Director, including the Chief of Staff, the Associate Director, the Chief Engineer, infection control physicians.

Mr. DOYLE. Uh-huh, and so what action as the VISN 4 Director did you take in light of that?

Mr. MORELAND. Well, first off, as mentioned earlier, I really have to wait until the OIG criminal is finished, because they don't want us contaminating their investigation with other actions and findings until they are finished, and we will do that at that time.

Mr. DOYLE. Dr. Petzel, you said that you do not believe what happened in Pittsburgh is the result of a bunch of inadvertent errors. Is that correct?

Dr. PETZEL. Yes, I did say that, sir.

Mr. DOYLE. And we understand that there is a criminal investigation pending which we are waiting the outcome for. Is that correct?

Dr. PETZEL. That is correct.

Mr. DOYLE. And are you here to tell this panel today and the family members sitting in this audience, when that report is issued, that there will be some accountability for what happened in Pittsburgh?

Dr. PETZEL. Yes, sir.

Mr. DOYLE. I want to assure the family members this isn't over and that we will continue to monitor this until the very, very end.

Mr. Chairman, I want to thank you for holding this field hearing. I appreciate it. I know the people in Pittsburgh appreciate it. We have a long history of serving our country. Men and women in Western Pennsylvania are among the first to step up when the

country calls. When we ask these men and women to go to battle for us, the very least we can do is make sure when they come home that they are treated with compassion.

I also want to say that I believe the vast majority of employees at VA Pittsburgh who I have had association with for many, many, many years, my father was 100 percent service-connected disabled vet who died when he was 61 years old as a result of his service to this country. I spent six years on this Committee with Sonny Montgomery when he was the Chair of this Committee. I want the people to know the vast majority of the people who serve our veterans in Western Pennsylvania care deeply about our veterans and try to provide the best level of service they can. And the volunteers who come to our VA hospitals in Pittsburgh come because they care and love these veterans, too. And when something like this happens, it breaks our heart, and it makes our blood boil, and we will get to the bottom of this, and we will get answers for these family members who have lost loved ones.

Mr. Chairman, thank you very much.

The CHAIRMAN. Thank you very much.

Dr. Murphy.

Mr. MURPHY. Thank you, Mr. Chairman.

I want to follow up on your statement, Doctor, about the Pittsburgh VA is not an accumulation of inadvertent errors. How would you describe it then?

Dr. PETZEL. I would describe it as, I think the IG did in that there were things that were not being done consistently, that we would want to have done, the refreshing of the copper-silver system, the testing being done maybe in a regular fashion sometimes, the fact that water temperatures varied tremendously across. They weren't at the level, such things as that. An accumulation of things that weren't being done perfectly that led to this storm.

Mr. MURPHY. And my understanding is, before personnel were let go and the pathogens lab was closed, there was people working at the Pittsburgh VA who had extensive expertise on Legionella, although it is not part of the subject of the Inspector General's criminal investigation. I hope that part of it is, any role that may have played which was a loss of expertise and was that expertise replaced.

Clearly a disease that is named after veterans, Legionella, would be something we want to pay particular attention to, particularly because it occurred, and it particularly concerned in areas that have transplants as you know with the medication people take.

Another area here is that, have you met with the families that are here today?

Dr. PETZEL. I met the family members today at this hearing. I have not met with them before.

Mr. MURPHY. Would you be willing to speak with more alone, in private, at some time——

Dr. PETZEL. At some point in time, certainly.

Mr. MURPHY. You will commit to that?

Dr. PETZEL. If it can be arranged, I will.

Mr. MURPHY. I think you are in charge of your own schedule, so can you make that commitment? You will make sure that if they want to meet with you, you will meet with them?

Dr. PETZEL. I can.

Mr. MURPHY. Thank you very much. I appreciate that.

The other aspects of lessons learned here go into also with regard to the documenting procedures. Now, you have read the whole Inspector General's report?

Dr. PETZEL. I have.

Mr. MURPHY. And have you read also the GAO report regarding actions needed to improve the administration of the Provider Performance Pay and Award Systems?

Dr. PETZEL. I have.

Mr. MURPHY. You have read that, too? And from that, are there also actions that you are putting into place or the VA is putting into place to change how those awards are given?

Dr. PETZEL. Yes, sir. In fact, before the GAO report, I was not happy with the way the Provider Performance Pay System was being administered, and we chartered a group to review that system, make recommendations about how we can tighten the requirements, tighten the oversight, and make this into a much more standardized procedure. So, yes, I agree with what the GAO said, and in fact, we had started before the GAO report in trying to reform that system.

Mr. MURPHY. What happens in that system then, if you find out that someone will be getting or has received an award, only to find that perhaps months or years later, that some tragic circumstance occurred under that person's watch which was preventable?

Dr. PETZEL. Well, first of all, they are not awards. This is part of their pay. This is a portion of the physician pay or dental pay that is put at risk for, depending on how well they performed. It is not an award, and I don't know whether there is a claw-back possibility associated with salary that someone has received or not. I can't answer that question.

Mr. MURPHY. Is that something that the VA is considering for any rule changes?

Dr. PETZEL. Not that I am aware of. No.

Mr. MURPHY. And what about if someone has left the VA? You had mentioned before a former employee. Is there any provisions, for example, looking at a person's pension?

Dr. PETZEL. I am not aware that except for a criminal conduct, I don't think that we are able to affect people's pensions after they have retired, but I quite frankly don't know.

Mr. MURPHY. That is my understanding if it relates to criminal activity, too. I hope that is something that you will review some way in the future, too, because sometimes things emerge later on.

Thank you very much. Mr. Chairman, I yield back.

The CHAIRMAN. Mr. Rothfus.

Mr. ROTHFUS. Thank you, Mr. Chairman.

Dr. Petzel, you state in your testimony that you operate with unmatched transparency in public and private sector health care, fostering a culture that reports and evaluates errors in order to avoid repeating them in the future.

There has been some very good reporting done here in Pittsburgh regarding the Legionella outbreak that has been done by the local news outlets based on documents they have been able to acquire through the Freedom of Information Act, but this leads me to won-

der why does it take a FOIA request for the VA to turn over relevant information, particularly when this Committee requested that same information back in January?

The Committee requested it on January 18 for documents. I sent a letter, along with the Chairman and Subcommittee Chairman Coffman, requesting all emails regarding Legionella from the Pittsburgh VA. We have yet to see them.

Can you tell us what the status of that is and when we are going to see those emails?

Dr. PETZEL. First of all, I regret the fact that you have not received those yet. I have told the Chairman previously when we have talked about delay of documents, it is my goal that you people receive as quickly as possible all the information you ask for. That is part of your responsibilities when you are acting as an oversight Committee for the VA. I understand that we are very close to being able to send those out, and I can't tell you what exactly the reason for them not getting to you as quickly as we would have expected them to, but I understand we are very close.

Mr. ROTHFUS. Thank you. Also based on some very good reporting that was done, again, by our local news outlets here in Pittsburgh, and documents that they did obtain through the Freedom of Information Act, we know that the VA in Pittsburgh found Legionella in its water system as far back as 2007, five years before they finally disclosed it to the public.

In fact, things got so bad that in September of 2007, 17 of 19 cultures taken in the intensive care unit tested positive for Legionella. What we don't know is how many cases of hospital-acquired Legionella have occurred since 2007, since those figures have not been released by the VA.

To clear up the record on this, has VA investigated the presence of Legionella at the VA Pittsburgh Health System dating back to 2007?

Dr. PETZEL. I have not seen the data going back to 2007. I have seen 2010, 2011, and 2012, and I can't answer that question, but we will find out, and I will get back to you.

Let me just make a statement, though, about Legionella. Up until now, recently, the standard in the community, as well as in the VA, was that if less than 30 percent of the cultures were positive, you did not have to do any reading. This was the standard practice, and our experience here in Pittsburgh has taught us and the Nation that that is not adequate, that we need to have more rigorous eradication when we find any positive cultures.

So the fact that there were positive cultures probably wouldn't have triggered anything in particular regarding Legionella in the VA or any other hospital in Pittsburgh or the country for that matter. So this experience here has really substantially, I would even say dramatically changed the way we, as an organization, and I, think the way the Nation is approaching Legionella and its eradication.

Mr. ROTHFUS. I would ask that you take a look at the VA and see what is being done with respect to the 2007 time period and let us know.

Dr. PETZEL. Yes, Congressman, we will.

Mr. ROTHFUS. Thank you. Thank you, Mr. Chairman.

Mr. MURPHY. Mr. Chairman.

The CHAIRMAN. Dr. Murphy.

Mr. MURPHY. Thank you. I just, my thanks to you for coming to Pittsburgh to you and the Ranking Member. This has been extremely important. It has given us a lot of insight. I just want to thank you for the honor. Seeing that I was on the Veterans' Committee once before, and it is like Mr. Doyle said, an honor to be back with you, and I also want to thank you for your ongoing tenacity in pursuing this. Our veterans deserve this and all those who engage so much in this country. So, again, my compliments to you.

The CHAIRMAN. Well, I thank the Members for their attendance. We will be leaving shortly to go back to Washington where there is continued questions that we will each be asked to deal with.

I would just ask the panel to put yourself in the shoes of the family members that are here today who have lost loved ones, and I am not going to ask you to comment, but just ask you deep down inside how would you feel, how would you feel if your loved one had died and then you found out the very person who was supposed to be preventing death like that to occur received a bonus. Any bonus. It doesn't matter if it is a Presidential Award or any other type of bonus.

You understand the gut-wrenching testimony this morning, you understand the concern from Members here, and I can tell you there were a number of Members of the Committee that wanted to make the trip, but unfortunately needed to be in Washington for briefings on Syria. We will continue to work with VA, with the Administrations, with the families, to make sure that preventable injuries and deaths don't occur. Nobody is perfect. We understand that. We understand that, and we want to help, but what we have seen and what we have heard so far doesn't give us a whole lot of faith. I know there has been a lot of preparation for this hearing, and I would expect nothing less, but a simple, truthful, transparent answer that required no preparation would have sufficed at this hearing today.

And with that, all Members will have five legislative days with which to revise and extend their remarks or add any extraneous material for the record, and with that, this hearing is adjourned.

[Whereupon, at 12:15 p.m., the Committee was adjourned.]

APPENDIX

Prepared Statement of Hon. Jeff Miller, Chairman

Good morning, and welcome to today's Full Committee hearing "A Matter of Life and Death: Examining Preventable Deaths, Patient Safety Issues and Bonuses for VA Execs Who Oversaw Them."

I would like to thank the good people of Allegheny County for hosting us today.

As most of you are aware, the Department of Veterans Affairs' Veterans Health Administration provides health care services for millions of American veterans, but a rash of preventable veteran deaths, suicides and infectious disease outbreaks at several VHA facilities throughout the country has put the organization under intense scrutiny.

Despite the fact that multiple VA Inspector General reports have linked a number of these incidents to widespread mismanagement at VHA facilities, the department has consistently given executives who presided over these events glowing performance reviews and cash bonuses of up to sixty-three thousand dollars.

Many Americans have watched in disbelief as these events have unfolded on their television screens and in the pages of their local newspapers.

For some, however, these tragic incidents hit much closer to home.

So I would like to take a moment to recognize all of the family members of those who have suffered preventable deaths at VA medical facilities as well as any veterans who have endured VA patient-safety incidents here in attendance today.

Additionally, I would like to recognize former American Legion National Commander Ray Conley, for whom the Pittsburgh Legionnaires' Disease outbreak is very personal because he was at the 1976 American Legion convention and in the hotel during the original Legionnaires' Disease outbreak in Philadelphia.

To the families of the fallen, I know I speak for every Member of Congress here today and every Member of our Committee when I say that we are deeply sorry for your loss and we simply will not tolerate substandard care for our veterans under any circumstances.

When we hear about it, we will investigate it, and keep the pressure on VA until the problems are solved, and those responsible for letting patients fall through the cracks are held accountable.

That is precisely why we're here today.

The purpose of this hearing is to examine whether VA has the proper management and accountability structures in place to stop the emerging pattern of preventable veteran deaths and serious patient-safety issues at VA medical centers across the country.

In doing so, we will specifically look at VA's handling of recent events in Pittsburgh, Atlanta, Buffalo, New York, Dallas, and Jackson, Mississippi.

For the folks we just recognized, the good people of Pittsburgh, and all those watching this hearing over the Internet, what you're about to hear may be painful.

But just so everyone understands the significance of the five locations I just named, I want to offer a brief rundown of why these incidents are so troubling to the Members of our Committee.

In Pittsburgh, VA officials knew they had a Legionnaires' Disease outbreak on their hands, but they kept it secret for more than a year.

Five veterans are now dead.

Despite all of that, VA Pittsburgh director Terry Gerigk Wolf received a perfect performance review during a period that covered the bulk of the outbreak and regional director Michael Moreland, who oversees VA Pittsburgh, accepted a sixty-three thousand dollar bonus just three days after VA's inspector general reported VA Pittsburgh's response to the outbreak was plagued by persistent mismanagement.

In Atlanta, two VA inspector-general reports identified serious instances of mismanagement that led to the drug-overdose death of one patient and the suicides of two others.

True to form, VA doled out nearly sixty-five thousand dollars in performance bonuses to the medical-center director who presided over the negligence.

During a visit to the hospital in early May, hospital officials told me that although they had identified specific employees whose actions had contributed to patient deaths, no one had been fired.

When I asked a roomful of Atlanta VAMC leaders if there were any other serious patient-care incidents Congress needed to know about, they said no, failing to reveal a previously unreported suicide the media would expose just four days later.

At the Buffalo, New York, VAMC, hundreds of veterans were potentially exposed to Hepatitis and HIV after facility staff had been reusing multi-use, disposable insulin pens.

At least eighteen veteran patients have tested positive for Hepatitis so far.

Additionally, officials at hospitals in Buffalo and Batavia failed to properly maintain medical records, leading to the damage of thousands of patient files.

Despite all of this, David West, the man tasked with overseeing the Buffalo facility, pocketed nearly twenty-six thousand dollars in bonuses.

The Dallas VA Medical Center has been the subject of a series of allegations from VA workers, patients and family members regarding poor care at the facility as well as more than thirty certification agency complaints in the last three years.

The fact that there have been so many allegations of poor care at this facility is troubling enough.

What's also troubling is that Congresswoman Eddie Bernice Johnson, of Dallas, worked for more than a year behind the scenes to get VA officials in Washington to seriously investigate the matter.

Amidst these accusations, two top VA health administrators in Texas have collected a combined fifty thousand dollars in bonuses since 2011.

The situation in Dallas mirrors another instance of VA's apparent failure to take multiple allegations of poor patient care seriously – this time in Jackson, Mississippi.

At the VA medical center there, a series of whistleblower complaints from medical center employees to an independent Federal watchdog called the Office of Special Counsel, or OSC, raised concerns about poor sterilization procedures, understaffing and misdiagnoses.

Based on OSC's recommendations, VA was required to investigate the complaints, but VA Undersecretary for Health Dr. Robert Petzel downplayed the problems by referring to them as "kerfuffles."

So is it any wonder that the OSC wrote to President Obama in March of this year to voice serious concerns with the outcome of VA's investigation and the manner in which it was conducted?

In her letter to the president, U.S. Special Counsel Carolyn Lerner said "it does not appear that the agency has taken significant steps in improving the quality of management, staff training, or work product" and that the whistleblower complaints "raise serious questions about the ability of this facility to care for the veterans it serves."

To me, that's about as far away from a kerfuffle as it gets.

There are two sides to every story, of course.

Later, you will hear from VA officials, who will likely tell you that these problems are all in the past.

But just last Friday, VA's inspector general released another report that will challenge that assertion.

After an investigation into the VAMC in Columbia, South Carolina, the I–G found that mismanagement at the facility helped create a backlog of thousands of gastrointestinal consultations, leading to nineteen instances of serious injury or death for veteran patients.

We have a photo on display here that I, myself, took during a recent visit to a VAMC facility in Albuquerque, New Mexico.

It depicts a quote from Dr. Petzel that was emblazoned on the wall of the facility.

It reads "Improving our work, is our work."

Well, it appears the work is not improving and the question VA officials must now answer is 'where is the accountability?'

We are not here as part of a witch-hunt, to make VA look bad or to score political points.

We simply want to ensure that veterans across the country are receiving the care and benefits they have earned.

No one is questioning whether VA officials are sorry for these incidents or if VA officials are committed to providing the best care possible.

We know that they are.

We also know that the vast majority of the department's more than three hundred thousand employees are dedicated and hard-working, and many veterans are satisfied with the medical care they receive from VA.

What we are questioning is whether VA has the proper organizational culture, accountability and management structures to minimize the future occurrence of heartbreaking situations like the ones I just described.

Considering that the VA executives who presided over the incidents I just described are more likely to have received a bonus or glowing performance review than any sort of punishment, the question we are asking here today is entirely valid.

By now it's abundantly clear to most people that a culture change at VA is in order.

Today, we will find out if VA leaders agree.

Prepared Statement of Brandie Petit

I am Brandie Petit, sister of Joseph Petit. I want to thank you for the opportunity to submit my statement about my brother. Joseph didn't have a lot as a child, but he wanted more. He wanted to be somebody. He wanted to make a difference. I remember Joseph sitting with me in his room, showing me the information he had about the Army. He told me "I want to be the best of the best" and therefore he wanted to be an Airborne Ranger. He believed he could make a difference. While growing up, Joseph was always very active and concerned about eating healthy and working out. At one time he had a 40-inch chest and looked a lot like Sylvester Stallone. He ran, weight lifted, drank raw eggs and protein shakes, and seemed to eat everything in sight. I can't ever recall Joseph taking any medications, even over the counter meds for something as minor as a headache. He worked very hard at everything he did. Once he put his mind to something, it would be done.

Joseph was determined to be an Airborne Ranger! But, he injured his knees while training to be the Airborne Ranger he desired to be. After seeking help for over 20 years from other options, it was a big step for Joseph to give up and finally go to the VAMC. My brother was able to care for himself and help others prior to going to the VA. He sought help for the pain in his knees. They treated his knees some, but the doctors said his pain was really just his brain making him believe there was pain and that there really wasn't any true pain or injury.

On Feb 27th of 2012, I took him to an appointment that the VA set up at QTC Medical Group in Atlanta GA. There he had to do several movements with his knees. I heard one of his knees pop, it sounded like a chicken bone snapping. The other one sounded like bone on bone grinding. Those noises gave me chills. If the pain in my brother's knees was imaginary, then please explain how I heard those noises. Why did my brother break his teeth gritting from the pain of trying to walk?

I am not sure of the exact date, but there was a day that Joseph spoke of, about him going to the VA and them not helping him. They told Joseph he needed to leave because he didn't have an appointment. The VA Police physically removed Joseph and put a standing order into place to arrest him if he showed up again without an appointment. This is NOT the way I feel anyone on earth should be removed or treated.

I am outraged at his treatment that day! I am very upset with the way Joseph and so many others are treated. My brother deserved more respect, if nothing else. If your job involves people, it doesn't matter how many credentials you have, **without compassion, credentials mean absolutely nothing!** The Bible states in the book of **Luke 6:27–36, love your enemies and treat others as you would have them treat you.** My brother treated everyone with respect!

Joseph was always more than willing to help family, friends, and even strangers in time of need. He truly cared about people and their comfort.

My mom and I were shown that same lack of respect when dealing with the VA after they found him dead. We didn't know where to go to pick up his belongings. I was driving and my mother was on the phone asking the VA Police where to go. Their reply was, "How did he die, was it suicide?" Now you tell me why they needed to ask my mother that? Just to rub it in her face that her only son had taken his own life? How rude! That's an example of how compassion should be more important that credentials! I do completely understand that credentials are essential, but we need to make sure that compassion is not forgotten when dealing with a person, a brother, a son, uncle, cousin, grandson, nephew, a friend, a soldier!

Joseph told me that if he did what they (the VA) said, they would fix his knees. He seemed to think if he played by their rules for a while, they would finally help!

We have documents of every time he attempted to reach out for help and those documents prior to being treated by the VA will show that my brother was of sound mind!

Some questions I still have are: How many medications should someone take? Why in the world would one person have to take more than 20 pills a day? That's simply a ridiculous amount of medication going into one body. Many of his medications caused hallucinations! What did he go to the VA saying the day before they found him dead and cold in a bathroom on the 8th floor? He said he was hearing voices. Hallucinating!!! Maybe those people should be prescribed the same medications that Joseph was. Would any of you be willing to take even one of those medications? I sure wouldn't!!

Due to the side effects, Joseph chained himself to the beam in the ceiling to make sure that he didn't sleep walk! He literally chained himself with a master lock and chain around his ankle so that he would not wake up hallucinating and harm someone. He had my mom keep the key to the lock and asked her to do a mental evaluation of him before she was allowed to unlock him.

My brother was a prisoner in his own body. Joseph couldn't shower regularly because the pain of his knees trying to step into the tub was too much to bear. He couldn't stand up without falling over or holding on to something for support. Not long before he died, my son who had just turned 12 watched his Uncle Joseph fall down the stairs of the porch.

My brother, who was so selfless and compassionate to others, was dying in front of me and I kept trying to get him to stop taking those meds!

He was not my brother any more; my brother was hiding in there somewhere trying to get help!He told me his doctors were concerned about the guns in the house, the guns weren't the danger though. Joseph was taught to fight as an Army Ranger. He didn't need a gun to harm someone. He was taught to protect and serve his country and to take out the enemy with any force needed. He did not commit suicide because he felt sorry for himself; he committed suicide to protect others from the voices in his head and hallucinations telling him to hurt others.

I was told that Joseph had been given information about homeless shelters. I can assure you that MY brother would have never been homeless!!! Shame on the American people who allow Veterans to become homeless. The words **"Homeless" and "Veteran" should not be used together!** How can we as Americans sit back and look down our noses at men and women who fight for our freedom of religion, freedom of speech, and all our many other freedoms? I do believe that OUR Veterans should be treated with more respect than I have seen. Go to a VA without your suit on and take a look around. I dare you! You will see a lot of men and women who served the same country that you and I serve in our own ways. They fought in one way or another for our freedoms. They are being neglected, forgotten, and shamed by the actions of our American people.

I don't believe my brother was perfect, nor do I believe any other person on this planet is. I do believe when someone says they have pain and they have the sounds of his knees, they should be taken more seriously. I don't know everything that happened with Joseph at the VA because I am not him. I can only go on the information he provided and that I witnessed first hand.

Nothing I say or do can bring Joseph back and I wouldn't dare bring him back to be mistreated again. I know he is with God! I know he is redeemed!

The following is a letter that I retyped word for word that Joseph wrote May 15, 1992 to Congressman Newt Gingrich. I think Joseph said it best himself. Please read below.

P.F.C. Petit
(Residence Georgia 30253)
13906 Ft. Campbell Blvd, Apt 2
Oak Grove, KY 42262

Congressman Newt Gingrich
P.O. Box 848
Griffin, GA 30224

Dear Congressman Gingrich:

I am Private First Class Joseph C. Petit, 253–98–3134. I enlisted in the Active Duty Army November 26, 1990, as an Infantryman and was scheduled to attend Airborne Training and Ranger Indoctrination Training before being assigned to a Ranger Battalion. I enlisted for four years and sixteen weeks.

I have documentation proving that I passed all of my physical flawlessly at the Atlanta Military Enlistment Processing Station.

In March of 1991, I was attending Airborne Training when I injured both my knees performing parachute landing falls. The orthopedic surgeon presently overseeing my case is Dr. Greer Busbee. Dr. Busbee did not examine me until more than six months after my injury. Dr. Busbee has formed the incorrect opinion that this may have existed prior to service. Dr. Busbee believes this is a temporary condition even after 14 months without any improvement. Dr. Busbee will not allow me a second opinion, corrective surgery, arthroscopy, arthrograms, or magnetic resonance imaging.

Presently a Formal Physical Evaluation Board has found me physically unfit for military duties and recommends a combined rating of 10% and that my disposition be: "Separation with severance pay if otherwise qualified." The Physical Evaluation Board says this condition is permanent. My legal representative told me that entitled me to approximately 4 months pay and Veterans Administration benefits. My written rebuttal must be received by the Physical Evaluation Board no later than 8:00 a.m., May 25, 1992, Central Time Zone.

The Physical Evaluation Board decision was based primarily on the statements of Dr. Greer Busbee. I believe Dr. Busbee's assessment of my injuries are incomplete at best.

I fully realize the risk of surgery. I want my knees repaired if possible or replaced with artificial knees. If possible, I would like to continue service in the Army. I still aspire to be an Airborne Ranger. If I am discharged without repair, I request financial compensation until they can be repaired because walking even slowly causes severe pain, popping, grinding and a feeling of joint separating.

Presently, I cannot perform any of the jobs that I have experience in. Any help would be greatly appreciated by my wife and I.

Sincerely,

Private First Class
Joseph C. Petit

P>F>C> Petit: Home:(502) 439–3675
Work: (502) 798–2753
P.E.B. (512) 221–1524
Dr. Busbee
Orthopedic Clinic (502) 798–8426
Hospital Information (502) 789–8400

Please read the below text messages between Joseph Petit and his sister Brandie Petit. Please understand the misspelled words were not normal for Joseph. He used very good grammar, spelling, and punctuation regularly.

Sept 19, 2012 @ 6:15 PM

Joseph sent Brandie a text stating "Home safely ; medication increased because of sounds heard lately."

Brandie's response "Thank you for letting me know. I love you."

Sept 27, 2012 @ 6:33 PM

Joseph sent Brandie a text stating "Hello, I made it home alive today. Anyway, I may have hallucinated last night ; or now ? Or have these occurences not happened yet ; is one of us hallucinating the other ? Is now really now? Does reality exist? Can exist possibly exist without reality? My meds . . . . Why yes they did change something.. Why do you ask???"

Brandie's response "I really wish you would get off all medications, you were much more normal before them. I love you!!!!"

Oct 12, 2012 @ 9:00 AM

Joseph sent Brandie a text stating "I am at the VA for the fourth day this week. Monday was a federal holiday. I did not understand until maybe Wednesday ; I am exhausted. Outpatient. All patients are limited in treatment until outpatient stabilized status. I am still physically reacting to hallucinations. Dr. Will and I have an appointment today. She is one of my favorite doctors. She is my psychiatrist. **I continue to chain myself to the ceiling;** somehow that seems to limit sleep walking. If I understand correctly my psychologist student has the credentials to diagnose and correct my files ; under the supervision of another doctor. Next appointment with him is Tuesday. GOD Bless You and Yours.

Brandie's response "God Bless You!!!"

Oct 22, 2012 @ 6:00 PM

Joseph sent Brandie texts stating "I have properly attended all four appointments at the Stockbridge VA Clinic begining June 2011. Today is the first time that I remained an outpatient. My new doctor set the referals I requested in writing. A few hours later, she called to say that my case is too complicated for the clinic. I am being transferred to VAMC Decatur. There is less chance of falling through the cracks in the system at this point. Perhaps Wednesday or Thursday I will know more."

Brandie's response "Ok"

Oct 23, 2012 @ 8:51 PM

Brandie sent Joseph a text stating, "I love you"

Joseph did not respond

Oct 24, 2012 @ 4:18 PM

Joseph sent Brandie texts that were very scrambled to say the least.

Joseph texted "I am home again."

Brandie's response "Good!!!!"

Joseph texted "Anxioty meds could be stronger."

Brandie's response "Give it to God!!! He helps me with anxiety all the time when people piss me off"

Joseph texted "This time when I heard the phone I did not jump."

Brandie's response "Good"

Joseph texted "I jumped again. i jump about half the time that this phone makes sounds. Even when I am expecting it. Probably looks hilarious."

My response was "Lol. Mine is broken so it doesn't make any noise at all"

Later this same day **@ 9:05 PM** Joseph texted "Trying to think ; not productive at this point."

Brandie's response "I'm sorry. Maybe you should not try to be as intelligent while on your meds. We all know you are VERY smart, no need to try to prove it all the time. We all love you just the way you are."

Joseph's response "Being mentally disabled slows progress, hallucinations keep life interesting. They gather groups of us together ; when someone pushes button 5 on the elevator, people seem to back away slowly ? There is talk of a sleep study for me, and neurology. Maybe progress will produce complete diagnosis."

Brandie did not respond

Nov 1, 2012 @ 7:03 PM

Joseph sent Brandie texts stating "I made it home safely."

Brandie's response "Good!!!! I'm having a rough week"

Nov 9, 2012 @ 1:03 PM

Brandie sent Joseph a text stating "I love you!!!!! I'm sorry I have been busy trying to adjust back to work and all the chores that come along with your new niece Lani Belle."

Joseph never responded. My mom called me within minutes and told me they had found Joseph. Thank God I know my brother was saved and I will see him again one day!

The following letter is from Joseph's longest and best friend of 34 years (Joseph was only 42 and made friends for life). My mom, Sandra Petit, requested his friend Mike to write his own recollection of the events that led up to Joseph's death.

When Joseph got out of the army he was always complaining about his knees hurting & said that the army wouldn't help him or fix them for him, it was hurting him all of the time but he would do whatever he wanted to do despite the pain, he was able to do his everyday activities so he had a sour taste in his mouth towards the government for not helping one of their own that was injured! He spent countless hours & many years trying to get help with " no results" but he kept trying. He told me of a time he went to the V.A. in Atlanta Ga. looking for some help & told them he was in terrible pain & that he needed help & the V.A. forcefully removed him from the premises when all he was doing was looking for help! He kept trying to get help & persistence paid off the V.A. finally agreed to help him, this meant a great deal to Joseph as he had been trying to get help for almost two decades. He was very happy to have the V.A look @ his knees after all this time. At this time in his life he could function just as well as anybody could it was just with a great deal of pain BUT HE COULD FUNCTION!! which means driving ,walking, limited running, exercise etc. the V.A. set him an appointment & sent him home with some medications for his head & said nothing is wrong with his knees to the point @ which he described & told him that it was Post Traumatic Stress

Disorder & that the pain was all in his head & if he took these medications & do specific exercises that his knees would quit hurting & he said that he's willing to try anything to see if it would ease up the pain but it never helped him. They made several appointments for him & they noticed (The V.A.) that he was not functioning like he usually did & lock him up in the cereal ward as he called it with all the nuts, fruits, & flakes & told me they were going to give him medicine for psychotic people that their attention is no longer on his knees but on his head & the V.A. got him in touch with a doctor that specializes in this field he said the gave him some papers saying in his words "that he was a nut" but he told me he would have to go along with them or they would not try to help him so he did what he was asked to do. He took the medicine as prescribed and just about every time he went to a appointment they would lock him up for being unstable or suicidal & give him more drugs & sent him home, drugs for his head & not his knees, I think he told me that the V.A. has prescribed him 27 different medications he had so much medication that he was unable to do any of the things that he could do prior to going to the V.A. such as driving, walking without assistance, it got hard for him to hold a conversation at times, he told the V.A. that he was scared that he was going to hurt someone or himself that he needed to be locked up till they fixed this medication problem that they created; they changed his meds & sent him home. He told me that he told them he had thought about killing himself but they ignored him so he went to bathroom & put a zip tie around his neck & someone walked in & found him in the floor & he was unconscious. The V.A. changed some meds & sent him home after a week or so. His next few appointments he told them that it wasn't helping him they needed to lock him up before he hurts someone or himself they still didn't listen to him and just kept telling him to go home its all in your head; he told them it was to the point where he would literally chain himself in his room & give his mom the keys to unlock him the next morning; that he needed to be locked away till they could get him on some medication that wouldn't give him these thoughts, they just ignored what he was saying after practically begging them to do something about this; "that his thinking wasn't clear, please lock him up he didn't want to hurt anyone", but they just turned him away & said its all in your head go home. This happened several times, he had several appointments after that for his mental state of mind. They all ended the same way, go home it's in your head. The next appointment Joseph didn't come home; they found him several, several hours later in the bathroom where he committed suicide! This could have been avoided! He was a good soldier
A good man
A good son
& A good friend!!

Mike

Joseph's favorite song at the time of his death was "Redeemed" by Big Daddy Weave, probably because it referenced the chains and how they were gone. I have attached the words for your reference.

"Redeemed"

Seems like all I could see was the struggle
Haunted by ghosts that lived in my past
Bound up in shackles of all my failures
Wondering how long is this gonna last
Then You look at this prisoner and say to me "son
Stop fighting a fight it's already been won"
I am redeemed, You set me free
So I'll shake off these heavy chains
Wipe away every stain, now I'm not who I used to be
I am redeemed, I'm redeemed

All my life I have been called unworthy
Named by the voice of my shame and regret
But when I hear You whisper, "Child lift up your head"
I remember, oh God, You're not done with me yet

I am redeemed, You set me free
So I'll shake off these heavy chains
Wipe away every stain, now I'm not who I used to be

Because I don't have to be the old man inside of me
'Cause his day is long dead and gone
Because I've got a new name, a new life, I'm not the same

And a hope that will carry me home

I am redeemed, You set me free
So I'll shake off these heavy chains
Wipe away every stain, 'cause I'm not who I used to be

I am redeemed, You set me free
So I'll shake off these heavy chains
Wipe away every stain, yeah, I'm not who I used to be
Oh, God, I'm not who I used to be
Jesus, I'm not who I used to be
'Cause I am redeemed

Thank God, redeemed

Prepared Statement of Gerald J. Rakiecki

I, Gerald J. Rakiecki have been invited by Congress to testify in regards to all the knowledge I have about Veterans health care at the Buffalo VA. This written document contains information about events which occurred from December 2011 through the present period of time. Some of the information was directly relayed to me by VA Buffalo HIMS Employee Mr. Leon Davis, VA Buffalo LPN Employee Patricia Morrison, VA Buffalo EMS Employee James E. Carney. The following is my statement and affidavit on this matter.

I served over two years consecutive active duty with the United States Air Force. I am a service connected (disabled) Veteran and I was honorably discharged from my military service. I am employed by the facility as a Police Officer. I have also served as a Steward and a Chief Union Steward with the Service Employees International Union, Local 200United which is the exclusive representative of the VA employees within the particular bargaining unit.

In the course of my collateral duties as Chief Steward, I represented Mr. Tracy Harrison, a VA Health Information Management Systems [HIMS] employee, who was in fact a whistleblower concerning the mismanagement of Veterans medical records. Mr. Harrison made a protected disclosure of damaged and mishandled records and was subsequently threatened by Associate Director [AD] Mr. Jason Petti.

In December of 2011, I became aware of these allegations of mismanaged records by Mr. James E. Carney, who was also a Union Steward under my charge. Mr. Carney explained to me the four HIMS employee's allegations. Over the next month and half, I had several conversations with Mr. Carney about these allegations and at first it was hard for me to digest the magnitude of what I was being informed of. According to Mr. Carney, approximately two-hundred and forty (240) boxes containing hundreds of patient records were wet, moldy, stuck together, out of sequence, out of order, inaccessible and unattainable.

Eventually, I informed Ms. Patricia Morrison who is also the current SEIU Divisional Chairperson, for the Buffalo Division. I relayed this information directly to her in January of 2012. In turn Ms. Morrison warned me to keep out of it. Ms. Morrison explained that AD Jason Petti confided in her (Morrison) with his plans take administrative action against the reporting HIMS employees in the form of reclassification, downgrading and possible removal from government service. It became clear to me; Ms. Morrison was placing her support as the SEIU Divisional Chairperson behind Jason Petti and the HIMS Manager Liz Kane, instead of the membership she was elected to represent.

I was aware of a subsequent meeting held between Labor and Management on this matter which took place on February 08, 2012 which proved ineffective. In fact AD Jason Petti made a CLEAR written THREAT against the four HIMS employees Mr. Leon Davis, Cathleen Manna, Pamela Hess-Wellspeak and Tracy Harrison. AD Jason Petti sent a Microsoft Outlook email in which he singled out the whistleblowers by writing "you four." AD Jason Petti also wrote that he expected the four to correct the problem during their work hours in addition to their regular duties (punishment for bringing it to light). AD Jason Petti attached the Union Chairperson Ms. Patricia Morrison to this email. This information is documented in the Agency Investigation/ OSC findings.

The four HIMS employees followed up by making a formal disclosure to the Office of Special Counsel [OSC]. In turn their disclosure resulted in an Agency Investigation. As a result of that investigation, a majority of the charges were sustained in September of 2012. An OSC report of the Agency Investigation was released to the public in the spring of 2013.

I represented Mr. Tracy Harrison in January 2013 through March 06, 2013 on a proposed discipline. Mr. Harrison was charged with being AWOL (absent without leave) and a Reprimand. Two forms of discipline for one incident. The fact is, Mr. Harrison requested annual leave in the VA's computer leave system. Mr. Harrison's leave was in fact approved and he took his approved leave. Ms. Liz Kane however, performed a corrected time card; reversing Mr. Harrison's approved leave so that she could impose discipline (AWOL and a Reprimand).

The evidence proved the discipline Mr. Harrison experienced, was a direct result of retaliation from HIMS Manager, Ms. Liz Kane. I successfully represented Mr. Harrison by proving to Assistant Director; Mr. Royce Calhoun the discipline was completely unwarranted, based on the facts in my investigation. I disclosed my proof of retaliation against Mr. Harrison in writing to Assistant Director, Mr. Royce Calhoun. Mr. Calhoun had assumed Ms. Kane's managerial duties for the VA Release of Information [ROI] HIMS on or about February 25, 2013.

What I have learned throughout this entire ordeal is that there are two (2) completely different standards of Employee conduct at my facility. The average Employees is held completely accountable for his or her behavior and or misconduct. However, this standard does not apply to high level Management Employees and Senior Executive Service (SES). Evidence of this exists in the Agency's Investigation of mismanaged records and the subsequent report filed by the OSC.

The Agency's Investigation and OSC findings clearly proved AD Jason Petti was found to have made four (4) separate threats against four whistleblowers that did their job by reporting wrongdoing. The investigation also proved that AD Jason Petti's investigation of the "moldy records" was not accurate. I believe it is plain to see that AD Jason Petti's investigation was in fact false.

However, AD Jason Petti was not disciplined. AD Jason Petti was recognized for acting quickly. AD Jason Petti was in fact commended for doing the exact opposite of what he should have done and what he is compensated with GS15 pay ($116,545 through 151,509) to do. Liz Kane received only counseling for her part. A verbal or written counseling is not even considered discipline.

VA Employees in the Senior Executive Service (SES) and high level Management Employees are supposed to be the pillars of integrity, morals and ethics. This entire ordeal has shown me that they are in fact, just the opposite. If an average employee were to be suspected of displaying a lack of candor. That Employee would be harshly disciplined based on a *preponderance of the evidence.* Which means the Employee would be suspended and or removed if Management "JUST BELIEVED" that they were not being "COMPLETELY TRUTHFUL."

Our system of accountability to our Veterans cannot work unless "EVERY" employee is held equally accountable. The fact that Veterans medical records were sent out to the retirement center wet, moldy, damaged, inaccessible and unattainable shows a clear DISREGARD FOR DUTY and serious ethical violations on the part of the Managers who were in fact "WELL AWARE."

The Managers involved displayed a total disregard for Veterans health. These Veterans depend on the VA to maintain and keep safe their records. Management failed to do so. Management attempted to cover it up, and Management congratulated itself for a job well done. DESPICABLE! Is the word I see fit to describe Management's conduct and how it affected our Veterans.

Veterans gave their lives in every war we fought. Veterans place their lives on the line for this county every day. We the VA are supposed to help them, treat them and keep them safe. Our Veterans should not have to put their lives on the line TWICE for their country, by seeking assistance or care from a VA Medical Center. Veterans should feel safe and most important BE SAFE, while being serviced and cared for at their local VA Medical Centers.

In closing, I will answers the questions put forth to me by this committee. I will state for the record that due to the aforementioned medical records, and the recent report of misuse of insulin pens. No, I will not seek treatment at the VA in Buffalo. I will not reconsider seeking treatment at the Buffalo VA, until this Agency takes appropriate action concerning the responsible Management officials [RMO].

No, I do not trust the VA system. It is a system in which Managers commit wrongdoing, cover it up and get rewarded for doing so. The end result is an inability for this Agency to identify serious issues and correct them quickly in order to properly serve our Veteran Heroes. Please feel free to ask me any questions and I will do my best to answer. Thank you.

Gerald J. Rakiecki

Prepared Statement of Sydney W. Schoellman

Good morning. I would first like to thank you all for inviting me here today. I feel honored and greatly appreciate the opportunity to testify on behalf of Veterans and their families. Before I begin I want to introduce myself and the gentleman sitting next to me.

My name is Sydney Willingham Schoellman. I live in Allen Texas with my husband and two children near both my Mother and one of my Sisters who is in attendance today, Sarah Bell. The gentleman sitting next to me is a great friend of the Willingham family named Larry Taylor. Larry is an attorney for the Cochran Firm in Dallas and previously served as both a District Attorney for Dallas County and on another occasion served as the Director of Outreach for Congresswoman Eddie Bernice Johnson. Larry and the Willingham family became dear friends due to our matching principles concerning faith, and our United States Veterans.

I come to you all today on behalf of not only my Dad, deceased Korean War Veteran Gary Willingham but also on behalf of all Veterans and their families. My Dad, Gary Willingham was a vibrant, God fearing patriot who at the age of 80 functioned in life as that of a 65 year old. He lived in his own apartment, drove himself around and even grew and harvested his own vegetables. He was a great man of faith who lived his life based on strong principles. My Dad loved the United States and when not busying himself with different events, you would find him combing news networks so that he could stay up to date with what was going on in our great Nation. He never passed on exercising his right to vote and never missed a birthday party for one of his very young grandchildren. He was the model of what a Dad, Grandfather and citizen should be. He was not a man that took handouts, not even when he struggled to raise 3 daughters on his own. Because he believed in earning everything he got he felt it was only appropriate to rely on the VA Health System for his healthcare needs, he did after all earn it. It was his pride and this belief that made him continue to use the Dallas VA for his healthcare for many years, never complaining. He believed, as my two children would say, "you get what you get and you don't throw a fit".

In 2009 he noticed a lump forming in his neck so he went to the Dallas VA to have it examined. A biopsy was done and he was told that it would take surgery to remove it but not to worry, it was benign. I took him to the Dallas VA in 2009 to have that lump removed. At that time we were told that they hadn't excised the entire tumor but they had no fear that it would cause him problems in the future. Over the next year in check-up after check-up he was told that they believed he had cancer somewhere in his body but that the origin of the cancer could not be located. Over the next year he would be subjected to multiple PET scans and at one point, a tonsillectomy. The guess made by the doctors at the Dallas VA was that the cancer could stem from his tonsils. After an unnecessary tonsillectomy they discovered that they had guessed wrong. By 2010 the lump had returned and the surgeons at the VA again recommended to my Dad that they should operate to remove it. In the morning of November 18, 2010 my sister Sarah, my Dad and I arrived at the Dallas VA at approximately 5:45 in the morning. We checked in to Day Surgery and were sent to wait in the waiting room for approximately thirty minutes or so. After those thirty minutes my Dad was called back to the surgery holding area. Once he had his gown on and was settled my sister and I were allowed to go back and sit with him. After continuous hours of waiting Sarah and I ran down to the canteen to grab a bite to eat. When we returned we were informed that they had taken Dad back to be prepared for surgery.

After a lot of pleading and being pushy we were escorted to the surgery prep waiting room. We spent another few hours there before they finally took my Dad, who had not eaten since the night before back into the OR. We arrived at the Dallas VA at approximately 5:45am and he was not taken back to begin the surgery until 2:25pm. After waiting for over six hours, two surgeons emerged and began telling us about the surgery. During their explanation we were told that multiple tears had been made into his jugular vein which caused a massive blood loss. To stop the blood loss they began clamping everything. The next statement is a direct quote from the surgeon, "we realized six minutes later that we had clamped his carotid artery". To sum our story up, because of the clamping of his carotid artery my Dad suffered a massive stroke. Due to improper tying off of the veins in his neck he would undergo 3 more surgeries to stop the internal hemorrhages that kept forming. His fifth surgery to place a feeding tube would occur a mere three days after the first surgery. My Dad would spend approximately three weeks in ICU and would later spend a week on a patient floor. After the week on the patient floor we were

told that he needed to be discharged because per his physician, "had he not suffered a stroke he would have already been discharged". At that time we were also told that due to the tracheotomy in his neck, he could not continue his care at the VA's rehab facility because they were not equipped to handle patients with tracheotomies. We were urged by an employee at the Dallas VA to get our Dad out of that hospital because it was not safe for him. We were also told to obtain his records as quickly as possible before they disappeared. Upon obtaining my Dad's records we found a fact that explained why the employee urged us so strongly to get them. By reading his records we discovered that his carotid artery hadn't been clamped for only 6 minutes. His brain was starved of blood and oxygen for fifteen minutes. Had we been aware of the actual amount of time his carotid artery was clamped, our decisions would have been far different. We used private insurance to place him at a Long Term Acute Care Hospital where he nearly passed away twice. He was then moved to another facility that due to a failed acquisition closed its doors a week after his arrival. He was subsequently moved to a facility where we later determined, using a hidden camera, that he was being abused. All of this, for a Man who stood up for his country? After an impromptu meeting with the Dallas VA Administration room was made available for him in their rehab unit. He spent the next six months or so completely immobile there at the opposite end of a hallway from the nurses' station. Every day his dignity was stripped away as he defecated in a diaper then dug his own feces out because he wasn't being tended to properly. We made several requests that he be moved closer to the nurses' station because of this issue and because of his severe paralysis. Those requests went unanswered though many promises were made. My Dad died on December 24, 2011 due to bacterial sepsis and aspiration pneumonia. E coli, like that found in feces was found in his body and around his heart. He drowned in the tube feedings that were improperly administered. Since his death we have filed a Federal Tort Claim against the VA. In response to our claim we were offered a very small monetary amount and were told, "well, he was 81 and had thyroid cancer". Among the doctors named in our claim was the attending surgeon. We were shocked to find out that he could not be held liable because, contrary to the surgical notes, he was not a Dallas VA employee. As a result the VA is refusing to claim full responsibility for an act committed in their facility.

I am here relaying our graphic, horrific experience so that no other Veteran or their family will experience what we did. In my time working for a large health system in Texas I learned quite a bit. I have been able to take what I learned and apply it to the experience we had and can tell you without any doubt that this system is severely broken.

I feel the key issues that need to be addressed are the following:

1. Accountability
2. Customer Service
3. Risk Management/Family Services
4. Secretary Shinseki

Accountability – There seems to be no accountability at the Dallas VA. It has become apparent to me that surgeons are allowed to operate on our Veterans under the supervision of people who aren't even employees of the VA. This isn't a fact that is communicated to our Veterans before they agree to surgery. You aren't told that the person supervising your surgery is not an employee of the health system and cannot be held accountable through the VA in any claim or complaint. Why are we allowing people not accountable by the health system to supervise or perform operations on our Veterans? Is this a cost saving measure? If so, I can testify that it ends in the Veterans, or families of our Veterans having no ground for retribution. This is a clever, intentionally crafted way for the VA to claim no liability for what is done in their own facilities. In our case the accountability was skirted with a simple statement made by the surgeon herself, "everything I did was done under the supervision of the attending". That statement was all it took for the VA to wash their hands of the situation. This "washing of hands" seems to be a common theme throughout this healthcare system. If you were to step outside of the VA Healthcare System you would see that administrations, physicians and employees are held very accountable. There is no explanation for why a Veterans hospital can have multiple complaints and life threatening or life ending mistakes and still have the same members in administration year after year.

Customer Service – Customer Service and Accountability go hand in hand. At a public health system patients pick and choose what surgeon or doctor to use. That is not the case for our Veterans. The Veterans that enter the VA Health System

are what you could call a "captive audience". Their earned healthcare is conducted in a place where customer service is not demanded. For some Veterans, the VA hospital is the only care available to them. Because they must get their care there, they do. These patients are captive within this health system and the employees and administration are well aware of that. Because the VA, unlike public or civilian hospitals, does not have to compete for its business there is no need to institute high expectations where customer service is concerned. These patients are real people, not numbers. Has the human factor been lost amidst the sea of paperwork and financials?

Secretary Shinseki – My last point has to do with Mr. Shinseki and his leadership. In article after article you can read of his inability to properly manage things for our Veterans. From claim back logs, lack of discipline toward his administrators and his propensity to wash his hands of an issue rather than dealing with it, Mr. Shinseki has proven that he does not deserve the responsibility he has been given.

I have seen and read about leaders within our government who, regardless of party affiliation, cannot get Mr. Shinseki to act upon or follow through on issues. Mr. Shinseki is the preverbal brick wall in most of the issues facing our Veterans. Where is his accountability? Why is it, no matter how well publicized an issue is, or how hard a battle is being fought for our Veterans, once it hits his desk it is dead in the water? What steps are being taken to fix this?

I feel fixing these issues is actually pretty simple. I propose that we use an outside agency to conduct Patient Satisfaction surveys with our Veterans. Most public hospitals employ agencies like these and use the results to set minimum performance standards for their hospitals. By implementing these surveys and requiring this accountability you will create an improved environment for our Veterans. It has been well documented that the administrators of the VA have been awarded bonuses with no regard to poor performance. With these surveys in place you are able to tie bonus eligibility and amounts to how the patient, our Veterans feel about the service they are receiving. I feel these surveys would also employ a degree of transparency that this organization hasn't had before. In addition to Patient Satisfaction surveys there needs to be a survey put into play that measures employee engagement as well. If we can improve the environment for the employees, they will provide a better quality of care.

It seems to me and I've concluded, after having many conversations with Veterans, current and past employees that one of the best ways to fix this broken system would be to approach the entire health system the same way a private health system approaches problems. I do not feel this can be done correctly using the internal resources now available to the VA. I implore you, please bring in an outside, objective party to examine these hospitals. Employ the service of a consultant who can create programs that will benefit our Veterans. The best way to fix these problems is to stop doing what has been done and look for other solutions to this ever growing problem.

I want to thank you all for asking me to testify today. I would like to leave you with one last statement and a video clip. On my Dad's deathbed, when he couldn't speak he wrote a note to me that said, "VA murderers . . . get them Syd". While I'm not "getting" anyone I will spend the rest of my life fighting for these national treasures and their families with the hope that no one will go through or lose what we did.

Prepared Statement of Phyllis A.M. Hollenbeck

August 22, 2013
The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street NW
Suite 300
Washington, DC 20036

Re: OSC File No. DI–12–3816

Dear Ms. Lerner:

Below are my comments on the Department of Veterans Affairs Investigative Committee Report of my July 2012 Whistleblower Complaints about the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi. As I stated in my testimony to the investigative committee, the committed and excellent employees in

the Primary Care Service of G.V. (Sonny) Montgomery VA Medical Center, and the Veterans they serve, looked to the committee to conduct their investigation with integrity. I believe the committee understood they held in their hands the chance to finally transform the Primary Care Service at the Jackson VAMC into a proper and true "medical home" for the Veterans. This means giving the Veterans the best medical care in the world, in a place worthy of taking care of the lives of Veterans—men and women who signed up to put his or her life on the line for people all over the world. There are no other humans on the planet like those in the United States Military.

I believe the investigative report highlights the global lack of respect for both federal and state laws and regulations, as well as VA policies, which constitutes the defining culture of "leadership" at the Jackson VAMC. This milieu led to the kinds of actions—and lack of actions—that caused the problems substantiated by the investigative team. These issues define Primary Care (PC) at the Jackson VAMC; they make up the longstanding model of Primary Care at the Medical Center, and they continue. And the cruel effects on the Veterans, and the committed Primary Care staff, are still without end.

My comments give an expanded history of the issues at the Medical Center, as well as an up-to-date summary of ongoing problems and attempted approach to any remedy or improvement at our VAMC. Those of us who work in Jackson are still aghast at daily events—yet we then remind ourselves that the decisions made and policies instituted by management are all cut from the same damaged cloth. And as the investigative report states on its first page, "Federal laws and regulations, as well as state laws", and "both VA and Veterans Health Administration (VHA) policy" have not been followed "due to mismanagement". Although the report equivocates at one point when it states "may have been violated" or "may not have been followed", later in the same paragraph it is noted that "the fact-finding team made a number of recommendations for the Jackson VAMC to adhere to or enforce current rules, regulations, or practices, and policies ... to ensure the service line complies with all applicable laws and VHA policies to maintain a high quality, safe health environment for patient care." Isn't all of Primary Care under this umbrella— everything that happens in Primary Care—and how much more serious can it be than breaking and ignoring the litany of mandates above?

It is discouraging to see the apparent gentleness with which the facility and its leadership are sometimes referred to by the investigative team: those in administration "may not have followed" laws and regulations; or "there is a lack of understanding among Medical Center leadership" regarding rules and policies. But there cannot be any plausible deniability in the leadership of the Jackson VAMC. I personally wrote emails about the issues above over several years, and both past and current leadership at multiple levels are longtime VA employees. In addition, it is the clear and inescapable responsibility of anyone in management to acquaint his or herself with, and follow, all applicable standards of operation and conduct—especially in a facility whose "service line" is taking care of fellow human beings. The rules are there for a reason, and they apply to all of us. Finally, Center Director Mr. Joseph Battle, in particular, cannot be allowed to continue to use the phrase "these things happened before I came" as a verbal shield. The same kinds of things are still happening; and once you take over command—of a business, medical center, ship, or family, or any other communal entity—everything is immediately and completely on your watch.

How did the G.V. (Sonny) Montgomery VA Medical Center end up in this way? Just as I tell a patient—when after years of talking about the unhealthy road he or she is on, and warning about consequences, that man or woman finally steps over the laboratory line into diabetes—this "didn't fall from the sky". One of the "vital signs" of a medical practice is that the people entrusted with others' lives do care. It is not enough to just "do" care, to set up a place called Primary Care on paper and in waiting and exam rooms, with staff and patients coming and going, and then measure metrics on spread sheets. Where care is delivered can't just look like a clinic; there has to be an honorable system surrounding the patient, with consistent and continuous care. And that means leadership in a medical center, the people with the power to provide the resources to do the job of committed employees, must also truly care. At the Jackson VAMC it is especially hard to read the auto-slogan at the bottom of official emails: ICARE—INTEGRITY, COMMITMENT, ADVOCACY, RESPECT, and EXCELLENCE. A clever acronym, but not one lived each day by the Medical Center leadership, especially with regards to respect for the Veterans and loyal staff.

I remember being astonished when I first came to the Medical Center in September 2008 and a physician introduced herself and immediately said, "I hope you don't quit like all the others." I soon understood why doctors left, and why I ended

up two years later as one of only three primary care physicians—and the investigative team's report identifies many of the startling issues.

The strong undercurrent that allowed and even nourished the "unhealthy" and illegal conditions in the design of Primary Care at the Medical Center was the antagonism set up between nurse practitioners and physicians. Dorothy White-Taylor, PhD ascended over decades to the position of Associate Director of Patient Care services, which essentially meant she had the power to affect everything that a medical center does—and to intersect with everyone in that facility. For almost two decades Dr. Kent Kirchner worked side-by-side with her in his capacity as Chief of Staff, and acquiesced to many of Ms. Taylor's decisions and set-up of services. When I first came to Primary Care, I was told that "Dot Taylor controls the real estate" when I wanted to move my exam room closer to where the medical assistant assigned to me sat, so we could coordinate our work with the Veterans. And most significantly, Dorothy White-Taylor was in charge of all nursing personnel, including nurse practitioners. Thus the NPs did not "answer" to any physician—and the Chief of Staff did not challenge this situation.

In addition, just before I arrived in September of 2008 Dot Taylor and Dr. Kent Kirchner proposed a plan to put an NP in charge of Primary Care instead of a doctor; I was told that several physicians rebelled, and worked with their union to make sure the idea was dropped. But even to a casual observer the idea that a department of Primary Care—in a medical Center—could ever be supervised and run by a nurse practitioner instead of a physician seems preposterous. But I soon also learned that the NPs constituted seventy-five to eighty-five percent of the clinicians "providing" care to the Veterans seen in PC at the Jackson VAMC; and that many times neither clerks nor other nursing staff nor the NPs themselves corrected the Veterans when they referred to an NP as their "doctor". This is an improper practice, as the investigative team report points out; and many states (including the State of Mississippi) have passed laws requiring that all people working in a healthcare facility have photo identification tags that not only prominently display the name of the employee but just as visibly show the employee's professional designation for clinical work, and level of experience. Interestingly, the fact that Dot Taylor was always referred to as "Dr. Taylor" in a hospital setting (although her work at the Medical Center was entirely administrative, and her field of doctorate study was also not as a medical clinician) set the tone for this, at the very least, lack of clarity for the Veterans. Commenting on a new 2013 law in Texas, a woman (Helen Haskell) behind a South Carolina law on requirements for hospital ID badges calls this "the most basic level of transparency", and notes that "It's very important to know who's providing your care because people have different areas of expertise, different levels of training." She speaks from a personal tragedy experience. As the investigative team report points out (page 26), the NPs at the Jackson VAMC wear the Federal Employee "PIV" badges—which "do not identify the individual's position or title". I know, and saw daily, that the NPs in Primary Care did not also wear the red tags given to them that said "NP" in bold letters.

And nurse practitioners are not the same as physicians. This is not about what is commonly called "protecting turf"—with the American public getting sicker and sicker, younger and younger, sadly there is more than enough healthcare work for well-trained and experienced doctors. I have been a physician for thirty-six years, and know that like the rest of the country Veterans are on what is known as "polypharmacy"—by most definitions, the use of six or more concurrent medications. Patients are all individual walking-chemistry-experiments. And so primary care is the hardest job to do well consistently in modern medicine. It requires all the brainpower and willpower and training (and blessing) a physician can muster to take full responsibility for the whole life of the patient during their entire life.

The total hours of coursework and training for a nurse practitioner ranges from 3,500 to 6,600 hours; for a fully-trained primary care physician the number is 21,000 hours. Physicians across the country study the same undergraduate premedical courses, and then the same medical school curriculum; must pass board examinations overseen by one certification body; and have standard state medical licensing requirements. Nurse practitioners do not have a standard degree curriculum nationwide; have three different certification groups who all have different criteria; and licensing requirements vary from state to state. Physicians are taught primarily by other physicians, and for primary care must finish a three-year residency training program; nurse practitioners are taught principally by other nurses and nurse practitioners, and do not do an additional educational/clinical training program such as a residency. Family physicians must pass board recertification exams every seven years, but no such monitoring exists for nurse practitioners; and physicians must complete 150 hours of continuing medical education every three years for licensure and board certification, whereas nurse practitioners only need to

complete 75 continuing education hours or take an appropriate recertification exam, with no specific requirement for "pharmacy content hours".

As Dr. Reid Blackwelder, President-Elect of the American Academy of Family Physicians has eloquently written in a 2013 Wall Street Journal essay "the work of many nurse practitioners begins only after a physician has already made a diagnosis". He notes that studies showing "similar outcomes" with physician and nurse practitioner care result from collaborative practice with physicians. He highlights that "the extensive and diverse medical education and clinical experience" that doctors receive "strengthens a physician's diagnostic skills"; and that a primary care physician must help a nurse practitioner on the healthcare team "when chronic medical conditions become unstable—a change that is inevitable". I would add that the moment(s) of change are not always simple and straightforward.

Dr. Blackwelder states that "requiring patients to accept less" than the medical care expertise of primary-care physicians as head of the medical home team is "unacceptable". Yet that is how Primary Care at the Jackson VAMC operated—in a department set up by Dorothy Taylor and endorsed by Dr. Kent Kirchner. Dot Taylor helped several nurses obtain more education and then become "grandfathered in" as nurse practitioners at the Medical Center—even though one of these NPs never obtained a nurse practitioner license until 4/10/2013, and ran (and still runs) the "Women's Health Clinic" alone and unsupervised since 1994. And as the investigative report reveals, the Jackson VAMC ratio of NPs to MDs is 3:1 (75% NPs and 25% MDs)—and the VHA national average for comparable healthcare facilities is the "inverse situation, that is, 3 MDs to 1 NP."

Under the plan put in place by Dot Taylor, more and more nurse practitioners were hired, and the work environment for the few physicians left in Primary Care became harder and harder. The first year I worked at the Jackson VAMC one of Dot Taylor's assistants told me she "forgot" to block out my requested leave for the entire year—and I could just have the already-scheduled Veterans rescheduled as double-bookings for weeks, or I could just not take any annual leave. When I asked why I was overbooked most days anyway, she (not a clinical staffer) told me I saw my patients "too often"—and got Dr. Kirchner to write me an email to that effect. When a Veteran newly transferred to me walked into the clinic three days in a row, and threatened me he wouldn't leave the clinic until I "did what he wanted", becoming delusional about surgery he'd had, I had the male head nurse in the clinic help me call the police and have the man removed from my patient panel and clinic. All of this was documented in the medical record, including a note from a psychiatrist regarding the patient—but several weeks later I saw the same patient back on my schedule and a note in the chart from the same assistant of Dot Taylor. It stated that "per Dr. Taylor" the Veteran had asked to be reassigned from the provider he was given after he threatened me—and that "per Dr. Taylor" the Veteran was being assigned again to me. Dot Taylor controlled nurse staffing and assignment in the clinics, and I was the last provider (including all NPs and the other two MDs) to have an RN assigned to my PACT (medical home model of care) team—one year after everyone else in all of the other Primary Care clinics had fully-formed teams on board, and one year after all other providers had the added vital help an RN can provide for the patient and their ongoing care, "off-loading" some of the workload of an NP or MD and making the care of the Veteran less likely to be delayed. Finally, one of the subspecialty physicians gave me copies of the reports on Primary Care provider panel sizes—and I saw that my panel was the largest of anyone in the department, with the two other physicians "capped" much lower than my total number of patients. The more patients in my panel the more Veterans needing appointments, and prescriptions, and ER and inpatient admission follow-ups, and tests and consultations and walk-ins and phone calls and letters and message "alerts"—all of which meant a lot more work and worry and responsibility for me. And I wrote emails about the dangers to the Veterans, and the ethics and consequences of overloading a primary care clinician, and got no response from leadership—including none from Dr. Kirchner. I soon saw that speaking up meant I was a charter member of what I politely call "the feces roster", but I kept writing and I kept records.

Because this was all still about people's lives. One either gives up or stands up. And I didn't look for this battle; it came to me.

The PC service then limped along with an acting physician chief, Dr. Cornelius (Sean) O'Neill, who was still overloaded with direct patient care duties (and thus weakened), as the number of MDs dwindled down and the number of NPs increased—and the dual chains of command remained in place. There was no crossover or collaboration between the camps. The PC service ran as approximately 20–24 solo private practices, with office space grouped into 4–5 clinics; the number of NPs and MDs was always in flux, and then the number of clinics changed. And this kind of organizational chart ensured that although the few physicians in Primary

Care, like all physicians on a medical staff, had a certain percentage of their charts reviewed (called Peer Review, mandated by medical staff bylaws), none of the NPs ever had any of their clinical work checked. The investigative team report substantiated this—and emphasizes the fact that all along the Medical Center leadership never put into effect any appropriate monitoring of NP clinical practice (meaning no chart review of any care given to Veterans by any and all NPs) even though leadership knew that the NPs at the Medical Center had licenses from states that required collaborative agreements with physicians. To date, there is still no program in place to comply with the law and regulations. And Medical Center leadership knew that each state licensing board specifically spelled out the rules and requirements for these collaborative agreements.

What is abundantly clear from the report is that no one in leadership (from the VISN to the Primary Care service) ever cared about the letter of the law or the implications of a proper collaboration program—what they did care about was making the physicians do what they were told so the dysfunctional and illegal practices could go on as always. To hell with the Veteran. To hell with the physician's license. To hell with any nurse practitioner licensing laws. Yet the NPs continued to provide up to 85% (at the peak of NP vs. MD numbers in PC) of the care for the Veterans. And everything that happens to the Veteran starts—or stops—in Primary Care.

I went to my 35th medical school reunion at Brown University on Memorial Day weekend in May 2012, and received a call from one of my nurses telling me that the DEA had arrested Dot Taylor on narcotic fraud. I remember saying "You're making this up" to my teammate, although Dot Taylor's prior history of being in a drug rehabilitation program in the past, and more recent concerns regarding abnormal behavior consistent with what is called an "impaired employee", especially due to possible substance abuse, were well known. It is still unclear why all charges against Dot Taylor were finally dropped, in three different counties; the investigative team report refers to certain Justice Department actions on oversight and regional jurisdictions. Inquiries regarding whether random drug testing is done in the Jackson VAMC (or other VAMCs) have not yielded a definite answer.

When I returned from leave in early June, the first thing I learned was that DEA agents had come into the Medical Center, reviewed narcotic prescribing procedures in the facility, and announced that nurse practitioners using a single "institutional" DEA number was not a valid avenue to prescriptive authority for controlled substances. An NP in my primary care clinic came up to me my first day back and said he was supposed to ask me to review a chart on a Veteran he'd seen earlier that day, and "after discussion" with that NP order and sign for the Veteran's narcotic prescription. I told the NP that just reviewing a chart for narcotic ordering on a patient was illegal and a violation of Federal law/DEA regulations—and that NP (William Hubbard), who knew me and my ethics, smiled and said he knew I would not agree to such a process but he "had to ask" per Drs. Lockyer and Kirchner because otherwise at least 75% of the Veterans wouldn't be able to get their narcotics renewed. But who was responsible for this crisis? Clearly, it was the Medical Center leadership who set in place and kept in place the design of Primary Care at the Jackson VAMC—and now had another improper scheme to "take care of" the Veterans. Laws and regulations be damned once again.

An email soon arrived that began "per COS"—meaning Chief of Staff, Dr. Kirchner, and signed by Dr. Lockyer, head of Primary Care—and spelled out this same process for the three remaining physicians in Primary Care to "help" their "NP colleagues" and ensure that the Veterans got their narcotics. The memo stopped just short of ordering the doctors to sign the prescriptions, but its intent was abundantly clear; any doctor who didn't go along wasn't a team player and was going to hurt the Veterans. At that point I felt Medical Center leadership had definitely gone too far and I called Angela Lee at the local DEA office. She told me unequivocally that such a procedure is illegal and not to participate under any circumstances. She also gave me contact information for Jeff Jackson, the lead DEA agent on the Jackson VAMC/Dot Taylor case.

Another email came, stating that everyone hoped for a swift conclusion to the narcotic dilemma, and leadership was working with the DEA, but still asking the three Primary Care physicians to do the same illegal act. We then had the monthly Primary Care staff meeting (which includes clerical, nursing, NP, and MD employees) at which Dr. Lockyer reviewed minor issues only, never mentioning the recent DEA events and problems, and then proposed to end the meeting early. I asked for the microphone and stated it was extremely upsetting to me that we had a narcotic prescription crisis—and that he was not opening the meeting with it. Dr. Lockyer said it was not a crisis; I told him I had spoken to the DEA and the leadership proposal for even a temporary solution was illegal. He stated he hadn't told the physicians they had to sign the prescriptions—and I replied "Oh yes, your emails were very

clever" but that the intent was clear. I reminded him that I had already sent an email to both physician and administrative leadership (including Drs. Lockyer and Kirchner, and Mr. Battle) proposing a legal interim process. My email suggested bringing in locum tenens doctors (temporary physicians) who could see each of the NPs' patients who needed narcotics, and also having the Pain Clinic physicians who already saw some of those Veterans take over writing their narcotic prescriptions instead of giving everything back to Primary Care.

What ensued were more illegal schemes to get the narcotics to the Veterans; from one email from the Red Clinic, it appears a locums physician did sign some narcotic prescriptions on NPs' patients. Another email said that written paper requests were to be given to the Primary Care office (called the "Red Clinic") at the end of each day, in a "warm hand-off" from a nurse from each clinic, and would be "reviewed" by Dr. Lockyer. One email said that an administrative aide was bringing narcotic requests late that afternoon, and pleaded with the Primary Care staff not to "give Mr. Funchess any grief" because it wasn't his fault. "Grief" apparently meant not being happy to be asked to break the law. Interestingly, as I had made it clear in several emails that I would not break the law, I was not asked to look at prescription requests.

The next "protocol" was that the written warm hand-off requests were now to be taken to the Medicine department office (this email came from Dr. Jessie Spencer and her administrative aide Kristi Richardson) at 1600 hours each afternoon, and physicians would be "assigned" to review the requests overnight. Decisions on narcotic prescriptions would be available the next morning. However, in an outrageously unethical and illegal scheme, the "assigned physicians" turned out to be medical residents (physicians in training) from the University of Mississippi Medical Center—young doctors whose evaluations were done by Dr. Spencer and overseen by Dr. Kirchner. These young doctors' careers were in their hands—and leadership was telling them to break the law.

The investigative team report (especially on pages 41 and 42) is once again much too kind to Medical Center leadership regarding this chain of events. It appears they took the word of Drs. Kirchner, Spencer, and Lockyer, and Mr. Battle, but the report does note that Dr. Kirchner "reviewed the DEA website" as well as requesting "review and advisement" from Regional Office, DEA and VA Central Office, VISN and the Mississippi Board of Nursing. However, as DEA agent Jeff Jackson discussed with me, a graduate physician in training (resident) is expected to know that a face-to-face visit with a patient is required in order to prescribe controlled substances—and there is no excuse for senior physicians such as Drs. Kirchner, Lockyer, and Spencer somehow not knowing that what they were asking other physicians to do was illegal. It is clear that Medical Center leadership were scrambling to come up with a way to get the narcotics to Veterans, a laudable goal, but this was a crisis of their own making due to years of unsupervised, not legally licensed (individual state, and Federal DEA regulations) NPs who far outnumbered physicians in Primary Care. Jeff Jackson told me that when leadership complained that the DEA was hurting the care of 43,000 Veterans connected to the Jackson VAMC, he told them he was not responsible for improper care/narcotic polices—they were.

Page 41 also states that in July 2012 Dr. Kirchner et al asked Primary Care physicians to sign narcotics prescriptions without a face-to-face encounter with the patient, after the above DEA and administrative reviews. However—I had already sent emails in early June 2012 telling leadership, including Mr. Battle, that such a practice was illegal per the DEA. It also defies logic to think that since the DEA arrested Dot Taylor at the end of May 2012, and in early June 2012 prohibited the prescribing of narcotics by NPs at the Jackson VAMC, and were asked for advisement then by leadership (per the report), that somehow DEA agents forgot to review with, and/or advise, the three physician chiefs and VAMC leadership, and VISN administrative (Ms. Rica Lewis-Payton) and VISN medical leadership (Dr. Greg Parker) about basic Federally-mandated controlled substance regulations. Jeff Jackson told me in person that he had personally reviewed such issues with leadership—and knowing and enforcing such regulations is what the DEA does.

It is not until August 2012 that a "Controlled Substances (CS) Clinic" was "developed"—although I know I suggested this legal interim solution in an email in early June 2012. Primary Care staff know that several locums physicians refused to do more work than clinically appropriate, meaning they would only write prescriptions on the Veterans scheduled to see them, and who they had time to examine and review charts on, and not on all the walk-in patients for narcotics, or patients seen that day by their NP who also wanted narcotics—and that the "overflow" volume of narcotic requests were then taken to the Red Clinic to be addressed by either Dr. Lockyer or Dr. Kirchner.

I know from direct conversations (the physician and DEA agent Jeff Jackson) that one locums physician was horrified at the amounts, reasons for, lack of urine drug screening, trial of other non-narcotic modalities, and/or pertinent physical examinations that she found in the CS clinic—all patients of NPs. She contacted the DEA on her own regarding this issue.

The investigative team report states that on November 30, 2012 the CS clinic was closed, and that all NP-patient prescriptions were then written by NPs who had "obtained individual Federal DEA certifications, as allowed by Mississippi and other states." But the email notifying PC staff that the CS clinic was being closed went out on a late Friday afternoon—and the email response then of one NP ("Does this mean that NPs will write narcotic prescriptions on Monday morning?") was never answered. There was no smooth transition from the end of the CS to all Veterans seen by NPs getting their narcotic prescriptions as "usual"; the clinic ended because locums physicians had raised continual concerns, and were speaking up, and perhaps for economic reasons (locums are expensive). But there is an inherent contradiction in the investigative team's report. Since none of the Collaborative Agreements (CAs) were being legally followed no NP was legally licensed—and thus could not legally obtain an individual DEA number. Legally following the signed CAs means abiding by the strict requirements—both of the physician's professional board of licensing as well as the NP's board. But no monthly chart reviews and no quarterly face-to-face meetings with the physician collaborator were ever done; and physicians had more than four CAs, or were out-of-state, temporary, or no longer at Jackson VAMC physicians—all violations. And the report is in error in stating that of the five physician collaborators for Primary Care NPs only three of them work in Primary Care—two work in Primary Care, and three doctors do not. This means those three physicians are in violation of the law, as it states the collaborator must be in the clinical discipline the NP practices. An ophthalmologist is the collaborator for two Primary Care NPs; a nephrologist is one; and one is an otolaryngologist. And one physician has 14 collaborative agreements: Dr. Jessie (Moorefield) Spencer—also, for unclear reasons, referred to as Dr. Jessie Crawford Moorefield in Attachment B of the report. The nephrologist is Dr. Kent Kirchner, who until September of 2012 served as Chief of Staff, and for years has only had very limited direct patient care. (It should be noted that although the investigative team report states I alleged that Dr. Kirchner had 160 CAs, my documented testimony to the committee states that another physician, an executive with the Mississippi Board of Medical Licensing, told me that our Chief of Staff had "163" agreements; this is Dr. Vann Craig. I referred the committee to him for specifics, and encourage this to be pursued. I can only guess that it refers to a total number of CAs over years, and that Dr. Kirchner signed off on all NP credentialing. As noted later, this NP credentialing was also not done correctly.)

And of further interest, Dr. Spencer has been Chief of Medicine for several years, with very limited direct patient interaction; and in the past year has also served as Interim Chief of Staff for several months (and will be again as of the week of 8/26/13)—and as of Friday, August 23, 2013is suddenly also the Medical Director of the new Women's Health Clinic at the Jackson VAMC, ribbon-cutting August 26, 2013. **BUT**—Dr. Spencer is an internist, not an obstetrician-gynecologist, and does not have a clear process of coordinated care at present with the unsupervised NP (Penny Hardwick) who is the only other clinician in the Women's Health Clinic.

In October 2012, the Medical Center leadership found itself with yet another crisis in its lap; a crisis of its own doing. A quarterly medical staff meeting was held in early December—for which, for some mysterious reason, there are still no meeting minutes. (They have been requested several times.) Nurse Practitioners have been allowed to attend as nonvoting members of the staff; although as the investigative report points out, since the NPs were not LIPs (licensed independent practitioners), until many obtained Iowa licenses in 2013, these NPs should not have been granted clinical staff privileges but rather credentialed under a written "scope of practice". A scope of practice agreement would mean they were not independent "staff members" under Medical Staff Bylaws (standard bylaws per VHA and JCAHO). And this issue has been brought up by physicians over the years I have been at the Medical Center, but due to the fact that the NPs far outnumber MDs at the Medical Center, as well as the power of Dr. Taylor and fear of retaliation, doctors remained circumspect.

Present at this medical staff meeting were the interim Chief of Staff (Dr. Garcia-Maldonado, from a VAMC in Texas), Mr. Battle, and Dr. Greg Parker who is Medical Director for the VISN; Dr. Parker is also a Veteran and receives part of his medical care at the Jackson VAMC, as he publicly stated, and is well-acquainted with how it runs. Mr. Battle and Dr. Parker ran the meeting. The key issue was that since all NPs licensed in Mississippi renew their licenses from October 1st to

December 31st, and most of the NPs at the Medical Center had Mississippi licenses (which require a Mississippi-licensed physician collaborator), leadership needed the physicians to "do the right thing and help the Veterans" by just signing the collaborative agreements. Otherwise, most of the Veterans wouldn't have anyone to see them—which would never have been a problem if enough physicians were in Primary Care. Mr. Battle and Dr. Parker told the physicians that the agreements were "just a formality", and didn't mean anything because the NPs (especially per several who spoke up at the meeting) "don't need supervision". But several physicians spoke up, stating they had spoken with the Mississippi Board of Medical Licensing (including Drs. Vann Craig and Randy Easterling), as well as reviewed the Mississippi Board of Nursing guidelines, and all physicians understood that signing a collaborative agreement meant the physician was responsible for everything the nurse practitioner did. When questioned about the ramifications for a physician's license and career if the NP did something that led to a medical malpractice lawsuit, Mr. Battle stated that "you can't get sued in the VA"; when reminded you can, just via another legal route, he stated "Well, they don't put your name on it." When physicians replied that yes, they do, it doesn't just say "VAMC Jackson" on the court papers, and it will be reported permanently, as a major issue to the National Practitioner Data Bank, Mr. Battle (astoundingly, and with no interruption by Dr. Parker) told us that "Well, you can just write them a letter saying you never really supervised that nurse practitioner."

The physicians were stunned. The complete lack of decent human regard for what it means to have a medical license, and ethical care of the Veterans, and licensing laws and regulations. The flagrant disregard of the fact that the rules of licensing are there for a reason—the reason is that the work of medicine is the care of human lives. Nothing about that work is "just a formality".

Mr. Battle and Dr. Parker then went on to tell us how they planned to make sure the NP collaborative agreements were signed: fifty-percent of whatever "performance pay" a physician was eligible for each year was automatically off the table unless a physician signed a collaborative agreement, and any physician licensed in another state had to also get a Mississippi medical license so they could be "available" to sign a collaborative agreement. It was clear that the physicians were expected to bail out mismanagement. And one might call the plan a type of extortion.

Several physicians once again asked that Mr. Battle and Dr. Parker get written, official opinions from all state and Federal regulatory authorities so that if physicians signed CAs on NPs they didn't interview or hire, and had no control over, that it didn't put the doctors' licenses at risk. Dr. Sean O'Neill gave a focused but impassioned summary that relying on verbal promises from management in the past (e.g. with regards to narcotic prescribing, as well as Medicare Home Health certifications) turned out to be dangerous for physicians and nurse practitioners. Promises were made to check into this, but no definite deadline for completion given by management; leadership reiterated that the CAs were just a piece of paper to keep the licensing boards satisfied. Finally one longtime Jackson VAMC physician choked up as she repeated to the men at the front of the room "You just don't get it. We can't trust you."

A 7/24/13 General Accountability Office (GAO) report states that the "performance pay policy gives VA's 152 medical centers and 21 networks discretion in setting the goals providers must achieve to receive this pay, but does not specify an overarching purpose the goals are to support. VA officials responsible for writing the policy told us that the purpose of performance pay is to improve health care outcomes and quality, but this is not specified in the policy. Moreover, the Veterans Health Administration (VHA) has not reviewed the goals set by medical centers and networks and therefore does not have reasonable assurance that the goals make a clear link between performance pay and providers' performance. Among the four medical centers GAO visited, performance pay goals covered a range of areas, including clinical, research, teaching, patient satisfaction, and administration. At these medical centers, all providers GAO reviewed who were eligible for performance pay received it, including all five providers who had an action taken against them related to clinical performance in the same year the pay was given. The related provider performance issues included failing to read mammograms and other complex images competently, practicing without a current license, and leaving residents unsupervised during surgery. Moreover, VA's policy is unclear about how to document certain decisions related to performance pay." This makes it clear that the Jackson VAMC currently has the right to do whatever it wants with regards to performance pay for physicians—but it also seems to make it clear that being an excellent clinician, and improving healthcare outcomes and quality, is not the main, unqualified evaluation concern of this or other VA Medical Centers.

No written, final legal opinions or decisions were ever presented to the physicians at the Jackson VAMC. The extensive Attachment B listings show how the CA issues were addressed, often in improper fashion. But it all looked good at the time. In addition, Medical Center and VISN leadership counted on what had always been true: no one looking too closely.

The investigative team report also outlines the dangers to Veterans' care when clinicians are overbooked and overloaded, and not able to keep up with an impossible workload. It is possible to give a human being more work than it is possible to complete in each cycle of twenty-four hours—indeed, one of the emails from Kristi Richardson/Dr. Spencer noted that there was a large volume of narcotic requests to review, and "there are limitations to what we can accomplish in one business day".

I was warned by other physicians not to speak up until I was past the two year probationary period for all employees, as leadership could fire me without reason during that time. Once I was able to do so, in October of 2010, I began to write emails (notifying the union of each concern) to both medical and administrative leadership documenting the way the policies of the Medical Center affected patient care—what it meant to work with overloaded/double-booked schedules, and no right to change that; the impossibility of even being able to read all the "alerts" (messages, results etc.) coming in twenty-four hours a day (average at least 100 per day) to a physician or nurse practitioner, never mind act on each one; and that forcing a physician to take on more work than is humanly possible to do conscientiously puts that physician in an ethical dilemma. I reiterated that state medical licensing boards require a physician to not overload themselves—and that according to the rules of our current universe one can only see one patient at a time. When I told Dr. Lockyer that one can only read one alert at a time, he asked me if I needed help reading; when I said no, but no one could keep up with the volume of work, he asked me if I was saying I couldn't do my job. I said no, that was not what I was saying. And I repeated what I had told him many times, and a concept that guided me as I tried to do my best for each Veteran in the midst of the ugly chaos of Primary Care—a doctor can only go as fast as is safe. And the report reiterates the unsafe conditions of the set-up of Primary Care at the Medical Center.

Knowing and working in the reality of Primary Care at the Jackson VAMC means working with your heart in your mouth every day, because you know you cannot get to all the messages and results. You pray that the most important ones will rise to the top somehow and be brought to your attention by your nurse or someone else on your team or another contact by the Veteran, for the alerts are not prioritized in the computerized medical records system (called CPRS). In the year since I transferred (for serious health reasons) from Primary Care to Compensation and Pension, six physicians and one nurse practitioner have sat in my old seat and been responsible for my panel of patients. Every one of these clinicians has stated it is not possible to do the job as one human being—and indeed, as of late August 2013, the plan is to bring in two locum physicians to split the work.

And why locums again? Because the fourth "permanent" Primary Care physician, who only came onboard in June 2013, just gave his notice. He is an experienced doctor, who moved from another state to come to Jackson and told me he wanted to work with the Veterans and make being in the VA healthcare system a career. The Veterans and staff loved him, and everyone was finally relieved to think there would be some continuity again after a year of distress. But the same kind of scheduling was done to him—double-booked at 0800 hours on his first day, when he didn't even know, or have access to, the computer system—and when he spoke up promises to lower his daily workload were made but then broken.

Then an even more worrisome event occurred. (Nursing staff and the new physician informed me in real-time of these events, as what was happening was of grave concern to the care team and the new physician asked to speak to me.) After four other physicians, starting in the Emergency Room, had appropriately refused to write narcotics for a Veteran due to the clinical situation, this new Primary Care physician was asked repeatedly by the acting Chief of Primary Care (Dr. Alan Hirshberg, from the Lebanon, PA VAMC) to order the controlled substance. The Veteran had gone to the Primary Care administrative office and complained he wasn't getting what he wanted; of note, Dr. Hirshberg himself did not want to write the prescription. The Veteran was also not a patient assigned to the new physician, and he had never met the man. The new physician refused, putting a short note in the record that he had been asked by Dr. Hirshberg to order narcotics for the patient, and did not feel comfortable ethically or morally doing so; he also stated he had then asked the acting Chief of Staff (Dr. Fashina, here for ten weeks and now just gone back to a Texas VAMC) to talk to Dr. Hirshberg about the plan for the Veteran.

The next day (a Saturday) Dr. Hirshberg came in and told the new physician he needed to delete that note from the medical record—and altering a medical record

is illegal. The new physician refused, appropriately, but the next Monday the same demand was made of him. He did not agree; it is not clear if Dr. Hirshberg himself had the note deleted.

It seems clear that Dr. Hirshberg was more concerned with keeping a complaint from a Veteran from escalating (perhaps his bonus is tied to the number/type of complaints or "Congressionals"?) than with the best clinical care for the Veteran. When "caught" on the record making an illegal request of a fellow physician he wanted the "evidence" deleted—"as if it never happened", to quote a clean-up company's commercial slogan. This was the same scenario that I experienced in 2009, when a Veteran threatened me (and blocked the door with his chair) when I refused (on clearly evident clinical grounds) to "double his pain medicine"—the Veteran complained, and I was called to see Dr. Kirchner in the Chief of Staff's office. Dr. Kirchner told me the Veteran's wife worked at the Regional Office for the VA, and wanted me to delete my note from the medical record. I refused, and he eventually stopped asking me. However, Dr. Kirchner then lectured me on how the Veterans are in pain, and we need to be sensitive to that, and we have the Pain Clinic to help us. I told him that I had already consulted the Pain Clinic on patients, and they would write in the chart that it was not ethical to give a certain patient narcotics so "Primary Care to address pain issues". I asked Dr. Kirchner if the Pain Clinic doctor felt a controlled substance was unethical to prescribe in a certain clinical situation, why was it ethical for me to order it as a primary care physician?

Which brings us back to the investigative team's report substantiating that NPs illegally prescribed narcotics, and that unsupervised NPs took care of at least seventy-five percent of the Veterans. And these Veterans get a lot of narcotics—whether it is entirely appropriate, or not. The report notes that there is a high likelihood that the lack of proper monitoring of NPs is a serious medical care concern: "It is the professional expert opinion of the review team that there are enough problematic indicators present to suggest there may be quality of care issues that require further review" (page 3), as NPs were "practicing outside the scope of their licensure." The investigative team had the good sense to admit that when you have all this unsupervised work done by people who were supposed to be supervised, you have no way of knowing how many things were done wrong; many issues can go under the radar until something awful surfaces. In medicine, this "something awful" affects a person's life, and can cause death. All these years no one has checked the work of the NPs; unless someone digs deep, the fact that tragic events could have been avoided can be buried in the medical records as hidden malpractice. Patient confidentiality also precluded specific cases being brought to the attention of the investigative team.

The investigative team substantiated that the Jackson VA Medical Center does not have a sufficient number of physicians; the Medical Center, in fact, has the inverse ratio of physicians to nurse practitioners compared to other VA medical centers. A further safety issue related to this fact is that we have an epidemic of prescription drug abuse in this country now; and a physician has to think as carefully about prescribing narcotics as a policeman has to think about using a gun. Narcotics can be deadly force. Having nurse practitioners as the bulk of the people with this "unscripted" prescriptive authority is a decision that the VHA must review carefully. Many Veterans not only have chronic pain from multiple physical injuries, they have the global experience of pain from the combination of traumatic brain damage and psychological trauma; some can't think straight under stress even with all their willpower. They are given anxiety and depression prescriptions, and drugs to help them sleep, and they can use alcohol and other street substances, and sometimes share each other's medicines. The last thing our Veterans need is to be given too many narcotics, and started on the road to addiction as young men and women. The combination of all these drugs become "brain IEDs", internal chemical weapons, and can prove fatal in some Veterans. The VA has many documents and policies on Pain Management, and so-called multidisciplinary approaches to pan issues, but the reality at the day-to-day level of care is how easy it is for someone to point and click and order a narcotic in the computer.

The disconnection between the "ICARE" slogan and the VA Motto (taken from Lincoln's Second Inaugural Address—"to take care of he (and now she) who has borne the battle" –is heartbreaking. Every decision on how Primary Care delivers that care should be based on whether it helps accomplish the mission for the Veteran. These men and women have "heart-earned" the right to the best medical care humanly available. Anything that gets in the way, or makes the work impossible or even dangerous, must be stopped. I even wrote to leadership that they would not go to a medical office that ran the way they made us operate Primary Care, so why did they think that kind of clinic was okay for the Veterans? Yet even that did not merit an email reply.

Overloaded schedules mean Veterans can't be seen when they need to be seen; they are put out for months, or have to walk-in and wait hours. The investigative team report also noted that Veteran complaints substantiated these problems. Additionally, the report stated (page 30) that when a Veteran came in for an appointment and their (expected) provider was not present, the Veteran was then double-booked onto another provider's schedule, and seen. Two points need to be made. The first is although that patient might be given an appointment time he or she cannot always wait to be seen as an overbooked patient, and it is very upsetting to a Veteran to wait for months for a scheduled appointment and then find out at the clinic that no such provider is available. One's hairdresser does not operate this way. The second point relates to what happened after I was diagnosed with a serious medical issue in July 2011, and treatment then dictated I take extended medical leave for four weeks at the end of the year. In early November 2011my primary care team (my RN, LPN, and clerk) and I met with Dr. Lockyer to review with him the plan for coverage of my fully-booked clinics in December. He stated unequivocally that he and Dr. Kirchner had clinician coverage lined up—but when December came only on sporadic days was anyone assigned to see my patients. The Veterans scheduled for me came in, had the previously ordered follow-up labs done in the basement, and then were checked in by my clerk who had to tell them no doctor was available. The nurses then had to scramble to try to get one of the nurse practitioners in the Blue Clinic to see my patient—and weren't always successful; it was also a terrible position to be put in for both the Veteran and the staff. And the tests ordered were not followed up on, or Veterans notified. I came back from medical leave in January 2012 to an array of serious unattended problems.

The investigative team also noted that "the team cannot rule out the allegation" that Medicare Home Health Certifications forms are illegally completed, as "data pulling" is not easily available. However, the interviews the team conducted, and (once again), the lack of collaborative agreements and supervision of NPs, documented the high likelihood of such a situation. I also gave the investigative team an email memo from the Home Health Care coordinator at the Jackson VAMC in which she told the NPS to "have the doctors in your clinic sign those Medicare forms". Asking a doctor to sign such a form on a patient seen only by an NP is explicitly illegal, as it requests the doctor commit Medicare fraud—the form states at the bottom right corner that the physician who signs it "certifies that this patient is under my continuing care". Yet Dr. Lockyer signed some of these forms despite never seeing any patients.

I feel so strongly about what it means to be a physician that I wrote a small book on it— "Sacred Trust: The Ten Rules of Life, Death, and Medicine". The practice of medicine is truly a sacred trust, and the honor of working for the Veterans is humbling. In one of Mr. Battle's emails to the Medical Center staff he used the "sacred trust" phrase, but nothing changed in the building. Yet the work of medicine is of paramount importance. It is about peoples' lives—as simple and as serious as that.

It is clear from the investigative team's findings that leadership chose not to pay attention at multiple points. (The detailed spread sheet of Attachment B of the report is particularly striking.) This means they simply did not care about the Care of the Veterans. Deliberate moves were made by men and women with power. And this report shows just how cavalierly the Medical Center leadership operates—and still does.

After Dot Taylor was arrested, I told Mr. Battle in person (at a meeting to which I brought a union representative, Mr. Harold Miller) that the nurse practitioners were operating illegally and in violation of both VA regulations and our medical staff bylaws. He reiterated that "in the VA nurse practitioners are LIPs", even when I repeated that they were not; Mr. Battle chose to believe Drs. Kirchner and Lockyer, both of whom went on to breach ethics themselves. Mr. Battle only removed Dr. Kirchner as Chief of Staff under pressure from the DEA investigators and Veterans Liaisons from US Congressmen's offices. Dr. Lockyer was only removed as Associate Chief of Staff for Primary Care when the New York Times article (about the number and type of whistleblower complaints from the Medical Center, and a special letter sent to the President by the Office of Special Counsel) was published in mid-March 2013.

How did it come to this at the G.V. (Sonny) Montgomery VAMC? How could those in charge of healthcare for Veterans—those charged with carrying out the mission stated so simply and clearly in Lincoln's Second Inaugural Address—decide to violate, in the words of the report, "certain Federal laws and regulations, as well as state laws", as well as "due to mismanagement, both VA and Veterans Health Administration (VHA) policy"? These are not small things. And they don't happen over-

night. How could a culture of leadership become so sick at a healthcare facility? The only words that come to mind are hubris, and disdain.

Conscious choices have been made over years, and continue. As honest and fact-based as the investigative report is one of its troubling aspects is the tendency to soft-peddle the mindset of the "Medical Center leadership". Calling the deliberate decisions by this leadership to use unsupervised and not duly licensed nurse practitioners a "lack of understanding" of requirements does not do justice to the intelligence of these leaders. The investigative report states that the Medical Center leadership "erroneously" declared NPs to be licensed independent practitioners (LIPs), thus granting these NPs medical staff privileges, but then also stipulated that these "independent" practitioners must have collaborative agreements per individual state licensing boards. But this is not just something that happens to be a "misunderstanding"—this kind of approach shows an obvious and clear inherent contradiction. And the Medical Center leadership is certainly blessed with the brains needed to have understood all this. And it is not just "confounded" by the fact that no one in leadership made sure that ALL collaborative agreements were followed according to the law. Again—the fact that individual state nurse practitioner licensing boards (in particular, the state of Mississippi) had strict and precise requirements for supervision of nurse practitioners was not secret knowledge. The regulations were clear on the Board of Nursing (BON) website, and on the collaborative agreements that many physicians in leadership signed. And there is still no process in place for review of any work done by nurse practitioners. Contempt for the law, and for the welfare of the Veterans, still reigns.

This Medical Center leadership consists of the following: Rica Lewis-Payton, Greg Parker MD, Joe Battle, (previously, and for many years) Dot Taylor, Kent Kirchner MD, Jessie Spencer MD, and James Lockyer MD. All of these people kept ranks, and thought alike. Dr. Alan Hirschberg, acting Chief of Primary Care, appears to be trained at the same trough. And when Dr. Lockyer was finally made to step down as Chief of Primary Care, he subsequently went on to another job at a VAMC (in Tennessee) in charge of Primary Care. The position of Chief of Primary Care was held for this man by Medical Center leadership for a year until he came in June 2011. A simple Google search shows that in 2004 he lost (in summary judgment) a court case he brought against a private medical group; and this public document shows he had his salary dropped each year for four years due to inability to see enough patients, keep up with paperwork, and the number of patient complaints. (He never saw patients in clinic the entire time he was at the Medical Center.) Who at the Jackson VAMC gave him recommendations so he could do the same abysmally inadequate job as he did at the Jackson VAMC?

And things are not getting better. A newly trained physician (who recently finished residency) just came on staff, but the net gain now from the time of my whistleblower complaint in July of 2012 is only one doctor in Primary Care (total of four at present). Both the physician who quite after less than three months, and the new one right out of training were immediately overloaded in their daily schedules, double-booked each day even before walk-ins started to be added to the total seen by the end of clinic; and both of these physicians were just learning our computerized medical record system (CPRS). The clinic days stay in ugly chaos. There is no end to the constant stress on the Veterans who can't get appointments, can't get routine medicines refilled (I still get automatic renewal orders come up on Veterans I took care of for four years, and prescribed medicines for, as the "loose ends" are enormous in number.) Now the new physician is needing to have her daily schedule lighter, and as the schedule for my old clinic is (as usual overbooked) for months out, each day the clerk and nursing staff on my old team are having to decide who can be cancelled and rescheduled (yet again, some patients for multiple times) farther out. As the report states, this is not what VHA policy dictates (page 29), but what else can they do? And the committed and excellent staff of the Primary Care clinics does not see any hope in sight. Mr. Battle and Ms. Lewis-Payton brought in a team from the VHA National Center for Organization Development (NCOD). This group's "goal is to strengthen VA workforce engagement, satisfaction, and development in order to improve Veterans' services". However, the NCOD team findings confirm all of the same Primary Care management and patient care issues—and staff especially hammered in the lack of the simple courtesy of communication from management.

There is no way that this egregious discontinuity of care is safe, or acceptable; whenever there is a change of physician or a nurse practitioner for a patient in any healthcare setting the likelihood of issues being overlooked or lost to follow-up multiplies. But the most direct way to think about the situation in Primary Care at the Jackson VAMC is what some of my former patients ask when they come up to C & P to say hello: "Who is going to take care of me?"

Official emails have come out recently about identifying and "owning" a problem, and that if an employee identifies an issue he or she should be able to "shut down the service line" until the issue is fixed. This is akin to what the military calls a "safety stand-down" and it is something that is called for in Primary Care. But I do not believe that Medical Center leadership will follow its own preaching.

Mr. Battle has made much of the opening of the new Women's Health Clinic—but there is no physician hired for that clinic. The brochure states the services offered include "Maternity Care—7 days post-delivery only (including circumcision for newborn)—who is going to be doing that? (Circumcisions are also not routinely now done as part of best practices in pediatrics.) An unsupervised NP and her LPN (no RN is hired) and a clerk are the only staff for the Women's Clinic at present; this is supremely disrespectful to the Women Veterans, and also a fraudulent way to open such a clinic. No professional group I know of in any city, including the other medical groups in Jackson, would open a Women's Health Clinic without an Ob-Gyn physician on staff.

As I have written in the past to both administrative and medical management over several years, I do not believe that any of the people in leadership would tolerate going to a medical practice that ran like this—so once again, why do they think it is acceptable for the Veterans?

I have written documentation regarding all of the issues above, and this documentation spans my four years in Primary Care, as well as several emails from prior Primary Care physicians who shared with me an outline of the long history of chronic, basic problems in the department. Correction to report on witnesses interviewed: it is Dr. Jo (not Joe) Harbour, a woman physician.

The investigative team report does not state what disciplinary actions will be taken against those who broke the laws and regulations, but hopefully some consequences will ensue for these people. This should include the top leadership (medical and administrative), as well as nurse practitioners who knowingly did not follow their state licensing guidelines. One hears at the Medical Center about "Federal Supremacy", but the concept has been abused. It should not mean that the VAMC can operate as if it is "another country", or that state medical and nursing licensing boards cannot have access to what physicians or nurse practitioners do in the VA system. How else can true quality of care be assured and monitored—and why else do we have strict licensing requirements for medical professionals? In any other medical group, if a physician in leadership breached ethics and the law, and also asked other physicians to break the law (and especially did that to physicians in training), that physician would lose his or her job and have their medical license under investigation. Working in the VA system should not mean you can escape this reality.

All year long the Jackson VAMC has "operated" with an average of fifteen "Acting Chiefs" of departments (services)—and as of the week of August 26th, seventeen acting chiefs. Can this really be considered to be a fully operational medical center? The overwhelming entirety of the substantiated findings in this report is sickening, and concrete. One comes back again to how could this kind of constellation of "symptoms" and mismanagement "disease" come to pass? Whoever thought that the type of "leadership" seen at the Jackson VAMC (and apparently at other VAMCs to greater or lesser degrees) could ever be deemed appropriate? Many times in the morning my primary care team and I—after voicing prayers and hope for the day for our Veterans and our staff—looked at each other and repeated "Laugh or go crazy." In a truly very sad/funny way, the situation at the Jackson VAMC reminds one of the famous quote from Casey Stengel about the 1962 Mets—"You look up and down the bench and you have to say to yourself, 'Can't anybody here play this game?'" But the truth is, yes, a lot of people at the Jackson VAMC, and seemingly at other VAMCs, know how to "play the game"—the wrong one, where you gamble with the lives of Veterans who put their lives in your hands.

And so how does one finally make an impression on those who have the power to make the medical care given to the Veterans the best healthcare possible? To aim to make it the best in the world? To take all of the work that goes on at a VAMC dead seriously? I will end with the words of one of America's vital playwrights, Arthur Miller.

In "Death of A Salesman", Miller has a character say this: "But he's a human being, and a terrible thing is happening to him. So attention must be paid. He's not to be allowed to fall in his grave like an old dog. Attention, attention must finally be paid to such a person." So many, many Veterans and the fine, committed staff at VAMCs, feel that no attention is being paid. This cannot be allowed to stand as it is. And one simple change to make is to not have VA Medical Centers directed by non-medical people; they simply do not understand what happens on the front

lines, any more than someone who has not been a soldier can know what truly happens in the trench.

Arthur Miller also wrote a play called "All My Sons", in which the son of a manufacturer of defective airplane parts in World War II goes to war, and when he finds out the role his father played in the death of fellow soldiers, crashes his own plane and kills himself in response to the family responsibility and shame. The father learns the truth and says "Then what is this if it isn't telling me? Sure, [Larry] was my son. But I think to him [the pilots killed] were all my sons. And I guess they were, I guess they were."

Just so. I look at a Veteran, and I can see one of my sons who fought in the Army in Iraq. But that Veteran reminds me of so many more. For they are All Our Sons, All Our Daughters—and they deserve the very best the United States can give them. Nothing less.

We cannot fail them.

Prepared Statement of Robert E. Nicklas

Before I begin, I would like to take this opportunity to thank the committee for arranging this field hearing in Pittsburgh. Our family is very grateful to so many of the congressmen for your support in pursuing the answers our family, and those families of the other victims of the Legionella outbreak in Pittsburgh, deserve. Without the support of the Chairman of the House Veterans Affair Committee, Jeff Miller, Congressmen Tim Murphy, Keith Rothfus and Mike Doyle, Senator Bob Casey, and all of those who are here today and were with us at the Congressional hearing in February, we may never know the truth. With your support, however, we hope that we will have answers and accountability, not only for our loved ones but for all veterans who deserve better.

Thank you for the opportunity to share information about our father, William Nicklas, and our experiences with VA Pittsburgh Hospital System. Our father was not only, a devoted husband, father and grandfather but was a proud, loyal veteran who often spoke of the service he gave to his country. As a young man, he worked hard to gain the weight necessary for him to enter the military, and once accepted in the Navy, he worked just as hard, not only fulfilling his duties, but also providing the best service he could to his country, the Navy and his fellow servicemen. Upon leaving the service, my father met and married our mother and, subsequently, had three boys. While raising his family, he began his own auto body business where he worked until he retired. Being an extremely active man, he continued to keep himself busy by helping two of his sons begin their own business as contractors. In 2008, at the age of 84, he helped my brother construct a memorial to the WW II veterans in his community. He was known for his practical jokes, his love of sports, his ability to be the first and the last on the dance floor, and his undeniable dedication to family. He was, no doubt, the patriarch of our family who was there whenever he was needed. There was one other issue my father felt a deep sense of passion for...our country and its military personnel. Everyday, at our home, my father flew the American flag in his front yard as a symbol of his belief in this country. It was not often when we would see our father shed a tear, but each year on Thanksgiving Day as we sat around the table at my house, individually thanking God for the greatest things in our lives, it was always dad who, fighting back tears, would mention the soldiers who were away from home, fighting the war for this great country. He believed that those men and women deserved the utmost respect and to never be forgotten.

On November 1, my father entered the VAPHS due to nausea, which he believed stemmed from a new medication. This was the very day after the CDC advised Dr. Muder, Chief of Infectious Disease at VAPHS, that genetic testing confirmed two VAPHS patients contracted Legionnaires from the hospital. When my brother and father arrived at VAPHS, my father told my brother, "Go ahead. I'll be fine. They will probably just run some tests and release me." Again, my father's dedication to and belief in the VA led him to VAPHS. While he and my mother had private health insurance and could have accessed any hospital in the Pittsburgh area, he opted to go VAPHS because he believed that was where a veteran would get the best care. Or so we would have thought. Ironically, the very day my father entered the hospital, the CDC was already on site working on an ongoing problem with a deadly Legionella bacteria outbreak. Another significant event took place on the day that my father was admitted to the fifth floor of VAPHS - Dr. Muder, VAPHS Chief of Infectious Disease, reached out to several experts trying to locate someone who could do genetic testing and environmental Legionella sampling. Unable to find any-

one, UPMC's Director of Clinical Microbiology Labs, William Pasculle suggested that VAPHS contact Janet Stout, former VA employee. Dr. Muder responded to that suggestion by saying "I would love to have Janet do it but that's not possible due to her association with a certain person, the administration would go ballistic when they saw the invoice." This disappointing political decision was the first of many unconscionable, devastating decisions resulting in my father contracting the disease, which ultimately caused his death.

From November 1 through November 10, my father was allowed to shower and drink the hospital water. Never was anyone in our family ever advised that there was an ongoing CDC investigation and an Epi Aid investigation due to a Legionella outbreak being conducted at the very same hospital at the very same time. On Sunday, November 11, we received a call in the morning alerting us that they had moved my father to the 4th floor ICU due to elevated potassium levels. We were advised that he was fine, alert and otherwise OK and that there was no need to rush in. On November 12 or 13, we were advised that my father had an infection and a low-grade fever. When questioned about the source, the ICU staff was not certain but assured us that they were running the proper tests to determine the cause. As the next few days unfolded, we were told by the ICU staff that they believed the source of the low grade fever was a urinary tract infection which was also causing issues with my father's kidneys. Several days went by without any definitive cause of infection. You cannot imagine the shock and anxiety we experienced when, on Friday, November 16, as my wife and I listened to the local news on TV, we learned that the VAPHS announced a Legionella outbreak. Our disappointment mounted knowing that my father had already been in the hospital for 16 days.

On November 17, when we visited dad, we noticed that there were signs in the lobby water fountains, which read, DUE TO WATER LINE PROBLEMS, THIS FOUNTAIN IS OUT OF ORDER. As we entered his room in ICU, we saw a sign in the sink, which read, DUE TO WATER LINE PROBLEMS, DO NOT USE. There was no mention of Legionella or Legionnaires. We also noticed during our visit that dad was telling stories that did not make sense. When my wife mentioned it to the ICU nursing staff, she was told that it was a condition known as "ICU psychosis", a term used when patients show signs of delirium due to a prolonged stay in one room. We were assured that this would "clear up". At the same time, we were told that my father's kidney and liver were stressed but despite it all, the doctors assured us that he would be home by Thanksgiving.

Over the next few days, dad's condition deteriorated and his doctor began oral antibiotics, even though dad was suffering from bouts of diarrhea. On November 19, his doctor ordered the first culture for Legionella bacteria via a urine antigen test . . . nineteen days after dad entered the hospital, weeks after symptoms attributable to Legionnaires appeared, and with knowledge that they had an outbreak of Legionella. VAPHS further delayed the testing of this sample when the lab "lost" or "misplaced" my father's first sample. Once again, another sample had to be taken and on November 21, our family requested a meeting with dad's doctor due to the contradictory reports we were receiving from the ICU nurses and doctors when we phoned in to check on dad's condition. Our meeting was scheduled for 6:30 on Wednesday evening, November 21. Shortly before leaving our home to attend this meeting, my wife called ICU to check on dad and was told by the attending physician that they had just received confirmation that he tested positive for Legionella bacteria. When asked if this meant that he had Legionnaires, my wife was told by the attending physician, "we cannot say that right now". Stunned and disappointed, we arrived at the hospital for our meeting. We were told that they were treating dad with antibiotics and we subsequently learned that they had switched him from oral antibiotics to IV antibiotics. At this meeting, we were told numerous times by his doctor that she had expected him to make a full recovery prior to the diagnosis of Legionnaires. The doctor told us that even if the disease would clear, the repercussions of the Legionnaires were long lasting. The doctor suggested that we tell dad and once she did, his response was "just what I need".

That night began the slow, painful decline of my father. A man, who still, despite all that he was going through, wanted to reach out and protect his family, most importantly, his wife. He told us stories of people coming to get him...that they were trying to poison him and that we had to get out of there before they poisoned us, too. Over the course of the next 2 days, we watched my dad's mental state deteriorate further and further. He was obsessed with picking at his blanket. When we asked why, he told us "I have to get the poison off of me". My mom was called to the hospital on Friday, November 23, 2012, to try to help settle my dad who seemed extremely agitated. He was scared, he was worried, he was anxious, unsettled, still concerned that they were going to poison us.

In fact, as I sat there that night, holding his hand, he tried to "pick the poison" off of the back of my hand. He drew blood as he pinched my skin over and over and over again. We said our good nights, told him that we loved him and that we would see him the next day. That would never be. We drove my mom home and were planning to leave for the airport to pick up my brother, Ken. As we entered the house, the phone was ringing. My son answered the phone - it was the doctor advising us that dad had passed. My brother did not get here in time to see my father. Having to deliver that news to him as we stood outside of the airport was the toughest thing I have ever had to do. And why - why did this happen? Why were we not warned that the CDC was on site? Why wasn't something done after the 1st person died? the 2nd? the 3rd? the 4th? Why was the antigen testing not done sooner on my father, especially since they knew there was a problem? Who lost or misplaced my father's first sample? Why did the VAPHS not accept the help that they were offered by consultants such as Enrich or Liquitech? The questions go on and on and on.

Over nine months ago, we began to ask questions about this unfathomable situation, which has devastated our family. Those questions have led us on a journey, full of more questions with no answers. We realize that the power, which Congress has, could make all the difference in giving the families the closure they deserve by providing us with answers and accountability. We are here today to urge Congress to help us to get answers and to, ultimately, hold those accountable for the decisions that were made that led to this travesty. In February of 2013, we attended the Congressional hearing in Washington DC where several panels presented information on the history of the water system at VAPHS, the closing of the world renowned lab at VAPHS in 2006 and the subsequent senseless destruction of thousands of Legionella samples, the years of support offered by consultants to help manage the copper silver ionization system after the closing of the VAPHS lab, and the lack of training provided to those employees now responsible for monitoring that same system. At that hearing, no one from the Pittsburgh VA Hospital administration attended and those VA representatives who did, were unable to answer specific questions. While several startling pieces of information were revealed during that hearing, no specific answers were provided.

Since the hearing in February, many stories have appeared in the local newspapers, on local television, on national news broadcast such as CNN and CBS national news, yet still no answers and no accountability. In April of 2013, the findings of a four month long federal investigation by the U.S. Office of the Inspector General were released.

What we learned were that the copper-silver ionization system was not managed thus allowing Legionella to flourish in the system; there was little documentation of the system being monitored; communication between the infectious disease team and facilities management staff was "poor"; those in charge of the system did not routinely flush faucets and showers with hot water as advised by the manufacturer of the system; when personnel did flush the system, they did not raise the temperature of the hot water enough thus violating the VA's own guidelines; and staff did not test all health care-associated pneumonia patients for Legionella as, again, VHA guidelines recommend. The Director of the VA responded to this report by saying, "they validated what we already knew" and that she and other officials were in "total agreement" with the findings. All of this they knew. What else did they know? Management also knew that the first person contracted the Legionnaires in February 2011, that the first death from the outbreak occurred in July 2011 and they knew that there were 6 more people who were infected in the fall of 2011. One would ask ... Why, then, were people still being infected and still dying in November of 2012? What do we know? We know that after several of those deaths, VAPHS advised the families of most of those infected that the bacteria must have been acquired outside of the hospital even though they knew they had ongoing issues with Legionella.

Our family's disappointment and outrage did not stop there. In late April of 2012, we learned that the Director of VAPHS, Terry Wolf, and the Regional Director, Michael Moreland, each received a performance bonus in the approximate amount of $13,000 and $16,000, respectively. Yet, again, on May 2, 2013, it was announced that Michael Moreland was awarded the Presidential Distinguished Rank Award, which was approved by VA Secretary, Eric Shinseki and the White House. This award is given to less than 1% of the federal government's senior executives...54 employees this year! The award includes a bonus equal to 35% of the employee's annual salary. For Michael Moreland that salary was $179,700 making the bonus approximately $63,000.

I ask all of you present today, to imagine what my family has been through. Now, remember these veterans who senselessly lost their lives through a long, painful

process full of anxiety and struggle. I also ask everyone who is present today to reflect on this one question...What would have happened if you had performed your job in the same manner as the VAPHS administration? Would you still be employed? Would you still have your benefits? Would you be receiving bonuses?

My father, William E. Nicklas, was a man who served his country honorably and responsibly; a man who put himself in danger to protect his country and his comrades; a man who raised a family and instilled in that family that same sense of responsibility to themselves, their family, the community, and this country. He was also a man who held himself and his family accountable for their actions. We ask for nothing less for him and all of the other victims of this outbreak.

Again, we urge Congress and all veterans to join with us to demand answers and accountability. The same tax dollars paid by every citizen, including family members affected by this travesty, are the same tax dollars used to pay the salaries, the benefits, the bonuses and the budgets of the employees of VAPHS. We beg you to please help us to get the answers that these and possible other victims deserve!

William E. Nicklas
John Ciarolla
Clark Compston
John McChesney
Lloyd Wanstreet

Thank you for this opportunity to testify and I will be happy to answer your questions at this time.

Prepared Statement of Maureen A. Ciarolla

Good morning. Chairman Miller and distinguished members of the Subcommittee, I want to thank you for the opportunity to testify here today on behalf of my family regarding the VA Pittsburgh Legionnaires' outbreak. My name is Maureen Ciarolla. I am the eldest daughter of John J. Ciarolla, a United States Navy veteran who died from Legionella while residing in the VA Pittsburgh Healthcare System (Pittsburgh VA). I would like to note that our father is listed as one of the "probable hospital acquired" cases, due to having two family afternoon visits during the "2–14 day" incubation period. At our meeting with the Pittsburgh VA on March 12, 2013, we were told as such in that because of that fact we couldn't scientifically prove he acquired it at their facilities.

First, we would like to thank all the employees and staff at the Aspinwall facility who were very kind and professional while our father was there. We would give special thanks to Ms. Connie Coble-Roe, CRNP, (Certified Registered Nurse Practitioner), who we spoke to often about our father's on-going care and well-being, and also Ms. Heather F. Korpa, LSW Social Worker, who our father spoke about with great regard, in fact our brother remembers our father describing her as, "a Good Egg." We would like all of them to know our appreciation.

Our father entered the VA Pittsburgh Healthcare System on January 22, 2011, became a resident at the H.J. Heinz facility here in Aspinwall and died six months later. I want to make one thing very clear - while our father was in the Pittsburgh VA we were actively involved in his life and his medical care. As a matter of fact, there is a notation in his medical records, in fact "warning" that the "family is very involved with medical care."

Why we are here today has nothing to do with the people who work directly with the veterans like those I spoke of. We are here today as family members who lost a loved one, to take part in the continuous effort to find how and why this Legionella problem got so out of hand here in Pittsburgh causing our father and other veterans to die prematurely, obviously. There can be no more tolerance for the tactical usage of stonewalling, red herrings and we should reject any evasive responses to questions and compel a lucid answer by all means necessary. My testimony today is meant to ask for your help in demanding clear answers to questions and that those responsible are held accountable, for real. The families of the victims, the families who lost their loved ones and all veterans are at least owed that much.

This micro pandemic, if you will, in the VA Pittsburgh Healthcare System was predictable. In fact, in 2008, top ranking VA officials, some who are here today, were informed that this very situation was going to happen. If for whatever reason they weren't aware prior to 2008, they should have known this was going to happen in the near future. At one time, the VA Pittsburgh Healthcare System had the leading Legionnaires' research facility in the world called the Special Pathogens Laboratory. In 2006 an administrative decision was made to close this research department

and destroying decades of research in the process. This decision was deemed so bizarre and irresponsible that Congress had a hearing over this very matter.

Five years ago, to the date, on September 9, 2008 a hearing was held by a Subcommittee on Science and Technology. The subject was about how the lack of a coherent policy allowed the Veterans Administration to destroy an irreplaceable collection of Legionella samples. This report is public record and took place three years before our father contracted this fatal pathogen at the Pittsburgh VA. The information and discussions in that hearing record is the very reasons why we say this Legionella mess was indeed predictable. Here is what the report states:

"The collection of materials destroyed in Pittsburgh was the work of Dr. Victor Yu and Dr. Janet Stout, who have, during the last three decades, become world-recognized experts in identifying legionnaire's disease. Dr. Stout is widely recognized for her work in developing methods to keep Legionella out of water supplies at hospitals and nursing homes. Dr. Yu has an international reputation for his work on infectious diseases in hospitals."

Think about that, they had the most knowledgable people in the world on Legionella and basically showed them the door.

Michael Moreland, I believe, was the incoming Director of the VA Pittsburgh Healthcare System at that time. The record goes on to say that he and Associate Chief of Staff for Clinical Services, Dr. Mona Melhem oversaw the decision to close down the nationally acclaimed Special Pathogens Laboratory and ordered the acrimonious destruction of Legionella and other disease isolates and also water samples containing the Legionella bacteria that had been accumulated by Drs. Stout and Yu over the decades of their research on this disease.

Let's think about that for a moment. Decades of research accumulated by the world's most renowned specialists just tossed out the door. Your decision as the incoming director to close down a research laboratory of that caliber in his own hospital has to be the most incompetent decision any incoming person could make. These were the top people in that field. By all reasonable accounts they would have been the first responders the moment before this deadly bacteria reached this critical stage.

The Subcommittee's investigative report points out further, that:

1. After "months of investigation ... the Subcommittee have not revealed any credible reason for the destruction of the collection."

2. What was also evident was "that administrators at a major VA hospital had allowed personal animosities and goals to overcome its own processes."

Was there really animosity and goals involved there like the committee suggests?

3. Mr. Moreland and other witnesses from the VA should remember that their testimony today is under oath and it is simply not credible that important technical decisions were made entirely based upon conversations with no documentation.

If Mr. Moreland's testimony wasn't deemed credible back then, before deaths ensued as a consequence of his decision, how credible can his testimony be after this disaster?

4. The record continues, "I cannot imagine the circumstances under which a federal health agency official would unilaterally order the destruction of human tissue collection without receiving the approval of the agencies research office and the Research Compliance Committee. I cannot imagine why that official would apparently make false statements during the destruction to keep the Associate Director for Research at the center, in the dark until the destruction was complete."

5. When Dr. Stout was questioned about the need for ongoing research - because, these bacteria keep changing, so as to stay ahead of it, she states: "And if I may just add, in addition to therapy and treatment, we are also and have been for many years trying to put the tools in the toolbox to prevent the disease, which includes treatment of water distribution systems with various methods to control the presence of the bacteria in the water, and just like with antibiotics, there is no perfect solution so we continuously do research to perfect those techniques." She goes on to say "In the September issue of Clinical Infectious Diseases, there is a report demonstrating that there is an increase in the incidence, or the number of cases of legionnaires' diseases that have been noted" and she attached the report to her testimony.

Dr. Yu testified that "microbes are evolving and antibiotic resistant is now a major problem" and two days prior to the sample destruction they received commentary from one of their colleagues in France. "They believe that Legionella has the capability to evolve resistance to Levofloacin, and they wanted us to test their hypothesis with the organisms that we had in our collection."

6. And finally, one subcommittee member commented that "all of us may pay a price for this conduct, veterans most of all, because the Nation lost one of its leading research labs on hospital infectious diseases."

Well veterans did pay a price. The Center of Disease Control and Prevention's report to the U.S House Subcommittee on Oversight & Investigations at its hearing held in Washington DC on February 5, 2013, states in fact that 32 cases of Legionnaires disease were diagnosed at the Pittsburgh VA between January 1, 2011 and October 21, 2012. It verifies the Pittsburgh VA's claim - that only five patients definitely caught Legionnaires' disease while hospitalized at the Pittsburgh VA. But it also suggested that sixteen additional patients "probably" caught the disease at the Pittsburgh VA.

Prior to the release of the CDC report the VA was claiming that there was only one death. Only after this report were they compelled to come clean. There were at least five.

We don't know nor do I think we will ever know how many victims there were in the past or that exist today. They definitely chose to remain careful and quiet about this. In our case, on July 15, 2011, we were adamantly told by Tiffany Pellathy, our father's Critical Care Nurse Practitioner and Dr. Gilles Clermont, and I quote "Legionella had nothing to do with our father's condition; we treated and cleared that up with antibiotics, before he was put on the ventilator".

Additionally, I would like to point out the testimony from the February 5, 2013 hearing:

- Mr. Aaron Marshall, Operations Manager for Enrich Products, Inc., which supplies copper-silver ionization systems for the control of Legionella, testified that in June 2012, he was called in at the request of the Pittsburgh VA, to perform a review of the copper-silver ionization system and its operation at the University Drive facility, but that critical data was withheld from them. He testified "I requested but was denied access to view the Legionella test results." He also states "Had Enrich Products been aware of the presence of Legionella or Legionellosis cases at the VA University Drive Campus, we would have recommended implementing the reactive course immediately." He also said that they learned through the media that there were reported cases of Legionnaires Disease at the Pittsburgh VA and that there were deaths as a result, and there were quotes that offered doubt on the efficacy of copper-silver ionization. He stated "Copper silver ionization is an effective method of controlling Legionella bacteria. However, in order to maintain its efficacy, the installed system needs to be properly maintained and regularly monitored. And through today, (February 5, 2013) the VA has not shared its Legionella testing data or results."
- Mr. Steve Schira, chairman and CEO of Liquitech, Inc., the company that manufactured the Pittsburgh VA's Legionella prevention equipment, in his prepared statement he says: "While we continue to improve the technology, it is not plug and play. It requires regular maintenance, monitoring and validation. We have had some customers who experienced a re-occurrence of Legionella months or years after the installation of copper silver ionization, it was simply a matter of maintenance and, if LiquiTech was notified, we were able to correct the problem and eliminate the Legionella bacteria within 24–48 hours once action was taken."

He goes on to say that the "outbreak at the Oakland Pittsburgh VA could have been prevented with standard maintenance and open communications." There is no question the VA should have taken more assertive action. This outbreak would have been avoided with proper maintenance of the copper silver ionization disinfection systems.

Think about this: you eliminate the world renowned Legionella experts, whose life's work is all about preventing, eliminating and treating those that contract the deadly bacteria. When you ignore the procedures and the advice of the product's manufacturer that helps keep the bacteria in check. If he eliminated the advice and work of these people then the disaster is also predictable. Who was Mr. Moreland getting advice and counsel from?

Under Mr. Moreland's watch, adequate policies and procedures were either disregarded or non-existent, warning signs and recommendations were either ignored

or considered insignificant and there was certainly a complete lack of communication and/or requests for help according to the water systems' experts. To ouster the best minds on Legionella out of your company and disregarding the advice from the water system manufacturer while knowing that the deadly bacteria, Legionella, was lurking in the water systems at the Pittsburgh facilities has got to be one of the most incompetent decisions ever made. If you read the record of that 2008 hearing and all that was discussed there, it should be criminal.

We attended the hearings in Washington DC over this matter. There Mr. Moreland had no prepared statement and testified to that Sub-Committee that he didn't know too much about the issue or "that it's complicated," all to evade the questions that were posed. In fact he testified that "he first became aware there was a concern with Legionnaires at the Pittsburgh VA in fall of 2011." Apparently Mr. Moreland was clueless in 2006 about the Legionella bacteria generally, attending the 2008 hearings over that decision that led to the hearing and didn't learn a thing, and he was still clueless about the Legionella issues in his own facilities in 2011.

As an example, the Veterans Affairs Office of the Inspector General issued two reports: one in April and one in July, 2013, finding that the Pittsburgh VA had:

- Inadequate maintenance at all times of the copper-silver ionization system
- Failure to conduct routine flushing
- Failure to test all patients with hospital-acquired pneumonia for Legionella
- Inadequate testing requirements
- Utilizing loopholes in reporting Legionnaires to the CDC, state and county health agencies

Like I said, this situation was predictable. If it was indeed predictable, then casualties were imminent. If deaths were imminent, then that had to be acceptable to those responsible, knowingly. Mr. Moreland and his administration regime knew that the water system at these facilities had a Legionella problem, eliminating a diligent water monitoring scheme, obstruction of investigations and the misleading of families and agencies was no less than gross negligence and gross misconduct or absolute incompetence, either way a deliberate gamble - and veterans paid the price and lost their lives over it. There is no other way to look at it.

Dated: September 2, 2013

Prepared Statement of Robert A. Petzel, M.D.

Chairman Miller, Ranking Member Michaud, Members of the Committee, other Members in attendance today, ladies and gentlemen. Thank you for the opportunity to participate in this oversight field hearing.

The Department of Veterans Affairs (VA) is committed to consistently providing the high quality care our Veterans have earned and deserve. VA operates the largest integrated health care delivery system in the country, with over 1,800 sites of care. Each year, over 200,000 Veterans Health Administration (VHA) leaders and health care employees provide exceptional care to approximately 6.3 million Veterans and other beneficiaries. The VA health care system is consistently recognized by The Joint Commission and numerous other external reviews as a top performer on key health care quality measures. We operate with unmatched transparency in public and private sector healthcare, fostering a culture that reports and evaluates errors in order to avoid repeating them in the future.

In delivering the best possible care to our patients, one of VA's most important priorities is to keep our patients free from injury during their time at our facilities. In some cases, we have not done so, and I am saddened by any adverse consequence that a Veteran might experience while in or as a result of care at one of our medical centers. We send our sincerest condolences to those Veterans and their families.

When patient safety incidents occur at VHA, we are committed to identifying, mitigating, and preventing additional patient safety risks within the VA health care system. Where challenges occur, VA takes direct action to review each incident, and puts in place corrections to improve the quality of care provided and hold employees accountable for any misconduct. We work hard to incorporate lessons learned so that future incidents can be avoided or mitigated throughout the entire health care network.

In 1999, the Institute of Medicine (IOM) issued a landmark report on patient safety. Entitled "To Err is Human: Building a Safer Health System,"[1] the report estimated that 44,000 to 98,000 people die each year in hospitals across the country as a result of medical errors, making those errors the eighth leading cause of death in the United States. This report started a movement toward patient safety in medical facilities that has continued to grow to the present day. VA's response to the report was swift, and has been cited[2] as a model for other health care organizations.

In the same year the IOM report was issued, the Department established a National Center for Patient Safety (NCPS) to lead our efforts in this area and to develop and nurture a culture of safety throughout VHA. Every VA medical center now has at least one patient safety manager. These managers work to reduce or eliminate preventable harm to patients. They do this, in part, by investigating system-level vulnerabilities. There is strong evidence that system errors occur because of system failures rather than intentional efforts of individuals.

No hospital system can eliminate all individual errors, but our Department is designing systems that reduce the likelihood of preventable errors and lessen the potential harm to patients from errors that do occur.

VA relies on a tool called Root Cause Analysis (RCA) to determine the basic and contributing system causes of errors. RCAs study adverse events and close calls with the goal of finding out what happened; how it happened; why the systems allowed it to happen; and how to prevent what happened from happening again.[3]

When an RCA is needed, a team of experts from throughout the hospital and elsewhere work with those who are familiar with the situation in an impartial process to identify prevention strategies. They look at human and other factors, policies, underlying causes and effects, related processes and systems, and risks that are inherent in health care to find potential improvements in the way our facilities care for Veterans.

In order for VA's system to work properly, we have created an internal, confidential, and non-punitive reporting system, called the Patient Safety Information System, to make sure all VA employees feel protected reporting events and near misses so that we can learn, as an organization, from the concerns that have been raised.

We ask employees, Veterans, families, and visitors to our facilities to report not only incidents resulting in harm, but also close calls. We believe that a systems approach to problem solving requires a willingness to report problems or potential problems so that solutions can be developed and implemented—because we cannot improve what we do not know about. Because of our willingness to receive and review all reported incidents, more than a million reports (which include safety reports, aggregate logs and reviews, and RCA reports) have been generated and entered into our reporting system since it was established 13 years ago.

These reports are analyzed to address vulnerabilities that affect the system and spur system-wide improvements. The analysis of these reports is shared throughout VA, followed by notifications of lessons learned and the distribution of tools. For example, we have learned that errors in the operating room are often a result of poor communication. To address this issue, VA has established a program called medical team training to enhance communication among clinicians. Because we are an integrated system, lessons identified at one facility are communicated quickly across the entire VA health care system when necessary to reduce error risk. This results in an informed health care system that learns from past incidents in order to mitigate future adverse events.

When misconduct occurs, employees are held accountable through a range of actions and consequences that appropriately address the circumstances. For instance, actions may include counseling and training or severe discipline such as demotion and removal. Acts that are deemed blameworthy have clear consequences and accountability. Such acts include criminal acts, purposefully unsafe acts, professional misconduct such as patient abuse, professional incompetence, substandard care, and acts resulting from alcohol and substance abuse. While these instances are rare across the VHA system, there are processes in place for accountability when they occur.

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[1] Institute Of Medicine, Shaping the Future for Health, "To Err Is Human: Building a Safer Health System," November 1999.

[2] Professionals from 285 U.S. organizations and agencies including the Department of Defense and American College of Surgeons, for example, have attended VHA patient safety training programs. Internationally, 12 foreign nations have participated in patient safety training including Denmark and Australia, which implemented national programs based on the VA model. The VA National Centers for Patient Safety partnered with Agency for Healthcare Research and Quality for several years in the development and delivery of the national Patient Safety Improvement Corps initiative, which trained state-based teams from around the country.

[3] *http://www.patientsafety.va.gov/CTT/index.html.*

In addition, there are multiple layers of oversight within VA and VHA. VHA's Office of the Medical Inspector (OMI) is responsible for investigating the quality of medical care provided by VHA. VA's Office of the Inspector General (IG) conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter criminal activity, waste, abuse, and mismanagement. The IG and the OMI have both been involved in several of the situations the Committee is reviewing in this hearing, and their recommendations have helped guide our responses to those situations.

At the same time, we are committed to ensuring a "Just Culture", in which accountability principles are clearly stated but people are not punished for making inadvertent errors. Calling for punishment and termination of employees is not supported by the literature describing Just Culture as a model for management of mistakes and errors. Ignoring what the science of safety tells us about the causes of human error encourages staff to cover up or not report such errors. Recognizing that open reporting can lead to improved systems and behaviors within complex environments this concept has been promoted by the VA National Center for Patient Safety and external entities such as the American Nurses Association.[4] The Joint Commission standards specifically require that leaders create a "culture of safety by creating an atmosphere of trust and fairness that encourages reporting of risks and adverse events". Professor Lucian Leape of the Harvard School of Public Health has testified before Congress that the single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.[5]

Our patient safety programs, and other actions we have taken to reduce harm at our hospitals, have resulted in a number of important recent accomplishments. In the past decade, VA has:

- Significantly reduced the rate of inpatient suicides in our hospitals nationwide, from 2.64 per 100,000 admissions to 0.87 per 100,000 admissions;[6]
- Developed a program to reduce the number of patient falls in our hospitals by engaging our facilities in best practices resulting, in the overall major injury rate from falls dropping by 62 percent;[7],
- Developed a new patient-centric prescription label that enhances Veterans' ability to follow medication instructions provided on the label;
- Significantly reduced surgical morbidity and mortality in response to the feedback and information provided to facilities and their surgical programs[8] using the Surgical Lessons Learned program, which is now being expanded to other specialty areas;[9] and
- Developed an operative complexity model to assure adequate clinical infrastructure to support the complexity of surgery at VHA facilities. This model has now been implemented at all VA medical centers, and has been viewed favorably by other health care providers.

Because VA is committed to transparency of its quality goals and measured performance of VA health care we have established the VA Hospital Compare website for Veterans, family members and their caregivers to compare the performance of their VA hospital to other VA hospitals.[10] The VA transparency program, ASPIRE, ensures public accountability and encourages continual improvements in health care delivery. ASPIRE is a dashboard that documents quality and safety goals for all VA hospitals. The data shows strengths and opportunities for improvement at the national, regional, and local facilities. Additionally, VA's Office of Quality, Safety, and Value publishes an extensive annual Quality and Safety Report that details all aspects of our health care quality and safety by facility. The success of the VA transparency approach is reflected in VA's receipt of the Annual Leadership Award from the American College of Medical Quality in 2010.

Mr. Chairman, VHA is the same system of care that an investigative reporter described, a few years ago, as providing "the best care anywhere".[11] In 2012, 19 of

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[4] January 2010 Position Statement - http://nursingworld.org/psjustculture; http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Just-Culture.html

[5] ??

[6] Watts B. Archives of General Psychiatry 2012; 69:588–92.

[7] Mills, P. et. al. "Reducing falls and fall-related injuries in the VA System", Journal of Healthcare Safety, Volume 1, Number 1, Winter 2003.

[8] Neily, J., et. al., (2010)

[9] Neily J. et. al., JAMA 2010; 304:1693–1700.

[10] *http://www.hospitalcompareva.gov/index.asp*

[11] Best Care Anywhere, 3rd Edition: Why VA Health Care Would Work Better For Everyone by Phillip Longman

our hospitals were recognized as top performing by The Joint Commission on key health care quality measures. We pioneered the use of electronic health records. We've created a mental health care delivery system especially designed to meet the needs of our returning Veterans. VHA operates one of the highest quality care systems for mental health services in the country. VHA recently hired an additional 1,669 new mental health providers under the President's Executive Order and established 24 pilot programs with community providers across nine states and seven Veterans Integrated Service Networks to improve access to mental health care. In addition, VA has been a pioneer in the use of telemental health, providing mental health services within primary care, and has developed and implemented services such as the Veterans Crisis Line, which provides 24/7 crisis counseling services by trained mental health providers. We have an outstanding reputation within the health care profession for providing high quality, patient centered care—and for keeping our patients safe.

But, as Secretary Shinseki has said, we can do better, and we must do better. Our internal reviews have identified, and we have informed the Committee about a number of instances in which, for one reason or another, we have not kept Veterans safe in our hospitals. In every case the Committee has identified, we—and I personally—have spent considerable time learning what happened and why it happened, and developing plans and procedures to keep the issue from happening again. Let me briefly discuss what we now know about the events in Atlanta, Buffalo, Dallas, Jackson, and Pittsburgh—and what we are doing, and will do, to prevent reoccurrences.

Pittsburgh

Since we are in Pittsburgh today, let me begin by discussing the events that have occurred at our medical center here relating to Legionella bacteria. I want to begin by expressing my deepest regret and sympathy to the families of those patients with Legionellosis who died.

The Pittsburgh Healthcare System (VAPHS) is located in Allegheny County, PA, a region with one of the highest rates of Legionellosis in the country. Because of this challenge, VHA and VAPHS have worked for many years to develop guidance and implement mitigation efforts to prevent infection.

In late summer and early fall 2012, VA Pittsburgh noticed an unusual pattern of Legionella pneumonia cases. This observation led the facility to investigate a possible environmental link between its patient cases and water system. In mid-October 2012, VA Pittsburgh worked through the Pennsylvania State Health Department to submit three patient specimens to the Centers for Disease Control and Prevention (CDC) for genetic testing. On October 30, the CDC stated they had found genetic similarities between two of the patient samples and the environmental sample from VA Pittsburgh. This finding indicated that the patients may have acquired their infection while hospitalized at VA Pittsburgh.

On November 2, 2012, VA Pittsburgh invited the Allegheny County Health Department and CDC to participate in a formal collaborative review of recent Legionellosis cases at the facility and to assist with identifying a route of transmission. Upon determining that Legionellosis was present in the hospital water system, the CDC and Allegheny County Health Department recommended immediate remediation of VA Pittsburgh's potable water system. VA Pittsburgh promptly implemented an aggressive multiphase heat and flush and hyper-chlorination effort. The health care system then instituted, and has continued, water testing every two weeks to monitor bacteria presence.

VA has one of the most comprehensive Legionellosis prevention and assessment programs in the nation. VA policy requires every Medical Center to evaluate its risk for Legionella once a year and also requires that any transplant facility also test its water system twice annually by collecting samples by water or swab.

Historically, VA Pittsburgh Healthcare System's environmental surveillance strategy for Legionella exceeded this twice a year requirement. In the April 23, 2013 OIG report pertaining to Legionnaires Disease at VAPHS, OIG recognized that VAPHS has a long history of comprehensive mitigation efforts for Legionnaires Disease. However, the report identified several areas for improvement and the Joint Commission found insufficient compliance in some areas. In addition to environmental testing, Pittsburgh conducts specific clinical testing of patients that is necessary to detect Legionnaires' disease because patients with Legionella pneumonia cannot be reliably distinguished from patients with other bacterial or viral pneumonias. Pittsburgh has tested at a very high frequency rate, indeed the highest in the VA system.

Prior to the outbreak, VA Pittsburgh testing procedures involved the use of swabs and smaller water samples. These procedures were in accordance with accepted

standards, yet we now recognize that the pre-outbreak testing procedures are less effective at detecting water-borne Legionella than the one liter collection methods recommended by CDC and currently in use at VA Pittsburgh. Despite VA Pittsburgh's historical track record of testing for Legionella more frequently than required by VA policy, health care-acquired Legionella pneumonia contributed to the deaths of five patients between July 2011 and November 2012. Every one of these deaths is a tragedy.

In July 2013, VHA reexamined the Pittsburgh facility for evidence of compliance with the IG's recommendations. Of the 60 areas reviewed, just four required additional work or documentation. These four areas did not involve water testing. Rather, they focused on using higher chlorine ranges; automating the plumbing system; improving construction projects and risk assessments; and documenting routine flushing of hot water fixtures.

There are still two investigations pending related to Pittsburgh. Once these investigations are complete, VA will determine whether additional actions will be necessary.

According to the CDC and the U.S. Environmental Protection Agency, there is no one dominant, evidence-based primary prevention strategy for controlling Legionellosis in health care settings. However, by following the recent recommendations of external and internal review teams, including VHA experts, The Joint Commission, and the IG, VA Pittsburgh has been able to aggressively monitor and successfully control the presence of Legionella bacteria in its water supply.

The facility posts pertinent updates and information on its website, and has established a hotline for Veterans and their families who have questions related to Legionellosis. In addition, VA Pittsburgh is conducting informational sessions with Veteran stakeholders, employees, congressional stakeholders and the media. VAPHS uses these sessions to relay timely information and updates about their Legionella surveillance and treatment efforts to local community partners.

Throughout VA, we have renewed our commitment to preventing health care-acquired Legionnaires' disease and are continually looking to update best practices for prevention. In addition, in Spring 2013, VHA formed the Legionella Expert Work Group to review existing policies, develop options and standards as necessary, and draft a new consolidated policy relating to Legionella. The Work Group has developed a new draft Directive. Due to the comprehensive nature and industry leading standards and processes contained in the draft, the Directive is undergoing expanded reviews. Existing Directives established guidelines for the use of basic engineering controls as a primary means for Legionella suppression. The draft Directive enhances and expands on engineering controls, establishes mandatory standards, and identifies required processes at a wider range of facility types. The breadth and scope of these elements reflect the CDC statement[12] that "there is no safe level of Legionella in a water system." On August 21, 2013, a memorandum was sent to all VA Medical Centers that provided a summary of anticipated core elements of the draft Directive to aid implementation planning. Specifically, the memorandum identifies the engineering and infrastructure resources needed for compliance with new policy.

Atlanta

I would like to convey my sorrow and apologies to the families of the three Veterans who received mental health services at our Atlanta facility last year and died. These are tragic events that VA takes very seriously.

In May 2012, VA's IG received a hotline complaint alleging mismanagement and lack of oversight of care provided by the DeKalb Community Service Boards (CSB), which offer mental health care to Veterans referred to them by the Atlanta VA Medical Center under a contract managed by the facility. Later, the IG received an additional complaint that mismanagement may have contributed to the death of a patient on the facility's inpatient mental health unit. In April 2013, the IG issued two reports based on their investigation of those complaints, finding that VA facility managers did not provide adequate staff, training, resources, support, and guidance for effective oversight of the facility's contracted and inpatient mental health programs. We take these findings seriously.

Three patient deaths, including two suicides and an accidental overdose, were linked to the problems identified in the reports. The two suicides were related to inadequate oversight of contracted care; and the accidental overdose was linked to inadequate supervision of inpatients. A fourth death, also a suicide, of a Veteran

[12] CDC Testimony, February 5, 2013, before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, U.S. House of Representatives.

who had recently been treated at the Atlanta VAMC facility as an outpatient, was not related to the matters that were the subjects of the IG's investigations.

In response to these reports, VISN 7 and the Atlanta Medical Center have taken aggressive corrective actions to address all of the identified deficiencies. They have implemented system improvements to ensure patient safety both within the Medical Center and at its contract care facilities. The inpatient program improvements include new procedures for supervised urine drug screens, visitor and hazardous item management, and escorts for patients who are required to be off the locked inpatient unit. VA is also in the process of completing nationwide guidance on these same areas.

The Atlanta VA has significantly improved its monitoring and management of their contract mental health program. The facility has reduced the number of contracts it has with mental health organizations from 26 to five, and strengthened the contract's quality assurance monitors. VA licensed clinical social workers are embedded in the CSB sites to coordinate care for Veterans, and the facility has created a database to track clinical and financial data for every referral.

At present, 90 percent of Veterans served by the Atlanta VA receive new non-urgent mental health care appointments within 14 days, and the average wait time for a new appointment is 7 days. The Medical Center has a new long-term plan and new initiatives in place to expand mental health services and enhance access for Veterans. Among these are the expanded outpatient mental health services at the new health care facility at Fort McPherson, and a domiciliary that will open there in late Fall. These corrective measures and new initiatives have already improved the safety and quality of services at Atlanta and will continue to do so.

The Medical Center provides same day access for Veterans with urgent mental health needs, through the facility's Mental Health Assessment Team and its Evaluation, Stabilization, and Placement Clinic for Substance Abuse Disorders. The Mental Health Evaluation Team fully evaluates all Veterans referred for contract care before a referral is made. Atlanta also has an emergency department annex for mental health needs—this annex is open 24 hours a day, 7 days a week.

Jackson

On March 18, 2013, the Office of Special Counsel (OSC) sent a letter stating that OSC had found a pattern of issues at the Jackson VA Medical Center that are indicative of poor management and failed oversight. The letter cited five separate complaints received from facility employees since 2009.

Three of the complaints concerned allegations relating to the Sterile Processing Department. The letter alleged that poor sterilization procedures existed; that VA made public statements mischaracterizing previous investigative findings about the facility's sterilization procedures; and that VA had failed to properly oversee corrective measures within the Sterile Processing Department. The letter also cited complaints alleging chronic understaffing of physicians in primary care clinics; lack of proper certification for nurse practitioners; improper nurse practitioner prescribing practices for narcotics; and missed diagnoses and poor management by the Radiology Department. All of these complaints were referred to VA for investigation pursuant to 5 U.S.C. § 1213.[13]

At the time the March 18 letter was received, VA had already investigated the three whistleblower allegations relating to the Sterile Processing Department, responded to OSC, and taken actions in response to these allegations. Jackson has implemented stringent oversight processes to ensure reusable medical equipment is cleaned and sterilized according to manufacturers' instructions before every use. The hospital has also invested more than a million dollars into state-of-the-art reprocessing equipment to ensure proper cleaning and sterilization, and has transitioned to the use of more disposable devices when those are available. After receiving the March 18th letter, VA initiated a quality of care review of the sterile processing services at the facility. The review found that the VAMC now utilizes effective systemic processes to safely perform the re-processing of all critical and semi-critical reusable medical equipment in the facility.

The other two complaints discussed in the March 18 OSC letter had been referred to VA on February 29 and March 5. The February 2013 complaint involved the Pri-

[13] Pursuant to 5 U.S.C. § 1213, when the Special Counsel determines that there is a substantial likelihood that the information from a whistleblower discloses a violation of any law, rule, or regulation, or gross mismanagement, gross waste of funds, abuse of authority, or substantial and specific danger to public health and safety, the Special Counsel transmits the relevant information to the appropriate agency head and requires that the agency head conduct an investigation with respect to the information and any related matters transmitted by the Special Counsel to the agency head, and submit to OSC a written report setting forth the findings of the agency head.

mary Care Unit at the Jackson VAMC, and the March 2013 complaint contained allegations concerning the accuracy of certain interpretations by a VA radiologist who is no longer a VA employee. In response to these OSC referrals, we appointed a review team from outside the VISN to conduct a full investigation of the two new cases.

VA's reports on these two investigations were delivered to OSC on July 16 and July 29 and are currently under review by the Special Counsel. The findings and recommendations from these reports have been shared with the facility and the VISN, and efforts are underway to implement all of the recommendations in the reports.

On May 24 and June 12, OSC referred two additional complaints to VA for investigation. These referrals concerned pharmacy operations and the credentialing and privileging processes at the Jackson VAMC. VA's report on the credentialing and privileging matter was delivered to OSC on August 15. The VAMC is revising its process to ensure it is consistent with VHA policy. The Medical Center will ensure all members of its Executive Committee of the Medical Staff have equal access to review all credentialing and privileging folders prior to submitting its recommendations to the Director for approval. The report concerning pharmacy operations was delivered to OSC on August 27.

On April 3, 2013, VHA hosted a town hall meeting in downtown Jackson. The Under Secretary for Health was among the speakers at the meeting, which was attended by nearly 300 Veterans, facility staff members, and other community partners. During the town hall meeting the participants discussed many of the issues covered in the OSC letters and other issues of concern to Veterans. The Medical Center Director and other facility leaders maintain an open door policy for Veterans to speak with them about their concerns, and the Director has personally addressed the comments provided by them on comment cards at the town hall meeting.

Since October 2011, Jackson has undergone 108 consultative program reviews, site visits, and external surveys, including recent unannounced visits from The Joint Commission, the IG, the OMI, and the Occupational Safety and Health Administration. Recent recommendations have been minor, and Jackson is accredited by all appropriate agencies, including The Joint Commission.

Buffalo

On November 1, 2012, the Chief of Pharmacy at the VA Western New York Health Care System's Buffalo VA Campus discovered a collection of single-patient insulin pen injectors in the supply drawer of a medication cart without patient labels affixed to them. This type of insulin device was intended for individual patient use but was found to have been used on multiple patients by some nurses. Once the insulin pen misuse was detected, the facility removed all pens from usage on inpatient units. The Medical Center leadership immediately began the process to identify those Veterans admitted between October 19, 2010, when insulin pens were put into use, and November 1, 2012. In addition to this internal review, the facility convened a Root Cause Analysis to thoroughly investigate this medication administration practice.

The practice at Buffalo had been for the pharmacy to issue these pens to inpatient units at the facility, however, the pharmacy did not label the pens with instructions to be used "for individual patients only" prior to their distribution to the units. Nursing practice on the units was to print and place individual patient labels on pens when they were removed from the cart. According to an IG report on this event, some nurses did not follow the intended practice and assumed that the insulin pens operated the same as a multi-dose insulin vial, changing needles between patients while using the same insulin pen. This variation in usage was also identified by the facility's leadership finding that deficiencies related to nursing education and medication administration surveillance were specific to the usage of the pen.

Inappropriately using single-patient use pens on multiple patients carries the potential of blood borne pathogen exposure. VA's National Center for Patient Safety (NCPS) reviewed the extent of the problem VA-wide. This review noted the possibility that other VA medical centers could have potential patients at risk from insulin pen injectors. A review of system-wide data from fiscal year (FY) 2012 revealed that 90 percent of inpatient use of insulin pens across VA was concentrated in 5 VA medical centers, including VAWNYHS. Given the vulnerabilities identified in the use of these devices, each of these VA medical centers specifically reviewed their use of the insulin pens.

Eighty-two VA medical centers, accounting for the remaining 10 percent of inpatient use of insulin pens, had very low use in FY 2012 (average of 9 inpatients per VA Medical Center). A VA request for data on January 9, 2013, reported no insulin pen events in these low use facilities. In January 2013, the Buffalo facility identified

at-risk patients and began to notify 544 at-risk patients, consisting of those who had inpatient stays and orders for subcutaneous insulin during the two-year period the pens were in use. As of August 9, 2013, all patients have been contacted with the exception of two who have not responded to phone calls or mail. Veterans were informed of potential misuse of the pens, and offered testing for blood borne pathogens, and related care as needed. VA's Office of Public Health is conducting an epidemiological study using advanced genetic testing to draw any inferences about cause and effect.

As a result of the findings at the Buffalo VAMC, VA's NCPS published a Patient Safety Alert on January 17, 2013, prohibiting the use of multi-dose pen injectors, including insulin pens, on all VA patient care units with a few specific exceptions. The Alert also requires all facilities to update local policies regarding storage, labeling, and education of staff for safe use, which Buffalo has done. NCPS has communicated with the Food and Drug Administration to investigate potential safety improvements in the design and labeling of insulin pen injectors to ensure their safe use at all hospitals throughout the United States.

The IG report related to insulin pen usage at Buffalo states that the use of insulin pens on multiple patients was not a practice limited to VA. The report states that in January 2013, a private sector New York State hospital conducted an internal review in response to news media coverage of the Buffalo VAMC incident and determined that they may also have reused insulin pens. The private sector hospital identified more than 1,900 patients who required notification regarding potential exposure to blood borne pathogens.

Other patient safety organizations have since followed VA's lead. After NCPS worked with officials from the Institute for Safe Medication Practices[14], on February 7, 2013, the Institute issued a recommendation that all hospitals, public and private, discontinue the usage of multi-dose insulin pens within inpatient settings. Additionally, on March 25, the New York State Department of Health released guidelines related to the safe usage of insulin pens to all hospitals within the state.

Buffalo itself identified the issue, ensured that the inappropriate practice was stopped immediately, performed its own investigation, and took proactive steps to notify patients. All corrective steps based upon the facility's own recommendation, and the IG's recommendations, have been implemented. The Joint Commission conducted an out-of-cycle quality management review in June, which confirmed that all corrective actions related to insulin pen usage were taken and are in place.

Dallas

In response to congressional concerns regarding the operations and management of the VA North Texas Health Care System (VANTHCS) in Dallas, VA formed a review team comprised of senior leaders from throughout the VA system to review the concerns.

The team conducted a site visit to the facility during the week of July 15, 2013. They performed a review of the following areas: organizational behavior, leadership, and communication at the facility; the facility's quality management and patient safety programs; the employee and staff work culture environment; and the facility's clinical operations and patient outcome data. VHA will take any appropriate actions based on the recommendations of the review team.

Before I close, Mr. Chairman, let me address the issues of accountability and performance awards without going into any specific cases. The responsibilities of Network Directors and Medical Center Directors are vast and complex. No matter how well they do their jobs, they are certain to face adverse events in their areas of responsibility.

The performance of VA Senior Executives, including my own, is measured against a stringent and standardized performance measurement process. Both Network Directors and Medical Center Directors are evaluated using predetermined criteria in an annual performance plan contract. Performance awards are provided to senior leaders in response to their accomplishments as measured against their established performance contracts; their ability to lead change; and their impact on the organization's overall performance.

Individuals at all levels of our system, to include leaders, are empowered to take aggressive corrective actions that are necessary at each facility. When adverse events occur, there are many ways to hold people accountable, including removing the person from the position in which they serve. I can ensure you we are holding the appropriate people accountable as a result of management and oversight issues

[14] The Institute for Safe Medication Practices is the nation's only 501c (3) nonprofit organization devoted entirely to medication error prevention and safe medication use. ISMP is certified as a Patient Safety Organization by the Agency for Healthcare Research and Quality.

at the facilities that are the subject of this hearing. Because this is an open hearing, with members of the public present, by law I am not at liberty to provide specifics about what has been done in individual cases.

In fiscal year (FY) 2012, VHA treated 6.3 million unique patients at our 152 hospitals, 821 community based clinics, and 300 Vet centers. VHA had more than 700,000 Veterans admitted to our facilities as inpatients in FY 2012 and 83.6 million outpatient visits occurred at our hospitals and clinics.

The overwhelming majority of those visits were successfully completed, and we know Veterans and their families were satisfied with the outcomes as evidenced on our patient satisfaction surveys, which consistently show that our patients experience a level of satisfaction comparable to the private sector. The preponderance of evidence affirms that at the system level, Veterans are being well-served through a highly-effective integrated health care system that is administered by a caring and effective workforce.

What I can commit to you today is that VHA will never be satisfied when something—anything—goes wrong at one of our facilities, and the issue is in any way remotely our fault. I am always deeply concerned, as is my staff, whenever I learn of adverse events Veterans have experienced as a result of medical or system errors.

We will continue to train all VHA employees in proper patient safety techniques, and we will continue to investigate and make full disclosures following any injury to a patient.

We will continue to build a health care environment in which staff understands what constitutes an adverse event, and in which senior leaders endorse a culture of safety; one in which staff feel safe to report patient safety risks, and are empowered to make changes that will prevent those events in the future. Such an environment is characterized by increasing reporting and monitoring.

Finally, we will continue to identify, mitigate, and prevent vulnerabilities within our health care system, wherever we find them. And when adverse events do occur, we will identify them, learn from them, and improve our systems to prevent these incidents from happening again. This is commitment that requires constant vigilance, self-reporting, openness, and accountability.

Mr. Chairman, this concludes my testimony. VA will continue to ensure accountability and seek continuous improvement as it delivers high quality health care to our Nation's Veterans. I appreciate the Committee's continued interest in the health and welfare of America's Veterans. At this time, my colleagues and I are prepared to answer your questions.

Questions For The Record

Questions for the Record from the Honorable Jeff Miller, Chairman

1) During the field hearing, VA Under Secretary for Health Robert Petzel testified that, "I would agree that reviewing performance awards is appropriate" in response to a question I asked about the need for a "top to bottom" review of VA's bonus system. **When will this "top to bottom" review begin? Who will be in charge of it? When do you expect the review to be completed? Please provide the results of the review to the Committee upon completion.**

2) For months, VA has been telling the press and the public that VISN 4 Director Michael Moreland's $63,000 bonus as part of the Presidential Rank Award he accepted in April 2013 was under review. **When do you expect this review to be completed? Who has been in charge of it? Please provide the results of the review to the Committee upon completion.**

3) For months, VA has been telling the press and the public that fiscal 2012 performance awards for some senior executives in the Pennsylvania and Southeast medical networks have been deferred pending further review "and are not being paid at this time." **When do you expect this review to be completed? Who has been in charge of it? Please provide the results of the review to the Committee upon completion.**

Responses From: U.S. Department of Veterans Affairs, To: Chairman Miller

1. During the field hearing, VA Under Secretary for Health Robert Petzel testified that, "I would agree that reviewing performance awards is appro-

priate" in response to a question I asked about the need for a "top to bottom" review of VA's bonus system. When will this "top to bottom" review begin? Who will be in charge of it? When do you expect the review to be completed? Please provide the results of the review to the Committee upon completion.

VA Response: The Department of Veterans Affairs (VA) acknowledges the importance and significance of a comprehensive review of its performance awards.

In April 2013, VA's Corporate Senior Executive Management Office (CSEMO) completed an agency-wide review of VA's Senior Executive Service (SES) performance management system as part of VA's request to the Office of Personnel Management (OPM) for recertification. OPM's certification criteria for SES performance management system includes a review of all aspects of the system, including executive training, alignment of expectations with the strategic plan, individual and organizational performance measures, oversight, rating distinctions, award differentiation, and transparency throughout the process. OPM, with the concurrence of the Office of Management and Budget (OMB), determined that VA's SES performance management system warranted full certification, which was granted on May 6, 2013, and continues through May 6, 2015.

VA is required to report annually to OPM about the application of VA's SES performance management system. OPM annually reviews VA's distribution of ratings and awards in an effort to ensure that VA is making meaningful distinctions in ratings and providing awards that reflect performance. The attached letter from Ms. Elaine Kaplan, Acting OPM Director, transmits OPM's formal certification of VA's SES performance management system.

2. For months, VA has been telling the press and the public that VISN 4 Director Michael Moreland's $63,000 bonus as part of the Presidential Rank Award he accepted in April 2013 was under review. When do you expect this review to be completed? Who has been in charge of it? Please provide the results of the review to the Committee upon completion.

VA Response: VA has reviewed the process by which Mr. Michael Moreland was nominated for the Presidential Rank Award. Prior to submission, Mr. Moreland's nomination for the Presidential Rank Award was reviewed by the VA Presidential Rank Award Review Committee and then submitted by the Secretary of VA to OPM. At OPM,

Mr. Moreland's nomination was evaluated by a group of private citizens prior to its recommendation to the White House. Mr. Moreland's award was given prior to any awareness of the potential of preventable legionella deaths in one of the hospitals Mr. Moreland oversaw as its Veterans Integrated Service Network (VISN) Director.

3. For months, VA has been telling the press and the public that fiscal 2012 performance awards for some senior executives in the Pennsylvania and Southeast medical networks have been deferred pending further review "and are not being paid at this time." When do you expect this review to be completed? Who has been in charge of it? Please provide the results of the review to the Committee upon completion.

VA Response: Reviews of deferred performance ratings for certain VHA senior executives remain in process. Each affected SES employee is entitled to due process including a full and transparent review of all facts and circumstances regarding their performance. Furthermore, because the reasons for each deferral are different, the length of the review process can vary. VA will provide the Committee with additional information after completion of this process.

Statement For The Record

Congressman Brian Higgins, NY-26

I want to thank you for holding this very important hearing, and I commend the committee's commitment to making the health and safety for our veterans a top priority.

The Veterans Health Administration is America's largest integrated health care system with over 1,700 sites of care, serving 8.3 million Veterans each year. Given the recent revelations of deaths and infection disease outbreaks, it is incumbent on this committee and the Congress en masse, to ensure that the VA has proper man-

agement and accountability structures in place to stop the emerging pattern of preventable patient-safety issues at VA medical centers across the country.

As the committee is aware, at the VA facilities serving my community – the VA Western New York Healthcare System – a series of health safety issues have compounded to form a troubling pattern incompetence and preventable bureaucratic inefficiency. From issues surrounding the improper use of insulin pens, to the mismanagement of Medical Records, to the improper staffing of the emergency department, our veterans have been let down and their safety compromised. I encourage the committee to continue to look into these events to ensure they are never repeated.

Insulin Pen Misuse

On November 1, 2012 staff at WNYHCS discovered that insulin pens intended for individual patient use were being incorrectly used for multiple patients. In January 2013, the VA disclosed that between October 19, 2010 and November 1, 2012, 716 patients at the Buffalo VA Medical Center may have been exposed to HIV, hepatitis B or hepatitis C because nurses and medical personnel improperly reused insulin pens on multiple patients.

The insulin pen issue was investigated by the VISN 2 Network Office, WHYHCS, and VA's Office of Inspector General. They found multiple factors leading to the misuse of the pens including: lack of stable nursing leadership during the time of implementation, lack of training and education, length of time between training and actual implementation, and absence of a warning placed on the insulin pens themselves.

The VA Office of Inspector General Report (OIG) issued in May 2013 disclosed that twenty veterans treated at the Buffalo VA tested positive for hepatitis, fourteen of which tested positive for hepatitis B and six for hepatitis C.

Mismanagement of Records

Earlier this year, the Office of Special Counsel (OSC) investigated whistleblower information about poor record keeping and serious mishandling of medical records at both the Buffalo and Batavia VA sites. In May 2013, the OSC issued a report finding that for at least eight years, 20,000 to 30,000 medical files were randomly thrown in boxes and not maintained in accordance with requirements for records management, Social Security numbers were sometimes not properly attributed to the correct veteran name or mislabeled entirely, mold infested files were not handled properly to prevent further contamination and to ensure their restoration, and on several instances when veteran records were requested, rather than searching for information, staff deemed the documents to be "unavailable."

Timeline:

January 17, 2012

The employees initially report to the Director of VA Health Care Upstate New York that During a record retirement project they found five boxes contaminated with mold and were ordered the workers to put the moldy files in new boxes and ship them to a storage facility in Missouri – a violation of agency rules.

January 27, 2012

The Director instructed the facility's Associate Medical Director to review the claims and he reports back that his review "did not substantiate any of the concerns"

February 8, 2012

The employees turned whistleblowers met with the Associate Medical Director to reiterate their complaint about the records at Batavia

May 1, 2012

the whistleblowers file a complaint with the Office of Special Counsel and they notify Secretary Shinseki

September 6, 2012

The VA releases the findings from their investigation confirming the majority of the employees' concerns

February 4, 2013

the VA asserts that corrective actions related to the recommendations were completed

Investigation:

The internal VA investigation unveiled systemic problems with record-keeping in Buffalo and Batavia that would have affected not only the records of hospital patients, but also veterans who visited VA facilities for outpatient services. The VA's response showcased a complete lack of accountability. The OSC contacted the VA to determine whether any disciplinary action was taken as result of the investigation and the VA General Counsel responded that individuals received "written counseling" to ensure they understood the severity of the findings of the report, and were provided a point of contact for future guidance. The Associate Medical Director who did the initial check after the whistleblowers complained to him and concluded in his review that it "did not substantiate any of their concerns" was not disciplined but credited for his role with responding quickly, providing appropriate oversight and fully cooperating.

Improper Staffing in Emergency Department

On April 26, 2011, the OIG's Hotline Division received an anonymous complaint regarding quality of care and physician staffing in the Emergency Department (ED). Specifically, a complainant alleged that the facility appointed an ED physician who was considered "unsafe," and, following the physician's first ED shift, three patients treated by this physician required return visits to the ED. Further, the number of physicians has been insufficient to staff the ED since November 2010, resulting in "long shifts" and impacting patient care.

A Feb 2012 VA OIG report found that the Emergency Department at the Buffalo VA has been understaffed since at least November 2010, resulting in questionable appointment decisions by facility managers, as well as quality of care concerns. The OIG also found that facility managers had previously identified quality of care concerns with the physician, yet they had not taken appropriate corrective actions in response to these concerns, as required by VHA policy.

VA Responses

In response to the respective issues the Department of Veterans Affairs initiated reviews of the practices at the Buffalo VA Medical Center. These reviews and subsequent reports revealed several layers of systemic inefficiencies and proposed numerous recommendations to address them. The VA concurred with the recommendations and committed to conduct further reviews of policies and procedures to ensure inappropriate actions are prevented in the future. With the insulin pen issue the VA responded that all recommendations by OIG have been complied with as of May 31, 2013. With the medical records the VA responded that as of February 4, 2013 all required actions for WNYHCS Buffalo have been completed and additional records management training for all file room and medical center leadership have been completed. With regard to the understaffing of the emergency division, The VISN and Interim Facility Directors concurred with the findings and recommendations and provided an acceptable action plan.

In dealing with these issues I have had several discussions with the leadership at the Department of Veterans Affairs, and recently Undersecretary for Health Robert A. Petzel, walked me through the reforms implemented at the VA Western New York Health System in response to these incidents. Though most of these reforms have been implemented or are being implemented, one of Congress' most important roles is to conduct oversight. It behooves us to aggressively conduct this role to ensure that reforms are implemented on time and system wide, assuring the public that these incidents will never occur again.

I want to thank the committee again for holding this important hearing and I appreciate the opportunity to testify on this important issue.

Submission For The Record

THE VETERANS HEALTH ADMINISTRATION (VHA)

Report to the Office of Special Counsel (OSC)

OSC File Number Dl-12–3816

G.V. (Sonny) Montgomery Department of Veterans Affairs (VA) Medical Center

Jackson, MS

Report Date: June 21 , 2013

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

Executive Summary

Summary of Allegations

At the direction of the Secretary, the Under Secretary for Health requested that the Office of the Deputy Under Secretary for Health for Operations and Management send a team of subject matter experts to investigate a complaint filed with the Office of Special Counsel (OSC) by Dr. Phyllis Hollenbeck, a primary care physician and Whistleblower, at the G.V. (Sonny) Montgomery Department of Veterans Affairs (VA) Medical Center in Jackson, Mississippi (hereafter, the Medical Center). Dr. Hollenbeck asserts that employees are, or have, engaged in misconduct that may constitute a violation of law, rule, or regulation, gross mismanagement, and abuse of authority that may create a substantial and specific danger to public health and safety at the Medical Center. The Whistleblower alleged, in brief, that:

- The Medical Center did not have a sufficient number of. physicians in the Primary Care Unit (PCU), resulting in failure to provide adequate care for patients and proper supervision of Nurse Practitioners {NP), who provide the majority of patient care services {Allegation #1);
- Inadequate physician staffing levels resulted in failure to properly supervise NPs, which violates state licensure agreements, resulting in NPs practicing without proper certification (Allegation #2);
- Inadequate physician staffing levels resulted in numerous fraudulently completed Centers for Medicare and Medicaid Services (CMS) home health certifications/forms for patients (Allegation #3); and
- Narcotics were improperly prescribed, e.g., physicians prescribe narcotics for patients they had not treated (Allegation #4).

The investigative review team conducted a site visit at the Medical Center from April 15, 2013, through April19, 2013, and reviewed submitted documents; a second site visit was conducted by select team members on May 7 and May 8, 2013 to obtain and review additional staffing-related documents.

Conclusions for Allegations #1 and #2

Due to the complexities and interconnectedness of allegations #1 and #2, the team elected to investigate and dissect the two allegations concomitantly, including the findings and recommendations for both.

- The review team substantiates that the Medical Center does not have a sufficient number of physicians in the PCU and NPs have not had appropriate supervision/collaboration with Physician Collaborators.

The review team did not substantiate that inadequate care was provided (even with the noted scheduling problems). It is the professional expert opinion of the review team that there are enough problematic indicators present to suggest there may be quality of care issues that require further review. Although the review team found that all NPs have requisite certifications and licenses, NPs in the PCU were

erroneously declared as Licensed Independent Practitioners (LIP}, and the required monitoring of their practice did not consistently occur resulting in NPs practicing outside the scope of their licensure.

- The Medical Center's policy permitting NPs to practice as LIPs when that practice is not authorized by their individual state Practice Acts violates VHA policy. Only the two NPs licensed in Iowa are allowed to practice as LIPs.
- Granting NPs clinical privileges when they are not LIPs violates VHA policy. Only the two Primary Care NPs licensed in Iowa are allowed to be granted clinical privileges; all others must have a scope of practice.
- There is a lack of understanding among Medical Center leadership regarding NP practice and licensure requirements. This is evident by the fact that leadership erroneously declared NPs as LIPs and granted clinical privileges, yet they have also stipulated that NPs must have collaborative agreements per individual state licensing board requirements. This is further confounded by the fact that, despite requiring collaborative agreements (which is the correct approach), leadership has not implemented a process for ensuring all required collaborative agreements are in place, and the appropriate monitoring of NP practice by Physician Collaborators occurs.
- Ten of the 13 NPs currently practicing at the Medical Center and whose licenses require collaborative agreements have an approved collaborative agreement in place.
- Many, if not most, of the Primary Care NPs have not complied with state licensing board requirements for ensuring their practice is appropriately monitored by their Physician Collaborators, such as chart reviews and face-to-face meetings with the Physician Collaborator. In addition, the Medical Center has no process in place to ensure monitoring requirements are met.
- State requirements vary as to the appropriate ratio between NPs and a Physician Collaborator. Some states set no MD-to-NP ratio requirement. Others establish a ratio of 1 :3, 1 :4, or more. There should be a reasonable limit to the number of NPs per Physician Collaborator to ensure appropriate medical direction and supervision by the Physician Collaborator is provided, consistent with the terms of the collaborative agreements. We are aware that in March 2013, the Mississippi Board of Medical Licensure amended Rule 1.3 of Chapter 1 of Part 2630 of the Mississippi Administrative Code to state, in relevant part: "Any one Physician should have no more than four collaborative agreements." [See Mississippi Administrative Code, Part 2630, Chapter 1, Rule 1.3], Requirements for collaborating physicians, which states: "Physicians are prohibited from entering into primary collaborative agreements with more than four Advanced Practice Registered Nurses at any one time unless a waiver is expressly granted by the Board for that particular collaborative agreement." According to a notice on the Board of Medical Licensure's Web site, implementation of the amendment is suspended until July 31 , 2013. The consensus among team members is that the ratio should be limited to four or five NPs to one Physician Collaborator. Clearly, the one Medical Center Physician Collaborator, who has 14 current collaborative agreements, is in violation of this state requirement.
- All Medical Center PCU NPs currently have the required state NP licenses and national NP certifications.
- There was no evidence to indicate that the former Chief of Staff, Dr. Kent Kirchner, had 160 collaborative agreements, as alleged by the Whistleblower. The review team found evidence that Dr. Kirchner had only four collaborative agreements with Primary Care NPs during the review period of 2010 to present.
- The Medical Center PCU has an insufficient number of physicians.
- The NPs in the PCU have panel sizes that generally exceed VHA guidelines.
- Clinical quality data, available Ongoing Professional Practice Evaluation data, and the fact that only one provider has been reported to the National Practitioner Data Bank since October 1, 2010, for either a tort claim settlement or an adverse action against clinical privileges relating to the quality of care, are indicators that the Medical Center PCU staff is providing quality care. However, the following additional problematic indicators led the review team to conclude further review of the following needs to be conducted in order to explicitly declare that appropriate and adequate high quality care has been provided in the Medical Center PCU:

- Insufficient physician staffing;
- Sporadic tenure of Locum Tenens physicians;
- NPs functioning as LIPs, when in fact they are not;
- Failure to appropriately monitor the clinical practice of NPs;
- Lack of timely response by providers to Computerized Patient Record System View Alerts;
- Multiple patient appointment scheduling problems (e.g., double books, Vesting Clinic/Ghost Clinic); and
- Large volume of patient complaints regarding access to, and timeliness of, care

- The Medical Center NPs appear to be appropriately identifying themselves as NPs to their patients.

In summary, the team substantiates the Medical Center does not have a sufficient number of physicians, and NPs have not had appropriate supervision and collaboration with Physician Collaborators. The team did not substantiate that inadequate care was provided even with the noted scheduling problems. However, there are enough problematic indicators present to suggest there may be quality of care issues that require further review. Although the team found that all NPs currently have requisite NP certifications and licenses, NPs in the PCU have been erroneously declared as LIPs, and the required monitoring of their practice has not consistently occurred. NPs were potentially practicing outside the scope of their licensure and not appropriately monitored by Physician Collaborators.

Recommendations for Allegations #1 and #2

- The Medical Center leadership must immediately correct the erroneous declaration that all NPs will practice as LIPs.
- Medical staff bylaws must be amended to indicate that NPs are considered LIPs only when their state licensure permits or VA policy changes occur.
- The Medical Center leadership must immediately implement scopes of practice versus clinical privileges for NPs, who are not permitted to practice as LIPs.
- The Medical Center leadership must immediately ensure that all NPs who require collaborative agreements, in fact have them, and that they are approved by the NP's respective state licensing board.
- The Medical Center leadership should ensure the equitable distribution of collaborative agreements among physicians, and a reasonable limitation should be placed on the number of collaborative agreements for any one physician. If a state's Nursing Practice Act establishes a limitation on the number of collaborative agreements that a collaborating supervising physician may have with an NP at any one time, then the Medical Center needs to comply with such requirements.
- The Medical Center leadership should eliminate use of Locum Tenens physicians in the PCU to the extent possible.
- Locum Tenens physicians should not be allowed to be Physician Collaborators because of their short tenure.
- The Medical Center leadership must immediately implement a process to ensure that appropriate monitoring of NP practice by Physician Collaborators occurs and is documented in accordance with state licensure requirements.
- The Medical Center leadership must continue to aggressively work to hire permanent full-time physicians for the PCU to obtain an NP:MD ratio of 1:1. Once an adequate number of physicians is hired, the facility should reduce panel sizes for NPs to meet Veterans Health Administration (VHA) guidelines.
- The Medical Center leadership should consult the Office of Workforce Management and Consulting in VA Central Office to ensure they are utilizing all available resources to recruit primary care physicians.
- The Medical Center leadership should eliminate the use of Ghost Clinics. All clinics must have an assigned provider.
- The Medical Center leadership should eliminate the use of overbooked and double-booked appointments to the extent possible. The Medical Center leadership needs to implement the principles of open access scheduling, which means patients receive care when and where they want or need, including on the same day if so requested.

- The Medical Center must convert six-part credentialing and privileging folders to the electronic VetPro system, as required by VHA leadership.
- Veterans Integrated Service Network (VISN} 16 leadership should arrange for an external clinical quality review of all primary care at the Medical Center, particularly in light of the evidence that electronic View Alerts were often not being reviewed by physicians in a timely fashion, and NPs were practicing outside the scope of their licensure. The Medical Center should conduct a clinical care review of a representative sample of the patient care records for all 42 NPs, as well as all physicians, who worked in the PCU from January 1, 201 0, to present. The VISN should work with facility leadership to determine the sample size needed to ensure that the quality of care delivered by all of these providers was appropriate. If any clinical care issues are identified, the facility should consider expanding the sample. Specific cases involving unresolved questions as to quality of care should be referred to the Office of the Medical Inspector for further investigation.
- VISN 16 leadership should actively assist the Medical Center to implement these recommendations (and any others it deems necessary to ensure quality care is consistently rendered and available to PCU patients) through an approved action plan; and be responsible for submitting the action plan to the Under Secretary for Health along with periodic status reports (through to completion of all items).
- VHA should consider issuing an Information Letter (IL) to reinforce across the system the need for compliance with both NP state licensure requirements and with national policies on NP credentialing, privileging, and scopes of practice. Such guidance should identify Regional Counsel as an important resource for the facilities as they review program compliance requirements.

Allegation #3: Inadequate Staffing Results in the Improper Completion of Medicare Home Health Certificates/Forms

Conclusion for Allegation #3

The team cannot substantiate the allegation that CMS home health certificates/forms are/were completed inappropriately and in violation of Federal law because the Medical Center's PCU staff has not followed statutory and regulatory requirements of the Medicare home health program. However, the team cannot rule out that the allegation may have some merit given the noted statements of interviewees and the team's substantiation of allegations related to the lack of supervision of NPs and the lack of necessary collaborative agreements between collaborating physicians and the NPs.

Recommendation for Allegation #3

To determine whether Medicare home health certification forms are/were being appropriately completed by the PCU providers, VHA should task the appropriate VHA offices, e.g., the VHA Office of Compliance and Business Integrity and the Office of Patient Care Services, Home Health Program, to work together to conduct a random check of Medical Center PCU patient charts to determine if any Medicare forms are present, and if so, whether they were completed appropriately. Such findings need to be reported to the VHA Under Secretary for Health, who will then need to consider if any follow-up action is necessitated. Additionally, facility leadership should consider development of a training and educational module for completion of these forms to ensure PCU and other staff are aware of Medicare compliance requirements.

Allegation #4: Facility Uses Improper Procedures for Issuing Narcotics Prescriptions

The team fully substantiates the allegation that past Medical Center management advised its NPs, most of whom are licensed in Mississippi, that they did not need to obtain individual (Drug Enforcement Administration (DEA) registration or file it with the Mississippi Board of Nursing (BON), since they could rely on the institutional registration with a suffix. Further. the team found that the allegation that NPs in the PCU, including "grandfathered" NPs, were allowed to write narcotics prescriptions under the facility's institutional DEA registration number, which is in violation of Federal and State law.

Conclusions for Allegation #4

- Medical Center leadership was under the impression that all providers were allowed to use the institution's generic DEA number, as long as the provider was working within the scope of a VA provider. In fact, as explained above, as a

matter of Federal law and VA policy, where a practitioner's state of licensure requires individual DEA certification in order to be authorized to prescribe controlled substances, the practitioner may not be granted prescriptive authority for controlled substances without such individual DEA certification. Thus, with respect to NPs whose state of licensure required individual DEA certification to prescribe controlled substances, we substantiated the Whistleblower's allegations that the Medical Center's practice violated Federal law and VA policy.

- As of the writing of this report, all NPs are licensed as an NP in a state and are certified nationally as an adult or family practice NP, including the two NPs still at the Medical Center, who were originally grandfathered in from the NP licensure requirement. Grandfathered in NPs are not exempt from meeting any additional requirements by their state of licensure for obtaining prescriptive authority for controlled substances.
- When management was made aware that not all NPs were authorized by their license to write prescriptions for controlled substances, they took immediate action to stop the practice and attempted to put the prescribing back in the hands of staff physicians. The team confirmed that some, but not all, staff physicians agreed to renew prescriptions based on a records review alone; thus, we substantiated the whistleblower's allegations.
- When management learned that this practice was also improper because a face-to-face physician/patient encounter was required, they created the Locum Tenens clinic as a stop gap measure. Patients were physically seen by these physicians, and prescriptions written appropriately. These clinics continued until the NPs obtained their own DEA certificates. Current prescribing practices comply with Federal law and VHA policy.

Recommendations for Allegation #4

- The three NPs who have not yet received their individual DEA certificates should be encouraged to obtain them as soon as possible. Until that time, the NPs should not write prescriptions for controlled substances, and should rely on the collaborating physicians to write these prescriptions, as necessary.
- The NP functional statement, qualification standards, and dimensions of practice of the facility must be revised to be consistent with national policy per VA Handbook 5005, Appendix G6.
- The facility must complete a clinical care review of a random sample of the patient care records for the NPs who were prescribing controlled substances, outside of the authority granted by their license. This review should focus on patients who were actually prescribed controlled substances. A sample of at least 10 percent should be completed. If any clinical issues are identified, the review should be expanded.
- Facility policies and bylaws concerning the practice of NPs should be updated, to reflect VA national policies and the licensure and DEA requirements for this profession. Functional statements should be updated to reflect all current regulations.

Summary Conclusion

In conclusion, the team determined that certain Federal laws and regulations, as well as state laws, may have been violated. These are outlined in detail in the report. Additionally, the team determined that due to mismanagement, both VA and VHA policy may not have been followed , specifically credentialing and privileging and VHA outpatient scheduling processes and procedures. While no changes in agency rules, regulations, or practices should be taken as a result of this investigation, the fact-finding team made a number of recommendations for the Medical Center to adhere to/or enforce current rules, regulations, practices, and policies, as noted in the report and summarized in this Executive Summary. There was no evidence of abuse of authority; however, the team found potential liability from failure to follow VHA policies and procedures, specifically related to the PCU and physician oversight. Recommendations are made to ensure clinical reviews are conducted by VISN 16, which oversees the Medical Center to ensure the PCU complies with all applicable laws and VHA policies to maintain a high quality, safe health care environment for patient care.

Department of Veterans Affairs (VA)
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Attachmer

NP Name	Employment Status C=Current employee at JVAMC in PC CJ= Current employee at JVAMC not in PC NC= No longer employed at JVAMC	State of Licensure	NP License Original Date	NP Type Certification/ Date	CA Required Y or N	CA in Place Y or N	CA Date Current	CA Date Original	Collaborating MD/ work location	Individual DEA and issue date	NPDB Y or N
Abernathy, Sarah	CJ	MS	11/30/94	ANCC Family 12/1/94	Y	Y	10/11/12	12/00/10	Jessie Crawford Moorefield Jackson VAMC	6/26/12	N
Alderson, Joy	C	NC	1/24/98	ANCC Family 9/1/96	Y	Y	12/31/12	12/00/10	Safi Sobhy Soliman Fayetteville NC VAMC	N	N
Alford, Donna	CJ	MS	2/12/96	ANCC Adult/Ger 9/1/95	Y	Y	12/18/12	12/9/10	Jessie Crawford Moorefield Jackson VAMC	7/19/12	N
Anderson, Dora	CJ	MS	4/27/99	ANCC Family 12/1/98	Y	Y	12/15/12	12/7/10	Ronald Braswell Jackson VAMC	5/3/11	N
Anderson, Marie	C	MS	1/9/95	ANCC Family 12/1/94	Y	Y	3/22/13	12/21/10	Nikesia Beamon-Webb Jackson VAMC	1/9/13	N
Barham, Jennifer	CJ	MS	12/2/02	ANCC Acute Care 12/1/01	Y	Y	12/12/12	12/30/10	Carla Cole Hewitt Jackson VAMC	N	N
Beal, Monifa	CJ	MS	4/13/10	ANCC Family 3/15/10	Y	Y	12/5/12	9/7/11	Charlotte Scott-Bennett Jason Taylor Jackson VAMC	8/10/12	N
Bowman-Bingham , Kellie	C	MS	7/26/06	AANP Family 7/1/06	Y	Y	12/14/12	12/14/10	Nikesia Beamon-Webb Jackson VAMC	12/28/12	N

Attachmen

Brewster, Rebecca	NC	TN	8/13/04	ANCC Family 2/1/08	Y for Rx authority	N	N/A	N/A	N/A	12/7/06	N
Brown, Ginger	C	MS	12/16/93	ANCC Family 12/1/93	Y	Y	3/17/13	12/9/10	Jessie Crawford Moorefield Jackson VAMC	5/4/12	N
Bullie, Bianca	C	MS	12/9/11	AANP Family 11/1/11	Y	Y	10/30/12	2/7/12	Nikesia Beamon-Webb Jackson VAMC	1/16/13	N
Capps, Mark	NC	FL	3/5/03	ANCC Family 4/1/98	Y	Y - expired last 8 months of employ ment	Left Jackson 1/31/13- CA had expired 5/31/12	6/1/11	William Rummel Milton, FL		N
Christmas, Sandra	CJ	MS	4/8/09	ANCC Family 3/16/09	Y	Y	10/22/12	12/7/10	Tammy Sims Sanders Jackson VAMC	N	N
Clanton, Rebecca	C	MS	6/18/04	AANP Family 6/1/04	Y	Y	12/27/12	12/14/10	Jessie Crawford Moorefield Jackson VAMC	7/11/11	N
Denson, Ruby	CJ	MS	12/6/95	ANCC Family 12/1/95	Y	Y	11/6/12	12/9/10	Brendan Ross and Pamela Graham - Jackson VAMC	6/27/12	N
Dunn, Robert	CJ	MS	6/1/11	ANCC Family 9/1/07	Y	Y	3/22/13	7/19/12	Kent Kirchner Jackson VAMC	N	N
Emerson, Della	C	MS	6/28/05	ANCC Family 7/13/05	Y	Y	12/14/12	12/13/10	Donald Butcher (Locums) no longer employed at Jackson VAMC	4/27/13	N

Attachment

Evans, Sherrill	NC	MS	2/24/97	ANCC Family 4/1/97	Y	Y	Left Jackson 8/25/12-CA still in effect	12/7/10	Kent Kirchner Jackson VAMC	8/27/12	N
Franklin, Rose	C	MS	9/11/07	ANCC Family 9/11/07	Y	Y	11/13/12	12/16/10	Nikesia Beamon-Webb Jackson VAMC	8/2/11	N
Haney, Valerie	NC	MS	6/3/11	ANCC Family 10/1/01	Y	Y	Left Jackson 8/11/12-CA still in effect	7/19/12	Rachel Thornton Jackson VAMC	N	N
Hardwick, Penny	C	IA	4/10/13	ANCC Family 12/1/94	Y[1]	N	N/A	N/A	N/A	3/29/13	N
Holt, Stephanie (CJ)	CJ	MS	9/1/04	ANCC Family 9/1/04	Y	Y	3/20/13	12/13/12	Jessie Crawford Moorefield Jackson VAMC	N	N
Hubbard, William	C	MS IA	12/24/08 1/18/13	ANCC Family 4/28/08	Y[2]	N[3]	12/14/12	12/13/10	Donald Butcher (Locums) no longer employed at Jackson VAMC	4/1/13	N
Jackson, Maybelle	CJ	MS	8/22/97	ANCC Family 9/1/97	Y	Y	12/6/12	12/9/10	Jessie Crawford Moorefield Jackson VAMC	N	N
Jett, Michelle	CJ	MS	11/28/95	ANCC Family 12/1/95	Y	Y	12/19/12	12/8/10	Eric Undesser Jackson VAMC	12/22/10	N
Kendrick, Barbara	C	MS	9/9/04	ANCC Family 8/1/04	Y	N[3]	2/26/13	12/8/10	Donald Butcher (Locums) no longer employed at Jackson VAMC	1/9/13	N

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Liberto, Christine	NC	MS	12/21/94	ANCC Adult 12/1/94	Y	Y	Left Jackson 6/23/12-CA still in effect	12/7/10	Nikesia Beamon-Webb Jackson VAMC	N	N
Lofton, Grant	CJ	MS	12/18/97	ANCC Family 9/1/97	Y	Y	3/26/13	12/17/10	Ronald Braswell Jackson VAMC	N	N
Mack, Linda	CJ	MS	9/1/12	ANCC Family 9/1/97	Y[4]	Y	3/22/13	3/22/13	Kent Kirchner Jackson VAMC		N
McDonald, Irvin	NC	MS	Grandfather	AANP Family 12/1/99	Y for Rx authority	Y	12/9/10	12/9/10	Jessie Crawford Moorefield Jackson VAMC	N	N
McKinney, Kathleen	C	OH	3/24/05	ANCC Family 4/1/04	Y	N[5]	4/29/13	4/29/13	Chelsea Jones Jackson VAMC	N	N
Owens, Sylvia	C	MS	4/10/09	ANCC Family 1/26/09	Y	Y	10/30/12	12/7/10	Nikesia Beamon-Webb Jackson VAMC	2/27/13	N
Ransberg-Garner, Carolyn	CJ	MS	12/17/98	ANCC Family 12/1/98	Y	Y	11/18/12	12/13/10	Jessie Crawford Moorefield Jackson VAMC	3/21/12	N
Richardson, Tyronda	CJ	MS	8/19/05	ANCC Family 7/8/05	Y	Y	10/22/12	12/8/10	Anita Basu Jackson VAMC	N	N
Robinson, Cheryl	CJ	MS	3/14/97	ANCC Family 12/1/96	Y	Y	4/19/13	12/8/10	Jessie Crawford Moorefield Charlotte Scott-Bennett Jackson VAMC	3/14/12	N
Shegog, Miranda	NC	MS	9/26/11	ANCC Family 7/14/11	Y	Y	Left Jackson 6/23/12-CA still in effect	2/7/12	Kent Kirchner James Lockyer Jackson VAMC	N	N

Attachment

Shirley, Sara	C	AR	2/27/96	ANCC Adult 4/1/89	Y for Rx authority[6]	Y	6/7/12	6/7/12	Jessie Crawford Moorefield (Spencer) Jackson VAMC	2/22/11	N
Speed-Brockman, Jean	C	MS	11/27/95	ANCC Family 12/1/97 and Adult 12/1/95	Y	Y	3/22/13	12/7/10	Jessie Crawford Moorefield Donald Butcher (Locums) no longer employed Jackson VAMC	6/26/12	N
Stringer-Bell, Nikeba	CJ	MS	12/4/98	ANCC Family 12/1/96	Y	Y	11/8/12	12/7/10	Jessie Crawford Moorefield Jackson VAMC	2/27/13	N
Sutton, Debra	C	MS	9/21/04	ANCC Family 9/1/04	Y	Y	11/26/12	12/17/10	Jessie Crawford Moorefield Jackson VAMC	4/9/13	N
Thomas-Wolf, Dwan	CJ	MS	2/22/00	ANCC Family 8/1/99	Y	Y	11/6/12/	12/7/10	Jessie Crawford Moorefield Jackson VAMC	4/15/11	N
Thompson, Carol	CJ	MS	11/28/94	ANCC Adult 1/11/92	Y	Y	3/17/13	12/9/10	Jessie Crawford Moorefield Jackson VAMC	10/21/00	N
1 Penny Hardwick: NP was grandfathered prior to obtaining IA license on 4/10/13. Per VHA Directive NP would have required a CA for prescriptive authority under her grandfathered status. Once she obtained IA license she no longer required a CA.											
2 William Hubbard: NP required CA under MS license, which NP had. CA no longer required since 1/18/13 under IA license.											
3 William Hubbard and Barbara Kendrick: Physician Collaborator was a Locum Tenens and is no longer employed at the Jackson VAMC. Collaborative Agreement is thus not in effect.											
4 Linda Mack: NP was grandfathered. Per VHA Directive would have required a CA for prescriptive authority under her grandfather status. However, NP did not have CA prior to 3/22/13.											

Attachment

5 Kathleen McKinney: NP required to have CA per OH license. However, she did not have CA prior to 4/29/13. The CA signed by NP and MD on 4/29/13 has yet to be approved by the OH Nursing Board.

6 Sara Shirley: NP required CA for prescriptive authority per AR license. She has prescriptive authority and DEA license but CA only in effect since 6/7/12. Prior to that date there is no evidence of a CA.

ATTACHMENT C

Memorandum

Subject

Revised Policy Regarding the Federal Government
Practitioners Program (FED DOC}
(DFN: 601–04)

Date

JUL 31, 2012

To

Special Agents in Charge
Assistant Special Agents in Charge
Diversion Program Managers
Diversion Group Supervisors

From

Joseph T. Rannazzisi
Deputy Assistant Administrator
Office of Diversion Control

The purpose of this memorandum is to clarify the Office of Diversion Control's (OD) policy regarding the Drug Enforcement Administration (DEA) Federal Government Practitioners Program (FED DOC). FED DOC practitioners are individuals who are direct hire employees of a Federal government agency (not contract practitioners) and are eligible for a fee exemption as set forth in 21 Code of Federal Regulations (C.F.R.) ◆ 1301.21 (a)(2). DEA has a longstanding policy regarding FED DOC practitioners that permits a DEA registration be issued to the practitioner in one state as long as that person maintains a valid professional license in any state. This memorandum reaffirms the FED DOC policy providing the following criteria are met:

- The FEDDOC practitioner's registered business address must be the official place of business.
- A FEDDOC registration can only be used for official duties on behalf of the Federal agency.
- Whenever a FED DOC practitioner changes his or her official place of business, he or she must request a modification of registration pursuant to 21 C.F.R. ◆ 1301.51, to reflect the location at which he or she is currently practicing.
- A FEDDOC practitioner must maintain a valid and current professional license. If the practitioner holds a professional license in a state that requires two licenses, then the practitioner must keep both licenses active and current only if the registered address is in the same state as the licenses, in order to be in compliance with that state.

The following Federal agencies are current participants in DEA 's FED DOC Program:

BOP - Bureau of Prisons
CDC - Centers for Disease Control and Prevention
DHS - Department of Homeland Security
DOJ - Department of Justice
FAA - Federal Aviation Administration
FDA - Food and Drug Administration
HHS - Health and Human Services
IHS - Indian Health Services
NASA - National Aeronautics and Space Administration
NCI - National Cancer Institute
NIH - National Institutes of Health
NIMH - National Institute of Mental Health
NOAA - National Oceanic and Atmospheric Administration
PHS - Public Health Services
USDA - United States Department of Agriculture
USPS - Unites States Postal Service
VA - Department of Veterans Affairs
U.S. Capitol Physician's Office
White House

If a FED DOC practitioner wants to maintain a separate DEA registration for a private practice, which would include prescribing for private patients, he or she must be fully licensed to handle controlled substances by the state in which he or she is located pursuant to 21 C.F.R. ◆ J 306.03(a). Under these circumstances, a FED DOC practitioner is not eligible for the fee exemption under 21 C.F.R. ◆ 1301.2J(a)(2), to conduct his or her private practice and must pay DEA's registration fee.

Any questions regarding the FED DOC Program may be addressed to the Registration and Program Support Section at (202) 307–7994.

- The NP functional statement, qualification standards, and dimensions of practice of the facility must be revised to be consistent with national policy per VA Handbook 5005 appendix G6.
- The Medical Center must complete a clinical care review of a random sample of patient care records for the NPs, who were prescribing controlled substances outside of the authority granted by their license. This review should focus on patients who were actually prescribed controlled substances. If any clinical issues are identified, the review should be expanded.

Facility policies and bylaws concerning the practice of NPs should be updated, to reflect VA national policies and the licensure and DEA requirements for this profession. Functional statements should be updated to reflect all current regulations.

VI. A listing of any violation or apparent violation of any law, rule, or regulation

The team substantiated that former Medical Center leadership directed NPs to practice under clinical privileges as LIPs, without regard to VHA policy or whether they were licensed as independent practitioners; did not ensure that the clinical practice of NPs was appropriately monitored by either their Physician Collaborators or through credentialing and privileging processes; and directed NPs to prescribe controlled substances using the institutional DEA registration with suffix, without regard to whether they were granted such prescriptive authority by their licenses or were required by their licensing board to prescribe under individual Federal DEA registration. The team also substantiated that Medical Center leadership requested PCP physicians to write controlled substances prescriptions for patients of the NPs based on a records review alone, without first conducting a face-to-face patient examination, under the belief that they were "covering physicians," and that some PCP physicians did so. These facility policies and practices violated the following Federal laws, rules, regulations and VA policies, as well as state licensing rules and regulations for collaborative agreements and controlled substances prescribing:

- The Controlled Substances Act, 21 U.S. C. ◆ 823(f) (DEA registration requirements);
- DEA regulations, 21 CFR ◆ 1306.03(a)(1)-(2) (Persons entitled to issue prescriptions);
- VA Handbook 5005, Part II, Appendix G6/27 (March 17, 2009), Nurse Qualification Standard VHA Handbook 1100.19, Credentialing and Privileging;
- VHA Directive 2008–049, Establishing Medication Prescribing Authority for Advanced Practice Nurses (August 22, 2008);
- VHA Directive 2012–030, Credentialing of Health Care Professionals;
- VHA Directive 2010–027, VHA Outpatient Scheduling Processes and Procedures (2010);
- VHA Updated Bylaws Template; and
- State licensing laws relating to collaborative agreements and controlled substances prescribing authority.

VII. Description of Any Actions to be Taken as a Result of the Investigation

No changes in national agency rules, regulations, or practices will be taken as a result of this investigation. Substantiation of the Whistleblower's allegations uniformly stem from the Medical Center's institutional failure to adhere to/or enforce current Federal laws and VA rules, regulations, and policies, as noted throughout the report. However, the team found that the facility's new leadership had taken some corrective measures to remedy past practices and prevent them from recurring. Leadership, under whom the noted non-compliant practices occurred, had already left the facility, and in some cases, the Department. VHA will be responsible for ensuring the facility completes the following recommended actions:

- Medical Center leadership must immediately correct the erroneous declaration that all NPs will practice as LIPs.
- Medical staff bylaws must be amended to indicate that NPs are considered LIPs only when their state licensure permits.
- Medical Center leadership must immediately implement scopes of practice versus clinical privileges for NPs, who are not permitted to practice as LIPs.
- Medical Center leadership must immediately ensure that all NPs, who require collaborative agreements, in fact have them, and that they are approved by the NP's respective state licensing board.
- Medical Center leadership should ensure the equitable distribution of collaborative agreements among physicians, and a reasonable limitation should be placed on the number of collaborative agreements for any one physician. If a state's Nursing Practice Act establishes a limitation on the number of collaborative agreements that a collaborating supervising physician may have with an NP at any one time, then the Medical Center needs to comply with such requirements.
- Medical Center leadership should eliminate use of Locum Tenens physicians in the PCU to the extent possible.
- Locum Tenens physicians should not be Physician Collaborators because of their short tenure.
- Medical Center leadership must immediately implement a process to ensure that appropriate monitoring of NP practice by Physician Collaborators occurs and is documented in accordance with state licensure requirements.
- Medical Center leadership must continue to aggressively work to hire permanent full-time physicians for the PCU, to obtain an NP:MD ratio of 1:1. Once an adequate number of physicians are hired, the Medical Center should reduce panel sizes for NPs to meet VHA guidelines.
- Medical Center leadership should consult the Office of Workforce Management and Consulting in VA Central Office to ensure they are utilizing all available resources to recruit primary care physicians.
- Medical Center leadership should eliminate the use of Ghost Clinics. All clinics must have an assigned provider.
- Medical Center leadership should eliminate the use of overbooked and double booked appointments to the extent possible. The Medical Center needs to implement the principles of open access scheduling, which means patients receive care when and where they want or need it, including on the same day, if requested.
- The Medical Center must convert six-part credentialing and privileging folders to the electronic VetPro system, as required by VHA leadership.
- VISN 16 leadership should arrange for an external clinical quality review of all primary care delivered at the Medical Center, particularly in light of the evidence that electronic View Alerts are often not being reviewed by physicians in a timely fashion and NPs were practicing outside the scope of their licensure. The Medical Center should conduct a clinical care review of a representative sample of the patient care records for all 42 NPs, as well as all physicians, who worked in the PCU from January 1, 2010, to present. The VISN should work with Medical Center leadership to determine the sample size needed to ensure that the quality of care delivered by all these providers was appropriate. If any clinical care issues are identified, the facility should consider expanding the sample. Specific cases involving unresolved questions as to quality of care should be referred to the Office of the Medical Inspector for further investigation.
- VISN 16 leadership should actively assist the Medical Center to implement these recommendations (and any others it deems necessary to ensure quality care is consistently rendered and available to PCU patients) through an approved action plan; and be responsible for submitting the action plan to the Under Secretary for Health along with periodic status reports (through to completion of all items).
- VHA should consider issuing an IL to reinforce across the system the need for compliance with both NP state licensure requirements and with national poli-

cies on NP credentialing, privileging, and scopes of practice. Such guidance should identify Regional Counsels as an important resource for the facilities as they review program compliance requirements.

- To determine whether Medicare home health certification/forms are/were being appropriately completed by the PCU providers, VHA should task the appropriate VHA offices, e.g., the VHA Office of Business Compliance and Integrity and the Office of Patient Care Services, Home Health Program, to work together to conduct a random check of PCU patient charts to determine if any Medicare forms are present. and if so, whether they were completed appropriately. Such findings need to be reported to the Under Secretary for Health, who will then need to consider if any follow-up action is necessitated. Additionally, facility leadership should consider development of a training and educational module for completion of these forms to ensure PCU and other staff are aware of CMS compliance requirements.
- The three NPs who have not yet received their individual DEA certificates should be encouraged to obtain these as soon as possible. Until that time, they are not writing for controlled substances. and are relying on the collaborating physicians to write for prescriptions as necessary.
- The NP functional statement, qualification standards and dimensions of practice of the facility must be revised to be consistent with national policy per VA Handbook 5005 appendix G6.
- The facility must complete a clinical care review of a random sample of the patient care records for the NPs who were prescribing controlled substances, outside of the authority granted by their license. This review should focus on patients who actually were prescribed controlled substances. If any clinical issues are identified the review should be expanded.
- Facility policies and bylaws concerning the practice of NPs should be updated, to reflect VA national policies and the licensure and DEA requirements for this profession. Functional Statements should be updated to reflect all current regulations.

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