"CORRECTING 'KERFUFFLES' - ANALYZING PROHIBITED PRACTICES AND PREVENTABLE PATIENT DEATHS AT JACKSON VAMC"

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

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

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

Wednesday November 13, 2013

Serial No. 113–44

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

85–869 PDF WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

JEFF MILLER, *Chairman*

DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida
DAVID P. ROE, Tennessee
BILL FLORES, Texas
JEFF DENHAM, California
JON RUNYAN, New Jersey
DAN BENISHEK, Michigan
TIM HUELSKAMP, Kansas
MARK E. AMODEI, Nevada
MIKE COFFMAN, Colorado
BRAD R. WENSTRUP, Ohio
PAUL COOK, California
JACKIE WALORSKI, Indiana

MICHAEL H. MICHAUD, Maine, *Ranking Minority Member*
CORRINE BROWN, Florida
MARK TAKANO, California
JULIA BROWNLEY, California
DINA TITUS, Nevada
ANN KIRKPATRICK, Arizona
RAUL RUIZ, California
GLORIA NEGRETE MCLEOD, California
ANN M. KUSTER, New Hampshire
BETO O'ROURKE, Texas
TIMOTHY J. WALZ, Minnesota

Jon Towers, *Staff Director*

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

MIKE COFFMAN, Colorado, *Chairman*

DOUG LAMBORN, Colorado
DAVID P. ROE, Tennessee
TIM HUELSKAMP, Kansas
DAN BENISHEK, Michigan
JACKIE WALORSKI, Indiana

ANN KIRKPATRICK, Arizona, *Ranking Minority Member*
MARK TAKANO, California
ANN M. KUSTER, New Hampshire
BETO O'ROURKE, Texas
TIMOTHY J. WALZ, Minnesota

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Page

November 13, 2013

"Correcting 'Kerfuffles' - Analyzing Prohibited Practices And Preventable Patient Deaths At Jackson VAMC" 1

OPENING STATEMENT

Hon. Mike Coffman, Chairman 1
Hon. Ann Kirkpatrick, Ranking Minority Member 3

WITNESSES

Ms. Phyllis Hollenbeck, Former Physician of Family Medicine, G.V. Sonny Montgomery VA Medical Center
Oral Statement 4
Prepared Statement 5
Dr. Charles Sherwood, M.D., Former Chief of Ophthalmology, G.V. (Sonny) Montgomery VA Medical Center
Oral Statement 7
Prepared Statement 8
Erik Hearon, Maj. Gen. (Ret), United States Air Force
Oral Statement 18
Prepared Statement 19
Mr. Charles Jenkins, President American Federation of Government Employees, Local 589
Oral Statement 29
Prepared Statement 30
Additional Statement 31
Ms. Rica Lewis-Payton, Network Director of VISN–16 G.V. (Sonny) Montgomery VA Medical Center,
Oral Statement 59
Prepared Statement 61
Accompanied by:
Dr. Gregg Parker, M.D.
Mr. Joe Battle

APPENDIX

Comments on Veteran Affairs Report of July 2012, WhistleBlower Complaints 82
Questions for the Record 122

"CORRECTING 'KERFUFFLES' - ANALYZING PROHIBITED PRACTICES AND PREVENTABLE PATIENT DEATHS AT JACKSON VAMC"

Wednesday, November 13, 2013

HOUSE OF REPRESENTATIVES
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [chairman of the subcommittee] presiding.

OPENING STATEMENT OF CHAIRMAN MIKE COFFMAN

Present: Representatives Coffman, Roe, Huelskamp, Benishek, Kirkpatrick, and Walz.

Also Present: Representatives Palazzo, Harper, and Thompson.

Mr. COFFMAN. Good morning. This hearing will come to order.

I want to welcome everyone to today's hearing titled "Correcting 'Kerfuffles' - Analyzing Prohibited Practices and Preventable Patient Deaths at Jackson VAMC."

I would also like to ask unanimous consent that several of our Mississippi colleagues be allowed to join us here on the dais to address issues very specific to their constituents. Hearing no objection, so ordered.

Today's hearing is based on serious allegations of wrongdoing at the G.V. Sonny Montgomery VA Medical Center in Jackson, Mississippi. Despite systematic problems at Jackson, VA has maintained that any concerns have not had a negative effect on patient care.

For example, the VA under secretary for Health, Dr. Robert Petzel, made the following statement in an apparent attempt to downplay the myriad issues at Jackson VAMC.

[Video shown.]

Mr. COFFMAN. Kerfuffles, that is a new word for me having been from the army and the marine corps. I do not think it was something in our lexicon. I do not think we are going to go there.

This clip represents the attitude of VA following years of prohibited practices at Jackson that have negatively affected care provided to veterans. That negative effect is apparent in the tragic story of Johnny Lee. Johnny Lee, an army veteran and long-time employee of Jackson VAMC, became a casualty of inept supervision and inadequate staffing on the part of the facility officials.

According to whistler blower reports, Mr. Lee went to Jackson VAMC for a routine skin graft operation in April of 2011. Following the operation, he was attached to a negative pressure wound therapy machine, often referred to as a wound vac, that is designed to remove fluids from sealed wounds.

Mr. Lee was then left unattended and connected to the wound vac for a number of hours. When Jackson personnel finally returned to check on him, he was dead, his body having been drained of all its blood, which spilled out on to the floor of the room.

Months prior to this horrible incident, the FDA released a safety report on wound vacs requiring frequent monitoring of patients with a specific caveat to, quote, be vigilant for potentially life-threatening complications such as bleeding and be prepared to take prompt action if they occur, unquote.

Mr. Lee's death would have certainly been prevented had Jackson VAMC officials heeded this warning, properly informed and supervised its personnel, and monitored Mr. Lee appropriately.

Today we will discuss the many serious issues that continue to plague Jackson VAMC. Under staffing of personnel has led to the over-reliance on nurse practitioners, resulting in many veterans not getting access to an actual doctor during their care at Jackson and nurse practitioners operating without supervision.

The routine practice of booking multiple patients for single appointment slots leads to patients being turned away without service. Thousands of radiology images have gone unread or improperly read, resulting in misdiagnosis of serious and in some cases fatal illnesses. Jackson VAMC management was aware of these allegations, but only undertook a cursory investigation to address it.

The facility also has narcotics prescription policies in place that led to the August 2012 resignation of the Jackson VAMC chief of staff and the May 2012 arrest of the associate director for patient care services on a prescription fraud charge.

Other allegations state that physicians at Jackson VAMC are frequently asked to sign Medicare home health certificates on patients they had not seen or for nurse practitioners they had not supervised which is essentially a commission of Medicare fraud.

Ultimately VA has taken inadequate action to hold Jackson VAMC management accountable for contributing to or approving of these systematic problems.

The Office of Special Counsel appropriately stated that the VA investigation into these matters has been insufficient and unreasonable, unquote.

In light of the obvious deficiencies we will discuss today, some of which have led to preventable patient deaths such as that of Mr. Lee, it is painfully obvious that VA is not taking the problems occurring at this facility seriously and is showing a lack of commitment that quite apparently affects care provided to veterans.

I now yield to Ranking Member Kirkpatrick for her opening statement.

OPENING STATEMENT OF ANN KIRKPATRICK, Ranking Minority Member

Mrs. KIRKPATRICK. Thank you, Mr. Chairman, for holding this hearing today.

I am sure we all agree that patient safety and quality of care are top priorities for this committee. I have been very concerned with the slew of patient care issues that have been brought to my attention just this year.

In September, the full committee held a field hearing in Pittsburgh, Pennsylvania that focused on five of the over 15 VA medical centers that have recently experienced patient care issues.

At this hearing, we are going to examine the policies and response of the Department of Veterans Affairs to several allegations originating from multiple employees spanning several years at the G.V. Sonny Montgomery VA Medical Center in Jackson, Mississippi.

These allegations include but are not limited to under-staffing of personnel, over-booking of patients, insufficient medical staff supervision, and improper Medicare certification and narcotics prescriptions.

I am troubled by the testimony of our first panel. After reading it and the associated reports, it seems to me that not much has improved over the years and patients continue to be subjected to improper care, unsafe conditions, and privacy violations. This, of course, is unacceptable.

I am equally concerned with what looks like nearly a complete collapse of the leadership team to hold managers accountable for improper actions, failures to follow established procedures, and a blatant disregard for policies that are in place.

Mr. Chairman, as you know, the Office of Special Counsel, an independent federal investigative and prosecutorial agency, raised concern in a March 2013 letter to the President and Congress about the Jackson VA Medical Center regarding the numerous whistle blower disclosures made by five employees and physicians.

In a subsequent letter in September 2013, the Office of Special Counsel sent another letter to the President explaining why they had found that the Department of Veterans Affairs' reports were deficient in the cases concerning the allegations made by the two physicians, Dr. Hollenbeck and Dr. Sherwood, both of whom are with us today.

I would like to hear from the VA what is being done to fix the problems that are being highlighted today and moving forward, what plan is in place to prevent them from happening in the future.

Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Ranking Member Kirkpatrick.

I ask that all Members waive their opening remarks as per this committee's custom.

With that, I invite the first panel to the witness table. On this panel, we will hear from Dr. Phyllis Hollenbeck, former physician of family medicine, and Charles Sherwood, former chief of ophthalmology at Jackson. We will also hear from Major General Erik Hearon, United States Air Force retired, and Mr. Charles Jenkins,

president of the American Federation of Government Employees, Local 589.

All of your complete written statements will be made part of the hearing record.

Dr. Hollenbeck, you are now recognized for five minutes.

STATEMENT OF PHYLLIS HOLLENBECK

Dr. HOLLENBECK. Thank you.

Good morning. It is once again an honor and a privilege to be asked to testify before a committee of the United States House of Representatives that focuses on the lives of our precious veterans.

The title of this hearing refers to kerfuffle, a funny sounding word whose meaning, to throw into disorder, should not be underestimated.

What I have witnessed in the primary care service at the G.V. Sonny Montgomery VA Medical Center in Jackson, Mississippi is a sad, serious, and self-perpetuating state of ugly chaos.

The VA's own investigative team report on my Office of Special Counsel whistle blower complaint substantiated that the medical center does not have enough physicians and nurse practitioners have not had appropriate supervision and collaboration with physicians.

The lack of required monitoring results in NPs practicing outside the scope of their licensure. It is crucial to understand that in all the years that NPs have existed at the Jackson VA, there was no oversight or review of their clinical care. Physicians had ongoing quality assurance and peer reviews done on their work. The NPs had none.

Dorothy Taylor-White oversaw this setup through her power over patient care services, but Dr. Kent Kirchner, chief of staff, enabled and agreed to this illegal operation.

And these unsupervised NPs outnumbered the physicians in primary care by a ratio of three to one and sometimes four to one.

This same cavalier attitude and laxity by medical center and VISN leadership towards safe and proper medical care for the veterans empowered the NPs to prescribe narcotics without physician supervision and without individual DEA registration numbers, in flagrant violation of federal and individual state laws and VA handbook regulations.

A practitioner who never obtained an NP license was the entire women's health clinic for two decades, writing narcotics and seeing patients independently.

Scheduling of veterans in a ghost clinic when no provider was assigned to that clinic, over-booking, double booking, and inadequate capacity for walk-in visits were all found. Both administrative and medical leadership were continuously informed of these issues.

In view of what has happened at Jackson, it is a blessing that this hearing comes as proposed changes to the VA nursing handbook have come out. The plan is to make all NPs in the nationwide VA system operate as fully independent and unsupervised without regard to state licensure requirements or scope of practice and not as part of a physician led veterans' care team.

My current work in the compensation and pension service allows me to see care from all clinics in the Jackson system. And this is

what I often see from unsupervised NPs. Diagnoses not made when they should have been. Common stellar examples are heart disease, diabetes, and asthma. Symptoms are not addressed or recognized and proper tests and treatments are delayed.

Even when diagnoses are made, diseases are not monitored or treated appropriately. Diabetes leads to chronic kidney disease and then the kidney disease is not noted until far advanced. A bizarre progress note template used for office visits different from what physicians use.

The NP does not take an adequate history for the veteran's current complaints. The same history and physician is cut and pasted into perpetuity as is the chronic problem including the diagnosis and billing code for URI, the common cold, forever.

The most compelling case is a veteran who had white blood cell changes showing the onset and insidious march of chronic lymphocyte leukemia for ten years and was only diagnosed when the severe abdominal pain caused by a mass was biopsied.

When I saw him in C&P, he was dying and he and his wife told me they remembered the shocked look on the face of the blood specialist when he reviewed the veteran's records.

Veterans suffer needlessly even when they do not die. Think of the veteran whose fatigue is not just due to his chronic medical problems but because of a new cardiac arrhythmia. When the subtlety of that diagnosis is missed by an NP, the veteran goes home and dies. When the symptom is acknowledged and an EKG is done, a pacemaker buys a few more years.

Quoting from the classic opening pages of Harrison's Textbook of Medicine, a seminal part of medical school education, disease often tells itself in a causal parenthesis. Skill and diagnosis reflects a way of thinking more than doing. The content of the record reflects the quality of the care provided.

My written testimony documents the vast differences in training and approach to the patient between nurse practitioners and physicians.

As Americans become sicker and sicker, younger and younger, and on more and more medicines, the VA proposal shortchanges the veterans. The care of human beings is too sacred to change a policy either for monetary or nursing lobby concerns.

The center director, Joe Battle, is fond of reminding us that while you are at the VA, you are on a reservation. This translates into federal supremacy, means we do not have to follow the laws.

It also means that medical and ethical boundaries are boldly breached. In this case, standing up to the federal specialness claim and going off the reservation is a sign of sanity and professionalism.

Duty calls us now as it called the veterans. Thank you.

[THE PREPARED STATEMENT OF PHYLLIS HOLLENBECK]

Good morning. It is once again an honor and a privilege to be asked to testify before a committee of the US House of Representatives that focuses on the lives of our precious Veterans. The title of this hearing refers to "Kerfuffle", a funny-sounding word whose meaning—"to throw into disorder"—should not be underestimated.

What I have witnessed in the primary care service at the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi is a sad, serious, and self-perpetuating state of ugly chaos.

The VA's own investigative team report on my Office of Special Counsel Whistleblower Complaint substantiated that "the Medical Center does not have enough physicians, and nurse practitioners (NPs) have not had appropriate supervision and collaboration with Physician Collaborators." It states "NPs were also 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." It is crucial to understand that in all the years that NPs have existed at the Jackson VAMC, there was no oversight or review of their clinical care. Physicians had ongoing quality assurance and peer reviews done on their work—the NPs had no oversight. Dorothy Taylor-White oversaw this set-up through her power over "patient care services", but Dr. Kent Kirchner, Chief of Staff, enabled and agreed to this illegal operation. And these unsupervised NPs outnumbered the physicians in primary care by a ratio of 3:1, and sometimes 4:1.

This same cavalier attitude and laxity by the Medical Center and VISN (Veterans Integrated Service Network) leadership towards safe and proper medical care for the Veterans empowered the NPs to prescribe narcotics—without physician supervision—without individual DEA registration numbers, in flagrant violation of Federal and individual state laws and VA Handbook regulations. A practitioner who never obtained an NP license was the entire Women's Health Clinic for two decades, writing narcotics and seeing patients independently. "A clinical care review" of records where NPs prescribed controlled substances "outside of the authority granted by their licenses" was called for in the report.

Scheduling of Veterans in a "ghost" or "vesting" clinic when no provider was assigned to that clinic, overbooking /double-booking, and inadequate capacity for walk-in visits were all found, and all these issues threaten the care of the Veteran. Both administrative and medical leadership were continuously informed.

In view of what has happened at Jackson, it is a blessing that this hearing comes as proposed changes to the VA Nursing Handbook have come out. The plan is to make all NPs in the nationwide VA system operate as fully independent and unsupervised, without regard to state licensure requirements or scope of practice—not as part of a physician-led Veteran's care team. My current work in the Compensation and Pension Service allows me to see care from all clinics in the Jackson system. And this is what I often see from unsupervised NPs (exacerbated by clinician turnover and discontinuity of care):

1.) Diagnoses not made when they should have been. Common stellar examples are heart disease, diabetes, and asthma. Symptoms aren't addressed or recognized and proper tests/treatments are delayed.

2.) Even when diagnoses are made, diseases are not monitored or treated appropriately. Diabetes leads to chronic kidney disease; and then the kidney disease is not noted until far advanced.

3.) A bizarre progress note template used for office visits, different from what physicians use. The NP does not take an ade-

quate history for the Veteran's current complaints; the same history and physical is cut and pasted into perpetuity, as is the chronic problem list—including the diagnosis and billing code for "URI"—the common cold.

The most compelling case is a Veteran who had white blood cell changes showing the onset and insidious march of chronic lymphocyte leukemia for ten years, and was only diagnosed when a mass causing severe abdominal pain was biopsied. When I saw him in C &P he was dying—and he and his wife told me they remembered the shocked look on the face of the blood specialist when he reviewed the Veteran's records.

Veterans suffer needlessly even when they don't die. Think of the Veteran whose "fatigue" is not just due to his chronic medical conditions but because of a new cardiac arrhythmia; when the subtlety of that diagnosis is missed by an NP the Veteran goes home and dies. When the symptom is acknowledged and an EKG is done as it should be, a pacemaker can buy a few more human life years. Quoting from the classic opening pages of Harrison's Textbook of Medicine, a seminal part of medical school education, "disease often tells itself in a casual parenthesis ... skill in diagnosis reflects a way of thinking more than doing ... The content of the record ... reflects the true quality of the care provided." My written testimony documents the vast differences in training and approach to the patient between nurse practitioners and physicians; as Americans become sicker and sicker, younger and younger, and on more and more medicines the VA proposal shortchanges the Veterans. The care of human beings is too sacred to change a policy for either monetary or nursing lobby reasons.

The Center Director, Joe Battle, is fond of reminding us that "when you're at the VA, you're on the reservation"; this translates into Federal Supremacy means "we don't have to follow the laws". It also means that medical and ethical boundaries are boldly breached. In this case, standing up to the "Federal Specialness" claim, and "going off the reservation", is a sign of sanity and professionalism. Duty calls us now—as it called the Veterans.

Oral Testimony
House Veterans Affairs Subcommittee
O & I Hearing
November 13, 2013
Phyllis A.M. Hollenbeck MD, FAAFP

Mr. COFFMAN. Dr. Sherwood, you are now recognized for two and one-half minutes.

STATEMENT OF CHARLES SHERWOOD

Dr. SHERWOOD. Thank you, Mr. Chairman and Members of this committee, for the opportunity to testify today.

My name is Charles Sherwood and I am a recently retired ophthalmologist with all of my 31 years of service to the VA at the Jackson VA Medical Center.

The so-called performance-based model for senior executive service managers was implemented by the Department of Veterans Affairs in the late 1990s. This compensation model in a modified form was extended to physicians by a law in 2004 and was implemented

in 2006. The model has been manipulated to emphasize pay and job security at the expense of health and safety of patients.

A federal trial demonstrated that a Jackson VA Medical Center radiologist scored income boosting relative value units by speed reading radiologic imaging studies. He was not reading all images in every study for which he provided an interpretation.

Fifty-two veterans on random reexaminations demonstrated misses in the radiologic interpretation provided by Dr. Khan. At least eight misses resulted in inoperable lesions, apparent cancers. At the trial, the names of the 52 victims was redacted.

To preserve their management positions, Jackson VA Medical Center administrators in response to a subpoena have refused to turn over the medical records of the 52 patients to the Mississippi Board of Medical Licensure. The State Board of Medical Licensure is investigating the radiologist who is a Mississippi licensed physician.

In response to my Office of Special Counsel complaint, the central office of the Department of Veterans Affairs refused to order the local Jackson VA Medical Center officials to make legally required institutional disclosures to injured veterans and their families. The 50 remaining victims do not even know they were harmed.

Congressional hearings have focused on performance bonuses for senior executive service managers. The response to my Freedom of Information Act requests for senior executive service compensation did not disclose their retention bonuses.

Physicians under the same compensation model as the senior executive service are eligible for up to 100 percent of their salary to be awarded as a retention bonus or a retention allowance.

I have provided this subcommittee a VISN 16 document referring to retention allowances for senior executive service managers.

To understand what actual compensation is being paid to senior executive service managers, retention bonuses must be taken into account.

Reform is required to protect patients by adjusting the pay system and preventing administrators from covering up patient injury.

I look forward to your questions.

[THE PREPARED STATEMENT OF CHARLES SHERWOOD]

Thank you, Mr. Chairman and members of the subcommittee. What follows is a continuation of my testimony. My name is Charles Sherwood. I retired from the VA in May 2011 as a physician with all of my 31 years of VA service at the G. V. "Sonny" Montgomery VA Medical Center. During the past fifteen years the Jackson VAMC has had a diverse leadership who all share a common trait, a progressive failure of their moral compass. The VA has a long and sordid history of intimidation and retaliation against employees who dare to object to poor patient care. On March 11, 1999 in this very room, the Subcommittee on Oversight and Investigations held a hearing entitled "Whistleblowing and Retaliation in the Department of Veterans Affairs". In his opening remarks, Subcommittee Chairman Terry Everritt, cited testimony from a 1992 Committee on Government Operations report (Report 102–

1062). He focused on the section of the 1992 report entitled "The DVA, Department of Veterans Affairs, discourages the reporting of poor quality care by harassing whistleblowers or firing them." Chairman Everett paraphrased from that section the words of Tom Devine, the director of the Government Accountability Project, who said "The Department of Veterans Affairs is a leader on the merit system anti-honor for one simple reason: free speech repression has been a way of life at this agency". (Full text at: http://commdocs.house.gov/committees/vets/hvr031199.000/hvr031199—0f.htm). I am dismayed to report to you that today, twenty years later, the leadership culture of the VA is unchanged with the exception of the improved sophistication with which it intimidates its employees.

The federal trial, which is the basis for my Office of Special Counsel complaint and my complaint to the Mississippi State Board of Medical Licensure, exposed the fact that this erosion of ethical boundaries is a systemic problem for the VA. Careerism and the pursuit of personal financial gain by members of the Senior Executive Service have virtually collapsed processes designed to assure patient safety. The unbridled power of these individuals to take whatever measures are necessary to polish their images and incomes with unrealistic performance measure data must be curbed. This federal trial proved that every conceivable level of management from the Undersecretary for Health to the service chief level were culpable in failing to protect veterans they are duty bound to serve. Failure to act against wrongdoing is complicity with it. The current management officials of VISN 16 and the Jackson VAMC are acting as a tight knit cabal. They continue to act to protect and preserve their own power and money at the expense of patients and employees alike. Despite public exposure and media attention, there has been no interest from Veterans Administration Central Office (VACO) to assume accountability and correct this recurring disgrace.

The federal civil suit by three female radiologists was based on discrimination, a hostile, intimidating work environment, and retaliation. It exposed the unprofessional practice of Majid Khan, a radiologist who admitted that he did not look at all images of every radiologic study for which he gave interpretations. Even Dr. Khan's immediate supervisor and co-defendant, Dr. Vipin Patel, admitted under oath that Dr. Khan's conduct constituted "intentional medical negligence". The motivation for this unprofessional conduct was money. A radiologist's pay and performance evaluation was based on productivity as defined by the Relative Value Units (RVU) that the radiologist could produce. The most complex radiologic studies generate the highest RVUs.

As other radiologists randomly discovered an unusually high number of obvious, critical errors by Dr. Khan in patients who were returning for followup imaging studies , Dr. Hatten maintained a log of these errors. This log was sent up the entire VA chain of oversight, which included Dr. Michael Kussman, the VA Undersecretary for Health at the time. Of the 52 cases Dr. Hatten shared with VA leaders at every management level, including the Office of Inspector General, there were, for example, five lung cancers having become inoperable by the time of their discovery.

VA officials have said that they performed due diligence by having five separate examinations of Dr. Khan's professional conduct. I provided the Office of Special Counsel a detailed explanation of the contrived nature of each of these reviews, administrative board of investigations (ABI), and Professional Standards Boards (PSB) to produce a desired predetermined outcome. To the unsuspecting observer these reviews appear to be a bonafide effort to find the facts. This maze of deceit allowed VA leaders to claim that no harm was done to patients, the errors uncovered were within an acceptable statistical norm, there was no responsibility for the VA to report these adverse events to the patients or their surviving family, and no indication to report Dr. Khan to his state licensing board nor the National Practitioner Data Bank. Dr. Eric Undesser, the chairman of the final AIB that exonerated Dr. Khan, admitted at trial that he was well aware that a finding of negligence by Dr. Khan would lead to numerous lawsuits against the VA.

I personally filed a professional conduct complaint about Dr.Khan before the Mississippi Board of Medical Licensure (MSBML). The mission of the MSBML is to protect all Mississippi citizens, including those who are veterans. In response to my complaint, the MSBML subpoenaed the Jackson VAMC for the 52 patient records as part of its investigation of Dr. Khan. The VA has incredibly and irrationally refused to comply with this subpoena, asserting the privacy rights of the patients. Patients don't know they were injured since the VA has never notified them, and they will never know if VA officials are allowed to continue this coverup by hiding their misdeeds behind privacy laws. The MSBML is a HIPPA exempted law enforcement agency with every right to the information it is seeking. This cover up is also in defiance of the VA's own policy for complying with State Boards of Medical Licensure (VHA Handbook 1100.18 Reporting and Responding to State Licensing Boards).

The VA's response to my OSC complaint is nothing more than a "smoke and mirrors" sleight of hand treatment of the facts. "Intentional medical negligence"1 resulting in the death and injury of patients is acceptable to the VA as long as the VA can manipulate these patients in to a statistically acceptable error rate, which the VA has assumed is present without actually establishing it as fact. The VA response is an extraordinary collection of useless contrived data presented as definitive technical fact, euphemistic phraseology crafted to misdirect the reader, and the omission of critical facts when they contradict the VA's predetermined conclusions.

Fred Lucas, an army retiree, Vietnam veteran, an former VA nurse wrote a guest column for the October 11, 2013 Clarion-Ledger newspaper. Mr. Lucas quoted Mr. Joe Battle, Jackson VAMC Director saying that the "The VA considers the case closed" referring to the radiology cases of injury never reported to the patients or families. Dr. Randy Easterling, President of the Mississippi State Board of Medical Licensure, in the April 3, 2013 Clarion-Ledger newspaper publicly criticized the Jackson VAMC leadership's failure to cooperate with MSBML's investigation of issues involving the Jackson VAMC.

For five years the position of Chief of Radiology at the Jackson VAMC has remained vacant. The position has been openly adver-

tised on three different occasions. Dr. Margaret Hatten and Dr. Brighid McIntire have served as acting chief of radiology during the five years the chief's positions has been vacant. Both of these ladies were plaintiffs in the Federal trial, and though qualified for the chief's position, they have never been entertained as serious candidates. This "chronic retaliation" is for their role in exposing the leadership culture of coverup of patient death and injury, lying as a matter of routine, self dealing, and the unethical treatment of patients, their families, and employees. The lesson that speaking truth to power will abort your career advancement has not been lost on other employees in the facility.

Before Kenneth Kizer, Undersecretary for Health during the Clinton Presidency, modified the Senior Executive Service (SES) compensation model to include pay for performance and generous bonuses, the current leadership ills were unknown. When members of the SES realized that there was essentially no oversight of the pay for performance system by VACO, and that it was easy to game the system, the least desirable elements of human came to the fore. In my own clinic, waiting times for the next available appointments and consults were reported to the VISN with false data which were never shared with me, while I was the ophthalmology section chief. Later, I discovered these false data by chance. The medical center director had no interest in hearing about or investigating the discrepancies in the performance data. In fact, Kent Kirchner, the chief of staff at the time, warned me away from pursuing any further inquiry into the unrealistic performance reports about the eye clinic.

I will conclude my remarks by suggesting to the committee that not only should performance bonuses for SES leaders be scrutinized but also should retention bonuses. SES leaders will howl that good executives cannot be recruited without the liberal use of these incentives. Awarding these compensation incentives should use honesty and integrity as bench marks for executives instead of the current performance measure system which continues to be ripe for manipulation.

No longer should VA executives be evaluated solely by their supervisors. This year the Chairman of the Joint Chiefs of Staff announced that the military would use the 360 degree evaluation technique for all high ranking officers. For years corporations and medical schools have been using this technique. The 360 degree technique allows peers and those supervised to provide and assessment of personal character in addition to their management qualities. The VA should adopt the 360 degree technique with evaluation instruments heavily weighted to measure moral fitness, honesty, and integrity. The VAs "All Employee Survey" doesn't do this.

Finally, some form of "claw-back" provision should be developed for use by the agency or Congress against the retirement benefits of SES employee who egregiously pursue personal agendas through the auspices of the official positions, or those who run out the clock into retirement or transfer. Evasion of difficult management issues is just as harmful as managing for personal gain. In both cases, these executives defraud the government by willfully failing to manage for the betterment of the veterans they have a fiduciary responsibility to serve and the public who provides their support.

The following narrative was submitted substantially in this form in support of my complaint to the Office of Special Counsel (OSC). This OSC was accepted for referral to the VA for investigation and designated as OSC complaint DI–13–1713. This narrative is not available on the OSC website for public access, and is included here for the purpose of establishing a context for understanding the full scope of VA leadership failures.

ALLEGATIONS:

1. Violation of civil rights proven in Federal civil trial: 3:08cv00148TSL–FKB. This trial concluded in August of 2010 and involved three VA physician plaintiffs vs VA management officials at the G. V. "Sonny" Montgomery VA Medical Center (GVSMVAMC) in the US District Court for the Southern District of Mississippi, Jackson Division {Brighid McIntire, et.al. vs James B. Peake, Secretary, Department of Veterans' Affairs}

Local VA defendants retained their positions without prejudice. This case proved that hospital leadership actions presented a clear and specific danger to the health and safety of the veteran public that was NOT addressed after conclusion of the lawsuit. Leadership officials would profit from their decisions under pay for performance VA bonus administration. (I will attach the trial transcript and relevant exhibits if this website supports it).

2. Systematic "gaming" of monitored performance measures to enhance professional advancement and increase pay for performance salary bonuses.

A CHRONOLOGY OF GVSMVAMC's CHANGE IN LEADERSHIP CULTURE FROM PATIENT CENTERED TO PERFORMANCE METRIC CENTERED

This is my personal recollection of events from my 30 years with this VA hospital.

1. Kenneth Kizer, MD,MPH served as VA Undersecretary for Health Affairs from 1994-1999. We began a program of health care quality measures under him.

http://www.ftc.gov/ogc/healthcarehearings/docs/
030611kitzerjama020221.pdf

http://www.ucdmc.ucdavis.edu/iphi/kizer—bio—03302011

The following 1996 document is Kizer's actual plan, and nearly all of it got implemented to some degree. Please note that a) this is the start of the VISN system b) established Primary Care as central healthcare focus [see Strategic Objective #2, Reducing Cost, Actions 5, 12, & 13] c) Incentive performance bonuses are established [see Four Domains of Value, Action 7 and Mission Goal II, objective 22]

http://www.va.gov/HEALTHPOLICYPLANNING/rxweb.pdf

2. Richard P. Miller was Center Director starting in 1996 or 1997 (the year Dr. Carter was shot and killed)

3. Miller retired around 2000. Robert Lynch was promoted to director in a very odd way. He went from Chief of Staff directly to director and bypassed acting as an Associate Director first. In fact, he leaped over our Assoc. Director at the time, a man named Bruce Triplett. A few months later, Lynch applied for and got the job of Director of VISN 16. This appeared to be a very inside job of self dealing since Lynch, Miller, and the retiring VISN Director, Robert Higgins, had all been the top leaders at the recently abolished "Re-

gional Offices" when Kizer set up the VISN system. We were not surprised, since Lynch as Chief of Staff had removed the chief of pathology, and selected his wife to be the new chief. To do this he had to entirely reorganize the department of pathology under the department of radiology and rename the whole thing the department of Diagnostic Services. This conveniently got around the prohibition of a manager supervising their family member. The wife was supervised by the chief of radiology who was supervised by Lynch. The radiology chief was Dr. Vipin Patel, the same individual in the Federal lawsuit cited in Allegations #1.

4. Dorothy White-Taylor, RN became Chief of Nursing in 2001. I cannot remember the date when Jonathan Perlin, MD from VA Headquarters decided to make chiefs of nursing the official at each medical center who would monitor the medical center director's performance measures, but it was about that time. I remember reading the email sent out over the old VISTA computer system to all the hospitals announcing this arrangement. That email should be indefinitely stored somewhere in the VA Headquarters information technology system. I received this email because I was both a VISN consultant for my specialty, and I had been on a VISN construction committee.

5. Soon after Dr. Lynch took over as our hospital director, an enormous emphasis was put on all sorts of performance measurements. This was the result of pressure from Headquarters and from the VISN director. It was natural for this to occur, since better performance measures translated directly into larger bonuses to the leadership (read Kizer's mission/ vision statement again)

6. A not previously seen cadre of nurses with clipboards were all over the place looking to find ways to make the performance data better. It was all whip and no carrot. These nurses who were not doing patient care, were nevertheless, counted against the total number of nurses the hospital was allowed to hire. They seemed to have a very protected role. When they showed up to ask you questions about your performance data, you were expected to drop everything and answer until they were satisfied.

7. I personally witnessed activity designed to defeat so called external audits of patient charts that were intended to see how well our hospital implemented good care practices compared to other VAs nationally and in VISN 16. This is what would happen. The contracted external review entity would notify the hospital a week before they would visit to review some number of charts with a specific diagnosis of interest. I don't recall how many charts would be pulled for any given external audit. The room used was near my office and I would pass by and see all the activity. Nurses or medical records technicians were assigned to go over the pre-selected charts in advance of the inspection. Charts not meeting criteria were exchanged for charts that did. When the external reviewers looked at this "not so random sample", our hospital got high performance numbers. I specifically remember asking Myrtle Kimble (now Tate) about this way of doing things. I had served with Ms. Kimble on the Utilization Review Committee as its chairman and knew her well. She told me that all the hospitals were gaming the system and that we had to also in order to keep a high performance rank among VA hospitals.

There was a nurse supervisor in charge of getting the charts requested for audit "cleaned up" The nurse had been given special authority to actually make appointments in the computer so that patients whose charts were to be audited would come to the hospital to correct their chart deficiency. For example, if a check of foot pulses was not recorded in the chart. This meant that patients came from long distances and would be called to the hospital for their chart to be treated. In addition to the risk of driving and direct expense to the patient, travel pay for these appointments was also paid.

Medical records technicians and nurses told me that they were paid overtime for any after hours and weekend chart work. I never knew if data were fabricated if missing from the chart or if patients could not be located. The entire system for external audit subverted the external audit process. The contracted external auditor was the Burton-Davis company, if my memory is correct.

8. When the external reviews began to review specific charts and not random ones, a new strategy went into place. As I understood it, all of these data gathering/ verification activities were run from the Chief of Nursing's office. In this case, all the charts from a specific clinic had to be available for review. Once the clinic had been identified (there were never any surprise reviews; the hospital always got advance notice of the date the reviewers would be there). Of course, you could not substitute charts that met criteria in this situation. You were forced to make an incomplete chart complete. Once again this was done by paying nurses overtime on the weekends and other times to call back to the hospital a patient to have his records completed. I know of some cases where patients were made to drive 60+ miles to have a blood pressure taken and recorded or a foot exam documented. Minor data points but an inconvenience to the patient and an added travel pay and nurse overtime expense for the hospital. But our performance numbers were excellent.

9. Some where in the mid-2000s all pretense at honest and accurate gaming of the system seemed to go out the window. In my own clinic the data self reported by our hospital through the nursing service data collectors and analyzers bore no resemblance to reality. I brought this up in an open Executive Committee of the Medical Staff (now known as the Clinical Executive Board) meeting with the Chief of Staff, Kent Kirchner, who strongly suggested that I be content with my clinic's performance doing so well. I don't remember if this was shortly before or after Hurricane Katrina. After Katrina most performance data changed to measuring services rendered to hurricane displaced victims. At that point the pressure on direct patient care providers relaxed somewhat for the next18 to 24 months.

10. Just before Richard Baltz was appointed as our medical center director, my chief of surgery, Charles Clericuzio asked me to prepare my own clinic's data for Mr. Baltz. Patient waiting and appointment times were the primary issue and the data and leadership expectations were divergent. Dr. Michael Palmer and I prepared a presentation of data we could document. Mr. Baltz was told we had the presentation prepared, but he never asked for it. The clinics identified by Headquarters for close monitoring and re-

porting were Cardiology, Urology, Orthopedics, Ophthalmology, and one other that I can't recall. These clinics had large patient panels and a high volume of new requests for patient services. I think most of the full time physicians strongly suspected that data generated by their clinics were altered for improvement, since failure to "massage" the data would adversely affect the hospital's reported performance measures outcomes. We almost never saw the data as it was actually reported until long after the fact. Once we realized that the leadership did not want to hear about the data being suspect, we quit trying to push the issue.

11. My last director retired under a cloud of employee complaints, but by this time the performance data factory was pretty much running on autopilot. The leadership culture was pretty well established and directed by the conflict of interest between the Director, Chief Nurse, and the performance measure chase which was directly tied to leadership compensation levels.

12. The best documentation of the culture that pervaded the hospital leadership comes, in my opinion, from the trial transcript and exhibits of civil trial number : 3:08cv00148TSL–FKB. This trial concluded in August of 2010 and involved three VA physician plaintiffs vs VA management officials at the G. V. "Sonny" Montgomery VAMC in the US District Court for the Southern District of Mississippi, Jackson Division {Brighid McIntire, et.al. vs James B. Peake, Secretary, Department of Veterans' Affairs}

This lawsuit documented direct injury (including deaths) to veterans from performance data driven malpractice that was and continues to be covered up by hospital officials. Use of harassment, intimidation, and discrimination in order to silence the plaintiffs reporting of patient safety and ethical violations, was proven for the plaintiffs on all claims against the VA. To this day, the responsible officials remain unaccountable for their actions and are still employed by the VA. VISN 16 and Headquarters officials with oversight responsibility have remain untainted by their failure to act to protect patients and employees. The physician who engaged in substandard medical care for the sole purpose of inflating performance measure data was giving a $5,000 special contribution award and allowed to leave VA employment. His "intentional medical negligence" was never reported to the Mississippi State Board of Medical Licensure. The more than fifty patients adversely affected have never been notified about what actually happened to them, except two who filed malpractice claims.

In 2010 there was a physician-led survey of physician attitudes and experiences with hospital leadership. The results were sent to the Secretary of the VA, the Mississippi Congressional delegation, VISN 16 Network Director, and others. I believe it was dismissed as the product of disgruntled employees. The result was that the failure to assure patient safety and the abuse of authority by VA leaders were ignored.

13. The absence of trust in VA leadership and low employee morale at the G. V. "Sonny" Montgomery VAMC is the result of the failure by numerous internal and external entities to conduct open investigations of allegations made to them. These so called investigations did not put witnesses under oath and did not generate a report or transcript. These include VA Headquarters, VAOIG, Of-

fice of Special Counsel (when Scott Bloch was the Special Counsel), The Joint Commission, and the Department of Labor. Officials of most of these entities were given information about abuse of authority and ethical lapses that led to the deaths of patients. It also demonstrates the inherent information advantage that the hospital leadership leveraged to undermine, dismiss, or deflect allegations of misconduct, mismanagement, and abuse of authority against them. It also demonstrates the inability of agencies with oversight responsibility to see and understand a pattern of mismanagement and abuse of authority over time by the same management officials. Each allegation appears to have been processed as solitary event with no appreciation for the larger picture of interconnected events in the management of the hospital.

14. Unrelated to the provision of direct medical care, but demonstrative of abuse of authority is the harassment and retaliation against two employees with military obligations. Major General Cathy Lutz and Colonel Dale Hetrick were audited to produce deployment orders many years after their deployments to Iraq and other conflict zones. This audit was proximate to their objections to the then hospital director and initially involved no other employees with prior military obligations. Although Human Resources (HR) was required to obtain their orders prior to deployment and maintain them in their personnel records, Colonel Hetrick and General Lutz were told that HR could not locate copies of their orders. The threat of large repayments of undocumented leave for military deployment unless the old orders were presented was used against them. The audit took place after Colonel Hetrick's retirement from the Marine Corp. reserve and encompassed the years 2004 through 2010. He was asked to repay $19,504.12 to the VA; a sum he did not owe. Colonel Hetrick chose demotion from his position as AA to the director, though he produced copies of his old orders, and General Lutz chose retirement instead of pursuing the matter in the courts.

15. The fault that makes all of this possible lies in the conflict of interest that is inherent in the Senior Executive Service retention and performance bonus compensation system. This money distorts the ethical boundaries of VA leaders and is directly tied to performance measure metrics as currently structured and administered within the VA. The absence of objective accounting principles to detect data corruption and manipulation are an incentive to "game" the performance data system as it currently stands. It is an open invitation for abuse. When successful lawsuits against the agency do not lead to reforms, even the leadership at the local hospital level, having no expectation of being held accountable, simply view such events as a nuisance and the cost of doing business. The cost to any individual member of VA leadership is nothing since the taxpayer bears court costs and judgements. Finally, without any "clawback" provisions in law, officials with oversight responsibilities near the end of their VA employment or current job have a strong incentive to ignore allegations of wrongdoing and simply run out the clock.

16. For the purpose of brevity the remainder of my written testimony consists of the following cited items:

a. Transcript, exhibits, jury verdict, and index to the transcript of Federal civil trial number: 3:08cv00148TSL–FKB,
UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION;
BRIGHID MCINTIRE, ET AL. PLAINTIFFS
VS. JAMES B. PEAKE,SECRETARY,
DEPARTMENT OF VETERANS' AFFAIRS
b. VA Organizational Code of Ethics
c. Office of Special Counsel Complaint DI- 13–1713 with whistleblower comments: http://www.osc.gov/FY%202013%20A.html
d. http://commdocs.house.gov/committees/vets/hvr031199.000/hvr031199—0f.htm
!999 O & I subcommittee hearing on VA Whistleblower Retaliation
e. VHA Handbook 1004.08 Disclosure of Adverse Events to Patients
f. Talking Points for Disclosure of Adverse Events to Patients
g. August 26, 2010 letter to Mark R. Chassin, President of the Joint Commission concerning understaffing in the Emergency Department, Radiology, and Primary Care
h. April 3, 2013 Clarion-Ledger, Some Nurses Lacked Papers, by Jerry Mitchell
i. August 22, 2011 Clarion-Ledger, Bill Minor Letter to the Editor
j. January 5, 2011 Memorandum from VISN 16 Network Director to Jackson VAMC Director. MICU Staffing and Emergency Department coverage
k. September 24, 2010 Executive Leadership Council South Central VA Health Care Network Video Conference minutes.
l. February 25, 2011 Executive Leadership Council South Central VA Health Care Network Video Conference minutes.
m. January 7, 2011 Email/ memo from Charles Jenkins regarding MICU understaffing and no leadership accountability.
n. May 5, 2011 Clarion- Ledger, "Death: Circumstances of case 'ghastly', attorney for family says" by Jerry Mitchell
o. PL 108–445 Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004 (Physician Pay Bill)
p. Sentinel Events definition and reporting, The Joint Commission: http://www.jointcommission.org/assets/1/6/CAMH—2012—Update2—24—SE.pdf
q. April 13, 2013, New York Times: "Conduct at Issue as Military Officers Face a New Review" by Thom Shanker
r. Department of Veterans Affairs, Veterans Health Administration, VHA Handbook 1100. 18: Reporting and Responding to State Licensing Boards
Federal trial transcript vol 3, p 190, line 21 through p 191, line 7

_____-

_____

_____-

_____

Mr. COFFMAN. General Hearon, you have two and a half minutes to deliver your remarks, please.

STATEMENT OF ERIK HEARON

Major General *Hearon.* My name is Erik Hearon, a CPA from Mississippi, and I also served 40 years in the air force and the Mississippi Air National Guard.

I am here today with but one purpose in mind, to praise and thank veterans for giving us the opportunity to hold such a hearing.

The issues are fundamental and the solutions are apparent, but they have eluded the VA management. Quality healthcare is a benefit earned by our veterans. It is not free medical care. Legislation protects it.

The two opening statements by the chairman and the ranking minority member were excellent. In fact, they said much of what I had in my remarks which are focused on the management side of the house since the medical side has been very well covered.

I had the honor of knowing Sonny Montgomery. His portrait is on this wall. I actually intentionally brought the hat for the dedication of the C17 to Sonny. His memory means a lot to me and to the veterans that are supposed to get quality care up there.

The remarks in addition to what you all said which was excellent, I would like for you to consider that a few months ago it was stated that the veterans' benefits processing would be privatized if they were not fixed by 2015.

I ask that you consider the comments in my written remarks and the estimated calculations from my CPA side of the brain that says we could save about $4.6 billion per year by issuing insurance policies to the veterans and letting them get their care much easier at private clinics than by traveling in some cases great distances to Jackson.

In May of 2011, there was a hearing held in this very room where a lot of promises were made by the VA, and I have seen no evidence that they were fulfilled. A quote from that is in my written remarks.

The Office of Special Counsel has been an integral part of getting information from and about the VA in Jackson and elsewhere. They are painfully aware of that operation.

I talked one week ago today with a veteran who had been misdiagnosed or not diagnosed at all, allowed only to see nurse practitioners, no physicians, for two years. He was informed that he had cancer earlier this year, had his entire stomach removed in September, and only then was he allowed to see a doctor who refused to give him leave from work. He was a VA employee as well. He was terminated and is short one month pay. And it has just been an absolute disaster.

The State of Iowa does not require collaboration. Some of our nurse practitioners have gone there for licensing in order to avoid the supervision that the patients so desperately deserve.

I am over time. I apologize. And I very much appreciate the opportunity to be here with you all. Look forward to any questions later.

[**THE PREPARED STATEMENT OF ERIK HEARON**]

"Correcting 'Kerfuffles' – Analyzing Prohibited Practices and Preventable Patient Deaths at Jackson VAMC"

For the O&I hearing on November 13, 2013 at 10:00; 334 Cannon House Office Building, Washington, DC

Written Comments for the Record by Erik Hearon, CPA and Maj Gen (USAF) (Ret.)

Honor Veterans with a Much Improved VA Health Administration and Central Office

Committee members and staff, thank you for your commitment to ensuring proper care for and treatment of our precious veterans. This hearing focuses on the VA Medical Center in Jackson, MS and is one in a long line of hearings you have held to focus on issues at many VA Medical Centers. This does not excuse Jackson. Instead, the pattern of ongoing but uncorrected errors lasting a decade or more proves many critical points about the systemic VA failures of leadership nationwide.

The dictionary defines kerfuffle as fuss, commotion, to disorder, confuse – all perfect descriptions for some aspects of the Jackson and nationwide VA operations.

In addition to these written comments, I have provided the Subcommittee with two copies of a videodisk of the April 3, 2013 "town hall meeting" in Jackson.

Panel 1 represents over two hundred people in the Jackson, MS area who are very interested in the VA providing the best professional, timely and organized health care to our veterans. Our group is composed of veterans, past and current employees of the VA and concerned citizens. We do not have an official name or a budget. One thing we do have is a strong ongoing commitment to exposing areas for improvement in Jackson and nationally until the issues are fixed.

We thank and support all VA employees who provide professional, caring health care to our veterans. Those who consistently follow the I CARE core values of Integrity, Commitment, Advocacy, Respect and Excellence should be emulated by the others. We wish there was no need for negative discussion, media coverage or Congressional inquiries. We also thank the Office of Special Counsel and every veterans' organization, each investing significant time and resources into improving the VA's management and health care.

One of the members testifying today in the other panel gave me the title "Chief Instigator." I wish that our group's work was no longer needed but there is no sign that we have succeeded in our pursuit for improved management. Transfers to the VISN (Veterans Integrated Service Network) office and to another VISN have not improved health for veterans overall.

During my forty years of military service I heard many stories about deficiencies in the operation of the Jackson VA Medical Center, which is named for G. V. "Sonny" Montgomery. Sonny served in World War II, earned the Bronze Star with Valor and the Combat Infantry Badge, served in the Mississippi House for ten years and served in the US House from 1967 to 1997, including chairing your committee from 1985 to 1997. The Montgomery GI Bill is named for Sonny, as are a C–17 cargo aircraft, the conference room

at the VA's Central Office and many other VA and non-VA facilities. Sonny also received the Presidential Medal of Freedom.

Whenever Sonny was asked "Are you red or blue?" his consistent answer was "I am red, white and blue." Supporting issues to protect national security and Veterans were at the top of his priorities. These issues have normally enjoyed broad bipartisan support and we trust that this pattern will continue. We are sure that the current committee has the same dedication to veterans as did Sonny.

We celebrated Veterans Day two days ago, honoring and thanking the millions of men and women, as well as their families, of all races and faiths who have defended our many freedoms. Their dedication and sacrifice have always protected our freedoms and us for centuries. Chairman Coffman's service in the Army and Marine Corps and during the Gulf War and the Iraq War are extremely laudable. We also thank Rep. Tim Walz for his twenty-four years of military service.

We must remember President Lincoln's commitment in his second inaugural address "to care for him who shall have borne the battle and for his widow and his orphan." The Department of Veterans Affairs has been responsible for fulfilling President Lincoln's commitment. I believe that the spirit with which Sonny served Veterans has been displayed in several management actions of the current VA administration.

The VA has more than 1,700 facilities, employs over 200,000 people and cares for over 6.3 million Veterans each year. The VA's Health Administration (VHA) expenditures are over $53.4 billion or about $8,500 per patient per year on average.

A House Veterans' Affairs Committee (HVAC) hearing in April 2013 included a commitment by a Congressman to the VA that he would introduce legislation to privatize the benefits process if the claims backlog has not been resolved by 2015. I ask that a similar challenge and commitment should be made now if some significant aspects of health care aren't dramatically improved. The replacement to the VHA should provide the same level of coverage and care through insurance from the private sector and would, I estimate, save at least $4.6 billion annually. The calculations for my estimate for this are at the end of these comments but the primary reason for the suggestion to change to insurance would be to provide better, safer and more appropriately monitored care.

While very many of the VAMCs' physicians and other health care professionals provide excellent care to the patients, management has a much more mixed record. The VA management's failures result in cancelled and delayed appointments, interim and occupants of what should be permanent employees, reduced continuity of care, failure to enforce standards due to the shortages and other issues leading to decreased patient safety and care.

The HVAC has been diligent in pursuing improvements at the VA, holding a hearing in Pittsburgh, PA on September 9 that focused on lack of accountability, questionable bonuses, preventable deaths and patient safety issues. Five VAMCs were in the spotlight: Pittsburgh, Buffalo, Atlanta, Jackson and Dallas.

Dr. Petzel was the lead representative in Pittsburgh from the VA. He has been the Under Secretary for Health for the VA since February 18, 2010 but is "retiring" some time in 2014. I attended

the Pittsburgh hearing and am convinced that the U.S. Representatives conducting the hearing were skeptical initially because of prior events but seemed insulted by some of the VA's responses that day and many failures to respond to the Committee before.

After the Pittsburgh hearing, an incredibly misleading and incomplete press release was published on behalf of Robert A. Petzel, MD, by the VA Central Office in Washington. The press release was a blurred snapshot with so much "photo-shopping" that the actual event was hard to visualize.

The most significant omission or kerfuffle in the press release is that virtually every medical treatment error relates to ongoing poor management over many years but no errors were mentioned. This includes management in some VAMCs, networks (a group of about ten VAMCs) and the VA's Central Office, from chiefs in hospital departments to the Secretary.

An ongoing lack of accountability by VA management personnel was one focus of the hearing. The Pittsburgh VA had five patients die and others sickened (all veterans) recently from Legionella, after multiple warnings about improper maintenance of the water system, going back to 2010. A simple fix had been recommended and ignored, resulting in the unnecessary deaths.

The Pittsburgh VAMC had a world-class research lab to study Legionella but it was closed several years ago by the hospital's director, Michael Moreland, and the samples were destroyed. However, Mr. Moreland was promoted to director over ten VAMCs as well as forty-three outpatient clinics and awarded a Presidential award for a "lifetime of service", based on the recommendation of Dr. Petzel. The award included a $63,000 bonus. The HVAC hearing focused on this as well. Dr. Petzel said "yes" when asked whether or not he would still nominate Mr. Moreland knowing all of the events leading up to the hearing and the deaths. Mr. Moreland's retirement was announced October 4 and his replacement was announced October 24, effective November 2. He was asked to return the $63,000 award during the HVAC hearing in Pittsburgh. The VA said that they do not have a mechanism to "claw back" bonuses. How do the circumstances around Mr. Moreland's promotion, bonus, etc. exemplify any standard of integrity, transparency, leadership, care, etc.?

Bonuses to "leaders" at facilities and networks with serious and well-known problems were another focus of the hearing but were not mentioned in the VA's press release. The criteria and calculations for bonuses are closely guarded secrets but the HVAC and some in the media have worked to crack the wall of secrecy. Some people directly or indirectly in charge of VAMCs which had, and often still have, significant medical errors received bonuses anyway as investigated by your committee.

Bonuses of over $408 million in a recent fiscal year show that bonuses are treated as an entitlement to some rather than for service over and above normal. If an employee cannot consistently follow the I CARE core values, they should be reprimanded, receive no bonus for that year and their appraisal should reflect this. An investigative story titled "Death and Dishonor: Crisis at the VA" aired two days ago on CNBC and highlighted the bonus issue in Jackson, as have other media reports.

Several families testified about suicides and other deaths resulting from VA errors and management issues, including under-staffing. Dr. Petzel's attempt at apologizing to the families was enough to make about 90% of the audience groan.

The VA's culture of tolerating a certain level of unnecessary patient deaths and injury should never have existed and must be immediately stopped, with disciplinary action for those who accepted it. Suicides and other unnecessary deaths have not received a proper and forceful response.

A culture of not removing problem employees exists in Jackson. Transfers from a VAMC to another VAMC or network have been considered as corrective but keep them on the VA payroll without taking real action.

The Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency. The OSC has received proportionately more complaints about the VA than any other US Government agency. Everyone who wants better performance at the VA at all levels appreciates the OSC's diligent work to make this happen. If the VA would pursue corrective actions on substantiated complaints we might not need this hearing. Secretary Shinseki has signed many reports to the OSC, including about Jackson, but no leadership personnel have received noticeable adverse actions.

Considering the reports to the OSC and the many reports of needed corrections from the VA's Office of the Inspector General, the number of repetitive problems should have been a huge wakeup call long ago.

Many issues have also been brought to the VA's attention by House and Senate Veterans' Affairs Committees. It seems like an extremely sad and expensive whac-a-mole game wherein the same problem occurs in a new location when the VA says it has resolved the same issue in recent but different locations.

Problems have existed in some VAMCs about improper narcotic prescriptions. The management of the VAMC in Jackson, MS has fought with the MS Boards of Medical Licensure and Nursing, as well as the DEA, about some Nurse Practitioners operating beyond their license. Some nurse practitioners at Jackson have even obtained a license from Iowa, although Mississippi has been their source before, because Iowa does not require collaboration or supervision of them by a physician. Ultimately patient health and safety are at risk as illustrated by a tragic situation described below.

Allowing employees who have been previously licensed in their state of residence and the VA facility at which they work to change to another state for licensing should not be allowed. It allows people to seek the path of least resistance (demonstrated professional knowledge). If they can not pass the test in their home state, move to Iowa or a similar state of lax licensing requirements. Patient safety is compromised now.

Patients around the country rely on state Boards of Health, Medical Licensure and Nursing as a critical link in assuring that only competent medical professionals are allowed to practice. Mississippi is no different. However, the "federal supremacy" concept precludes those state agencies from performing their normal monitoring duties to protect patient safety. The agencies cannot improve the attitude of a small percentage of those in Jackson who appar-

ently feel that the patients are an inconvenience but they can more diligently make normal inquiries as well as investigate complaints.

The legal concept of "federal supremacy" adversely impacts the health of VA patients. The state agencies already perform inspections in almost all hospitals, nursing homes, etc. to ensure the quality of patient care. They have been stiff-armed in Jackson and federal facilities throughout the country. The "federal supremacy" concept should be abandoned immediately for the entire VA system.

Effective initial and continuing training for VA supervisors and "leaders" does not exist. If the training were effective, the same or very similar problems would not keep appearing. Most VAMCs and networks are run safely and effectively but others do not have management with a sense of dedication, service and integrity. When the OSC investigated errors in prescribing narcotics and the VA promised they had changed, within one week the Jackson VA was again telling physicians to prescribe narcotics for patients they had not examined.

Many critical management practices must be corrected. The VA claims to follow core values as described in their I CARE posters: Integrity, Commitment, Advocacy, Respect and Excellence. If the VA lived by the I CARE values, job openings for medical professionals would be few and easily filled, "leadership" positions would be filled by permanent employees instead of having so many "acting service chiefs" (the Jackson VAMC has spent a year with 15–17 acting chiefs), continuity of care and management would be greatly improved with resulting increases in quality of care and employee morale, employee appraisals would be accurate, inspections would be routine, media and Congressional inquiries would not be feared, and VA press releases would be much more truthful.

Your full Committee held a hearing on May 3, 2011 in this same room. The subject was "Sacred Obligation: Restoring Veteran Trust and Patient Safety", a laudable and reasonable expectation. Chairman Jeff Miller's remarks included "After these incidents [of serious patient safety violations] the VA assured Congress and the country that it was aggressively addressing patient safety issues and never again would a veteran's trust be compromised by lapses in quality care at a VA medical facility and, yet, each patient safety incident has seemingly led the way for the next lessons learned and the unacceptable and inexcusable revelation that the patient safety culture in VA is fractured and accountability and leadership at the helm are lacking. The time for talk is over." (page 4) Legionella in Pittsburgh and a significant turnover and lack of physicians, at least in Jackson, are clear signs that the VA's assurances on May 3, 2011 have not been fulfilled. The subject for that hearing should have been easily understood and attained by the VA but it has not been in too many situations.

The culture that has grown over the last decade or more in Jackson has not improved the trust of veterans. Mr. Joe Battle, the center director, has been in Jackson for one year and ten months. In my view, Mr. Battle is a fine person and has tried hard to improve health care but has been hampered and constrained by the apparent lack of information and support by his staff, VISN 16 and the VA Central Office.

At the urging of U.S. Senators Cochran and Wicker from Mississippi, a "town hall" meeting was held in Jackson April 3, 2013. Robert Petzel, MD, Under Secretary of Health for the VA, was the key speaker, accompanied by Gregg Parker, MD, Ms. Rica Lewis-Payton from VISN16 and others. An opportunity to restore communications and trust between the VA and over 200 veterans in attendance was completely wasted and actually fueled the frustration. The third relatively recent article in the New York Times about the Jackson VA's challenges was in the next day's issue and was about one-half page with a photograph.

The ratio of physicians and nurse practitioners in primary care in Jackson has been skewed for years. The ratio has been three nurse practitioners (NPs) per physician but is now said by the VA to be approaching two to one. The 3:1 ratio evolving from the direct efforts of a former Chief of Nursing Services who resisted the hiring of physicians. She was arrested on narcotic charges May 23, 2012 and returned to work about thirteen (13) months later after criminal charges were dropped. She received her pay of about $170,000 annually throughout that absence. The New York Times reported in a September 9, 2013 article that she "received $61,250 in performance bonuses between 2003 and 2011". I personally had a DEA agent tell me that they would not be able to pursue the case against her "due to political pressure". She has been assigned to VISN16.

Another factor in some lapses in quality care is that the professional judgment and medical orders of some physicians were overridden by a nurse practitioner. While the large majority of NPs in Jackson provide caring and professional care, some appear to feel that they are qualified to make better decisions than the physicians. When this situation arises and particularly when it is allowed to stand, the insult to physicians is dramatic and well known among the staff.

Just this past Wednesday, one week ago today, I was told about and interviewed a veteran of over twenty years who also happened to be an employee of the Jackson VAMC. He and his wife told me that he had been seen for almost two years only by nurse practitioners and could not see a physician. They went back for his appointments each three to four months complaining of increasing levels of pain. Each time he was given medicine just above the level of aspirin and given another appointment. They said the VA drew his blood for a routine test on each visit but never ran a CA–125 test to check for cancer, although a CT scan had disclosed "something". He finally and totally lost faith in the VA's health care and obtained non-VA medical care, which discovered this past April that he had adenocarcinoma in the stomach. His private oncologist wrote him an excuse to miss work indefinitely while he received chemotherapy but the VA Human Resources department would only accept the document for six months. At the end of that time and while still receiving chemotherapy he had to argue with a physician in primary care and she finally extended the excused absence for three days, yes, three days. The physician also all but told him he was being a slacker, based on her view of other patients' actions. His entire stomach was removed about two months ago. Some of his small intestines were made into a stomach and

he continues chemotherapy. He missed an entire month's pay, has not received it yet, is out of the VA pay system, receives Social Security Disability and $230 monthly from the VA. He also lost about $5,000 out-of-pocket on insurance deductibles since he could not get his earned but insufficient care at the VA for his illness. He has not received an institutional disclosure from the VA, not to mention an apology for misdiagnosis. He has a wife and six children. The spirits of the parents are much better due to their faith than I expected but their upcoming financial and health situations are of great concern. In my view, he should immediately receive a personal apology from the primary care physician, his full pay for the month or so gap created when paperwork was not properly handled, reimbursement of the full amount of his insurance deductibles and an institutional disclosure to help him understand his legal alternatives with the VA. He is the second veteran I have talked to in the last five months with a very similar story.

The horrific situation described above comes after the well-publicized April 1, 2011 death of a veteran within a very few hours of surgery. Johnnie Lee bled to death in recovery because no one checked on him for hours. Before Mr. Lee's death, the FDA issued warnings in 2009 and February 2011. The medical procedure required checking the patient about every fifteen minutes. The VA claims that The Joint Commission (also known as JACO) investigated the case of Mr. Lee's death and decided that nothing was done wrong. In my mind, the quality of the investigation by JACO in this case was substandard and disqualifies JACO inspections as qualifying as any comfort about the quality of care at Jackson and nationwide.

At the Jackson VAMC, there are no orthopedic surgeons or podiatrists. It is obvious that those specialties and many others are needed for the patient population. Those services have been contracted to outside facilities. However, several if not all of the best local orthopedic practices have discontinued accepting referrals from the VA due to non-payment from the VA for extended periods. After relying on outside practices and being unable to staff the specialty themselves, the VA's Central Fiscal Office should be examined and reprimanded, if appropriate, with firings due to the impact on patient care of their delay in paying legitimate bills. The slow payments to vendors also came up in the April 3, 2013 "town hall" meeting.

There should absolutely not be funds for bonuses to VA "leadership" if the health care providers cannot be paid on time.

The terror faced by some veterans after medical errors has been exacerbated by the VA and US Attorneys. A World War II veteran in Jackson who drove other veterans to the hospital was blinded in both eyes after an undiluted solution was put in both eyes for cataract surgery. The covering to both eyes boiled away. His whole life turned upside down. Very limited help was offered by the VA. The VA and US attorneys fought him tooth and nail in court and lost. If his situation could have been made worse, the VA and US attorneys found a way to do so in this and other cases.

Accountability, highlighted at the Pittsburgh hearing as a critical factor, has been partially shown in two instances. A physician who was Chief of Staff in Jackson instructed physicians to prescribe

narcotics to patients who had not been examined by that physician, which risked the medical license of physicians who followed his instructions. He was ultimately removed from his "leadership" position where he saw very few if any patients but he remains in the Jackson VA medical center as a physician, creating "kerfuffle" or confusion among other employees as to his true role. Additionally, the Chief of Primary Care received enough encouragement to get him out of the Jackson VA but he transferred to a VA in Mountain Home, TN, in another VISN.

The VA website states that they are "the nation's largest integrated health care system . . . ". Some financial institutions were said to be too large to fail. I suggest that it is past time to consider whether the VA is too big to succeed.

What is the solution? Any solution must include the immediate retirement or termination of all "leaders" who knew or should have known of the practices which led to patient deaths or serious injury or who condoned lapses of ethics and integrity. The changes must be transparent and decisive to restore trust among the Veterans. Actions by people in "leadership" positions, as well as their lack of actions, send messages to employees and the veterans. The message so far has often been "no matter what you do or how much you ignore the I CARE core values, we will not fire you." To paraphrase General Colin Powell's first rule of leadership, "Being responsible sometimes means making some people very mad."

The solution to ongoing VA problems must also include the retirement of Secretary Eric Shinseki. While he had a distinguished military career, Secretary Shinseki has failed to acknowledge and correct leadership deficiencies or serious and well-known problems affecting many Veterans.

Secretary Shinseki has signed so many reports to the Congress and OSC acknowledging deficiencies that he has no plausible deniability about knowing of serious problems in VISN16, Jackson and elsewhere. Leadership starts at the top and he is directly and personally responsible for his failure to lead the VA or to hold his staff accountable. The responsible action is for Secretary Shinseki to resign, along with Dr. Petzel, Mr. Moreland and others. Those willing and able to perform for the veterans should be encouraged and the others should leave the VA. Only a clean house, with the windows wide open, will restore the lost trust of the Veterans and show that the VA truly cares.

Again we thank the Oversight and Investigations Subcommittee, the full Committee and your staffs for continuing to focus the VA on accountability, responsibility, transparency, transformation and fully pursuing their core values of I CARE. Thank you for the Accountability Watch featured on your website. We also thank the Office of Special Counsel and the media in Jackson and around the country for covering the shortcomings, as well as the successes, of the VA.

We especially thank those current and former VA employees who care for our veterans appropriately and who have shared information to improve the medical care.

We look forward to continuing work with the Committee in the future to support your critical oversight. Thank you and God Bless America.

Veterans Health Administration (VHA)
Comparison of Providing Insurance v. VHA Costs; Estimated
52 Medical Centers, 817 Community-Based Outpatient Clinics
Money spent in Veterans Health Administration, FY12, per VA Performance and Accountability Report, unaudited ($ in millions)
Budgetary; Part IV, page 4; Note (1)
Personnel compensation and benefits
Other contractual services
Supplies and materials
Land and structures
Equipment
Rent, communications and utilities
Grants, subsidies and contributions
Other
Less VA Community Living Centers / Nursing Home; Note (2)
Plus FY13 VHA construction request; Note (3)
Total
Note: FY13 discretionary funding for Medical Care $55,672 million
$417 million for General Administration and $1,271 million for construction and grants; Note (4)
2013 premium example; standard option for veteran only; includes
monthly gov't + employee premiums; Note (5)
times number of months to annualize
premium per patient per year; estimated
times number of unique patients in VA system; FY12 estimate; Note (6); in millions
Estimated premiums for veterans only; in millions $
Estimated additional amount for covered family—10%
Total estimated premiums (in millions)
Estimated savings to close VHA portion of VA (millions per year)
Notes:
(1) www.va.gov/budget/docs/report/PartIV/2012–VAPAR—Part—IV.pdf
(2) VA 2013 Congressional Submission; page 1A–5; FY12 estimated
(3) VA FY13 Budget Request, Vol IV, page 1–1
(4) www.va.gov/budget/docs/summary/Fy2013—Fast—Facts—VAs——
Budget—Highlights.pdf
(5) as an example, 2013 Blue Cross and Blue Shield Service Benefit Plan; non-Postal premium; page 150 of printed brochure; www.fepblue.org
(6) www.va.gov/budget/docs/report/PartI/2012–VAPAR—Part—I.pdf; page I–31
$ 27,529
11,580
8,784
3,231
2,058
1,869
1,300
1,040

(4,250)
1,024
54,165
600
12
7,200
6.2547
45,034
4,503
49,537
$ 4,628

Some articles (links where available) to some media stories about Jackson's VA and the VA system:

Title

Author; source; link

Death at VA hospital probed; Employee found dead in room after routine leg surgery

Jerry Mitchell; Clarion Ledger; published May 8, 2011

Jackson VA Hospital official (Dorothy White-Taylor) charged with drug fraud

Clarion Ledger; published May 24, 2012

Rep. Bennie Thompson asks probe of VA staffing, patient care

Clarion Ledger; published June 13, 2012

Documents link deaths to improper VA staffing

Jerry Mitchell; Clarion Ledger; published August 25, 2012

Narcotic scripts focus of VA probe

Jerry Mitchell; Clarion Ledger; published August 25, 2012

Congressional Investigation of Jackson VA in order

Charles "Todd" Sherwood; op-ed in Clarion Ledger; published September 12, 2012

Federal probe: VA hospital in Jackson subject of scathing report

Robert Burns (AP); Clarion Ledger; published March 20, 2013; clarionledger.com/viewart/20130320/NEWS01/303200028/Federal-probe-VA-hospital-Jackson-subject-scathing-report

Town hall opportunity to discuss veteran care at Jackson VA

Senator Roger Wicker; op-ed in Clarion Ledger; published March 24, 2013

Questions welcome at VA town hall meeting

Jerry Mitchell; Clarion Ledger; published March 30, 2013; clarionledger.com/apps/pbcs.dll/article?AID=2013303300025

VA's appalling failure in MS are not recent problems

Sid Salter; op-ed; Clarion Ledger; published March 31, 2013; clarionledger.com/apps/ pbcs.dll/article?AID= 2013303 310030

Some VA nurses went out of state for needed certification; certification from Iowa seen as way to skirt MS Boards

Jerry Mitchell; Clarion Ledger; published April 3, 2013; clarionledger.com/apps/ pbcs.dll/article?AID=2013304030012

Some vets frustrated by one-sided format at VA town hall meeting; Officials say hospital one of best in nation

Jerry Mitchell; Clarion Ledger; published April 4, 2013; clarionledger.com/apps/ pbcs.dll/article?AID=2013304040047

Meeting didn't give veterans chance to speak on issues

Clarion Ledger editorial; published April 5, 2013; clarionledger.com/article/20130405/ OPINION01/304050015/Meeting-didn-t-give-veterans-chance-speak-issues

VA can't get worse, must get better

Bob Slater, Madison, MS letter to the editor; Clarion Ledger; published September 19, 2013; clarionledger.com/apps/pbcs.dll/ article?AID=/201309201635/OPINION02/ 309200320

Counsel: VA deficient in care, responding to problems

Jerry Mitchell; Clarion Ledger; published September 22, 2013

Veterans no longer trust VA hospital for care; mentions numerous names

Fred Lucas (veteran); op-ed; Clarion Ledger; published October 12, 2013; clarionledger.com/apps/pbcs.dll/article?AID=2013310120035

A Pattern of Problems at a Hospital for Veterans

James Dao; New York Times; published March 19, 2013; nytimes.com/2013/03/ 19/us/whistle-blower-complaints-at-veterans-hospital-in-mississippi.html?emc= eta1&—r=0

Veterans Affairs Officials Offer Reassurance About Troubled Hospital

James Dao; New York Times; published April 4, 2013; nytimes.com/2013/04/04/us /veterans-affairs-officials-offer-reassurance-about-troubled-hospital.html?—r=0

V.A. Inquiry Finds Inadequate Staffing of Doctors at Mississippi Hospital; re accusations by Dr. Phyllis Hollenbeck

James Dao; New York Times; published September 9, 2013; nytimes.com/2013/09/09/ us/inquiry-finds-inadequate-staffing-at-mississippi-veterans-hospital.html?—r=0

Death and Dishonor: Crisis at the VA

Dina Gusovsky; CNBC documentary; cnbc.com/id/10001293?—source=vty%7C investigationsinc%7C&par=vty

20 Buffalo VA patients test positive for hepatitis

Jerry Zremski; Buffalo News; printed May 9, 2013; buffalonews.com/apps/pbcs.dll/artic le?AID=/20130509/ CITYANDREGION/ 130509231

Mr. COFFMAN. Thank you, General.

Mr. Jenkins, you are now recognized for five minutes.

STATEMENT OF CHARLES JENKINS

Mr. JENKINS. Thank you, Chairman Coffman, Ranking Member Kirkpatrick, and committee Members. I appreciate the opportunity to be here.

My name is Charles W. Jenkins. I am the elected president for the American Federation of Government Employees at the G.V. Sonny Montgomery VA Medical Center.

I represent over 900 employees at the medical center which includes some nursing assistants, licensed practical nurses, respiratory therapists, phlebotomists, and other direct care and non-direct care workers to do critical work.

I am a service-connected veteran myself and a large number of our employees that work at the VA are service-connected veterans who provide outstanding service to our men and women who served their country honorably.

I am here in front of this honorable committee to request investigations into a number of disturbing and preventable situations that occurred at the Jackson VA Medical Center.

Over the years, management has consistently been inconsistent in responding to staffing problems. Since 2003, AFG Local 589 has repeatedly requested that the VA leadership address short staffing and nursing personnel and a number of inpatient wards, particularly 2A, the surgery ward, and other wards. Management made a few improvements despite our many requests.

On April 1st, 2011, a veteran, a long-time employee by the name of Johnny Lee, who I knew personally, bled to death on 2A, the surgical ward.

This year, September of 2013, I was informed during a staff meeting that we had 14 patients fall in the month of September, 14 in one month.

I talked to the head nurse on that floor. I asked her about staffing. She acknowledged that they had a staffing problem. She also acknowledged that leadership was aware of the staffing problem.

Local 589 also filed multiple requests to the division director, Ms. Rica Lewis-Payton, and our current center director, Mr. Joe D. Battle, to request investigations into incidents of nepotism involving our chief nurse exec who is currently not in that job, Ms. Dorothy M. White-Taylor, and some of her deputy chief nurses.

Since 2012, AFG Local 589 has sent 12 written requests to the medical center director to investigate alleged violations by several members of his management team. Unfortunately, leadership has been very reluctant to address alleged violations of rules and regulations by certain members of their own team in comparison to complaints against regular employees which would be investigated quicker.

Despite numerous requests, management waited more than one year to launch an investigation into the improper hiring practices of Ms. Dorothy M. White-Taylor. Currently that is ongoing according to Mr. Battle in a memoranda I received from him dated in September.

VA leaders have also failed to hold a service chief of medical administration service accountable for giving employees unauthorized access to veterans' my healthy vet account.

Giving these employees this unauthorized access was a privacy violation of these veterans. Veterans were enrolled into my healthy vet account without their own approval or their own knowledge.

These actions constitute a clear violation of patient privacy and breach the sacred trust that our veterans expect and deserve. The veterans who receive their care at the G.V. Sonny Montgomery Medical Center and dedicated employees whom care for them truly deserve an investigation of the concerns raised by AFG Local 589.

Thank you all for giving me the time.

[THE PREPARED STATEMENT OF CHARLES JENKINS]

* G.V. "Sonny" Montgomery VA Medical Center in Jackson, MS has suffered for many years from understaffing of nursing positions, nepotism in hiring of nursing positions and other harmful

management practices that have hurt patient care and employee morale.

* AFGE Local 589 has repeatedly requested that management at the facility level and the VISN level address these issues. In almost every instance, management has been very slow to respond and typically has not taken any or preventive measures or other significant actions to address the problems raised.

* Understaffing in several areas of the facility has led to an increase in patient falls.

* Leadership at the VISN and facility levels have not held management accountable for providing unauthorized access to My Healthy Vet that resulted in violations of patient privacy and improper manipulation of enrollment data.

* Several managers have engaged in illegal nepotism by hiring their immediate family members to fill nursing positions at this facility, and have not been held responsible for their actions despite repeated requests by Local 589 for an investigation.

ADDITIONAL STATEMENT OF MR. JENKINS

STATEMENT OF CHARLES JENKINS, PRESIDENT

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES LOCAL 589
G.V. "SONNY" MONTGOMERY VA MEDICAL CENTER
JACKSON, MISSISSIPPI
BEFORE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
NOVEMBER 13, 2013

Chairman Coffman, Ranking Member Kirkpatrick and Members of the Subcommittee:

Thank you for the opportunity to testify today on behalf of Local 589 of the American Federation of Government Employees (AFGE) regarding understaffing of nursing personnel, nepotism in hiring and other practices that have adversely impacted employee morale and patient care at the G. V. "Sonny" Montgomery VA Medical Center in Jackson, Mississippi.

I have served as President of AFGE Local 589 since 2001. I have worked at the Jackson VA Medical Center for 18 years as a housekeeping aide, nursing assistant, and most recently, medical supply technician.

I am a service-connected disabled veteran who served in the Navy. Many of my coworkers also represented by AFGE are veterans who consider it a great honor to take care of other veterans as VA employees.

The front line employees represented by Local 589 are hardworking men and women who do their best to provide exemplary service to our Nation's Veterans. We have become increasingly concerned about a number of issues, summarized below. (A more detailed list of requests for investigation submitted by Local 589 is set forth in the Appendix.)

I. UNDERSTAFFING OF NURSING PERSONNEL

Since 2003, Local 589 has requested that management address severe short staffing of nursing personnel in a number of inpatient

areas that were resulting in frequent patient falls and other patient harm. Management has been very slow to respond and has not taken sufficient action to resolve the problem. While management has addressed understaffing in some areas, Ward 2A (where surgery and general medicine patients are cared for) continues to be very short staffed. On October 16, 2013, Local 589 learned that fourteen patients fell during the month of September.

II. NEPOTISM IN HIRING OF NURSING PERSONNEL

Since 2012, Local 589 has submitted multiple requests to the VISN Director and the Medical Center Director to investigate instances of nepotism involving the Associate Director of Patient Care Services and several Deputy Associate Directors hiring their own family members for nursing positions. Management waited for more than a year to convene an investigation. On September 30, 2013, the Medical Center Director informed Local 589 through a memorandum that the investigation is still ongoing.

III. MANAGEMENT VIOLATIONS OF PATIENT PRIVACY AND MANIPULATION OF ENROLLMENT DATA IN MY HEALTHY VET

Local 589 also asked management to investigate actions by a service chief that provided employees with unauthorized access to the My Healthy Vet accounts in order to artificially boost enrollment numbers for our facility. Management conducted an investigation in May 2013 but has not provided us with any of their findings.

Thank you for the opportunity to share the concerns of AFGE Local 589.

APPENDIX

> On May 29, 2013, (more than a year after I requested an investigation) I received a memorandum signed by Center Director, Joe D. Battle, which states they were appointing an Administrative Board of Investigation to investigate then Associate Director of Patient Care Services (PCS) Dorothy M. White-Taylor for making threatening remarks to me following my complaint about how she treated employees, her alleged employment of a nephew in PCS and her alleged receipt of prescribed controlled substances from certain VA providers.

> On June 6, 2012, Local 589 Vice President Nena P. Jackson and I sent a memorandum entitled "Request for Investigation" to Center Director Joe D. Battle, and Acting Associate Director of Patient Care Service (PCS) Ms. Thelma Gray-Becknell. Our memorandum requested an External Administrative Board of Investigation into the hiring and promotional practices of Nursing/Patient Care Services, in violation of Center Policy K–05–37 that restricts the employment of relatives.

> On June 12, 2012, Local 589 Executive Board sent a memorandum to the Director's office (date and time stamped June 12, 2012 @12:47 noon) which requested an "External Audit & Investigation" to be done in reference to all bargaining unit promotions and individuals hired by the prior Associate Director, of Nursing/PCS (Dorothy M. White-Taylor).

> On June 14, 2012, Local 589 Executive Board received a written response to our June 12, 2012 Request for External Audit & Investigation. The response was from Acting Chief of Human Re-

sources Management Service (HRMS) Tracy L. Skala and stated that the request was being reviewed. We have not been informed about any other actions since that date.

> On June 14, 2012 @3:14pm I sent six (6) emails with attachments stating our concerns about staffing and nepotism, among other matters, to the VISN Director and Medical Center Director. I was fully aware that Ms. Lewis-Payton and Mr. Battle were new to their positions. My information to them was a sincere attempt to inform them about past and current problems at our Jackson VAMC. On June 14, 2012 @9:33pm, Ms. Rica Lewis-Payton responded to my email. She stated, "I am on travel the next couple of weeks. Please be assured I will thoroughly review the documents. Thanks for your commitment to Veterans and the Jackson VAMC."

> On June 19, 2012, @5:00am I sent an email to Mr. Battle and Ms. Gray-Becknell discussing mismanagement, abuse of authority and understaffing, and requesting an external investigation.

> On June 25, 2012, I sent another email to Director Battle and VISN 16 Network Director Rica Lewis-Payton requesting an investigation of the same matters.

> On August 8, 2012 Local 589 sent a second request for an External Audit, in regards to the hiring and promotional practices of Dorothy M. White-Taylor.

> On September 4, 2012, during a Labor/Management meeting, Center Director, Joe D. Battle verbally stated that the Union's request for an External Audit & Investigation would be honored. There was no follow up action.

> On September 18, 2012 I sent an email to Director Battle to discuss the Union's request for an External Audit & Investigation that still had not been done.

> On September 24, 2012, @6:07am, I sent an email to Director Battle stating, "I have no faith in this VACO investigation at this point. If the investigator is Attorney John Davis (an HR consultant with VHA), I am extremely disappointed and believe a cover-up is at work."

> On September 26, 2012, @4:28pm, I sent an email to Director Battle requesting a written response to the AFGE Local 589's September 12, 2012 memorandum.

> On September 28, 2012, I receive a memorandum from Director Battle, stating that he had appointed John Davis over my objections, to conduct a fact-finding inquiry in connection with the various issues the Union has brought forward.

> On October 17, 2012, @6:01pm, I sent an email to John F. Davis, Mr. Battle and Ms. Lewis-Payton. I informed them that the Union disagreed with the "fact-finding" Mr. Davis did regarding the Union's allegations of nepotism.

> On November 14, 2012, @8:22am, Local 589 Vice President Nena P. Jackson sent an email to Director Battle asking him the status on the investigation concerning nepotism.

> On December 1, 2012, @3:07pm, Mr. Battle sent an email to VP Jackson and me. He stated: "I was given a preliminary review earlier in November but I asked for more work to be done so it is still in progress."

> Mr. Battle waited more than one year before he convened an ABI against Dorothy M. White-Taylor. (May 29, 2013) He used John F. Davis as the Chairperson.

> On September 25, 2013, Vice President, Nena P. Jackson and I sent a memorandum to Mr. Battle, requesting the status of the ABI done on Dorothy M. White-Taylor.

> On September 30, 2013, Mr. Battle sent the Union a memorandum stating that the investigation is still ongoing.

> As of the date of this hearing, the Union has not received any more information on this matter from Mr. Battle. Union officials were informed by anonymous sources that Dorothy M. White-Taylor was reassigned to a VISN position.

> Privacy violations:

o On December 7, 2012, I sent a memorandum to Center Director Battle, requesting an External Board of Investigation against Chief of Human Resources Office Management Services, Tiffany S. McFadden. Local 589 alleged the following violations against her: abuse of authority, violation of agency regulations and rules, violation of Privacy Act and Medical Center Policy Number B–136–25, gross mismanagement, violation of law against "Prohibited Personnel Practices" , 5USC Section 2302(b) (6). The memorandum also provided witness statements from six (6) employees.

o On December 10, 2012, the Chief of HRMS, Tiffany S. McFadden openly admitted to Jessie J. Thompson, President of SEIU, and me that she had assigned her husband (a non-employee) to work in a sensitive area of HRMS reviewing sensitive information.

o On December 11, 2012, during a Labor/Management meeting, I spoke with Center Director, Battle, and other PENTAD Leaders, regarding Ms. McFadden's admittance of having a non-VAMC individual (her husband) in a sensitive area. I further explained how she forced employees to work overtime without negotiating, and how her husband, a non-VA employee was reviewing sensitive information that had employees' names on it.

o On December 13, 2012, @9:29am, I sent an email to Ms. Rica Lewis-Payton, Mr. Battle and other PENTAD Leaders. I asked Ms. Lewis-Payton for her assistance, and requested that she investigate Ms. McFadden's conduct.

o On December 14, 2012, I spoke with Ms. Rica Lewis-Payton via telephone. I mentioned to her the Union's concerns about Ms. McFadden forcing employees to work overtime, and having her husband in a sensitive area of HRMS, and reviewing employee information. Ms. Lewis-Payton made a statement to me about this being a "witch hunt". Later on that same phone call, Ms. Lewis-Payton stated that there is no further need for an investigation into my allegations.

> Nepotism: On January 8, 2013, @7:30pm I sent an email to Mr. Battle and Ms. Lewis-Payton, informing them that an employee hired by Ms. McFadden had the same mailing address as Ms. McFadden. It was alleged that the employee is related to Ms. McFadden, which would constitute a violation of the law "Prohibited Personnel Practices" if proven true.

> On January 9, 2013, @2:44pm I sent an email to Mr. Battle and Ms. Lewis-Payton, in which employees had witnessed Ms.

McFadden's husband in a sensitive area of Human Resources again.

> On January 10, 2013, I was verbally informed by Mr. Battle that Ms. McFadden would be detailed out of HRMS and an ABI would be convened.

> On January 13, 2013 @04:24pm, I sent an email to Mr. Battle, thanking him for detailing Ms. McFadden out of HRMS and deciding to convene an ABI.

> On January 22, 2013, I received a memorandum from Mr. Battle informing me that an ABI would be done regarding the allegations that AFGE Local 589 brought forward about Ms. McFadden, Chief of HRMS. The allegations were: hostile working environment prohibited hiring practices by Chief of HRMS, fraternization by human resources management, unauthorized access to Human Resources by visitors, and mismanagement of HRMS processes by HRMS Leadership.

> On March 27, 2013, May 6, 2013, June 10, 2013, and September 25, 2013 I sent a memorandum to Director Battle asking for the status of the ABI on Ms. McFadden, and the recommendations from the ABI.

> On October 9, 2013 I received a memorandum in the AFGE mail slot, predated June 18, 2013. It stated, "Once the actions of the Board have been completed we will process your request under the Freedom of Information Act." This was signed by Center Director, Battle.

> On April 11, 2013, @5:11pm I sent an email to Center Director Battle requesting that Medical Administration Service Fred A. Nichols be investigated. My emails provided documentation of some of Mr. Nichols' past inappropriate conduct.

> On April 22, 2013, I sent an official memorandum requesting an External Investigation against Fred A. Nichols, for the following allegations: bullying and disrespectful conduct, mismanagement and abuse of authority.

> On May 29, 2013, Director Battle sent me a memorandum, stating that an ABI was being appointed to investigate the following allegations regarding Fred A. Nichols; hostile work environment, privacy violations pertaining to MyHealthyVet and abuse of authority.

> On September 25, 2013, AFGE Vice President, Nena P. Jackson and I sent a memorandum to Mr. Battle, requesting the status of the ABI done on Fred A. Nichols.

> On October 9, 2013, the Union received a predated memorandum (dated September 30, 2013) in the AFGE mail slot. It stated, "As of this date, the investigation on the Chief, MAS is still ongoing."

> Request for an Investigation against prior Acting Chief of Pharmacy Service, James H. Whelan: On June 21, 2013, I sent a memorandum to Center Director Battle, (date and time stamped @ 2:36pm) requesting an External Investigation (ABI) against James H. Whelan, Acting Chief of Pharmacy Service for abusing the leave of pharmacy techs and other employees we represent.

> On October 9, 2013, @6:46pm I sent an email to Mr. Battle, entitled "Following up on issues of importance". I mentioned that

the Union's request for an ABI on James H. Whelan had not been replied to.

> As of the date of this hearing, the Union had not received a response from Mr. Battle regarding our request for an ABI on James H. Whelan. Mr. Whelan is no longer Acting Chief of Pharmacy Service, but I was told he is still in a management role.

> Concerns about understaffing during Dorothy M. White-Taylor's tenure as Chief Nurse/Associate Director of Nursing/Patient Care Services:

o On September 18, 2003, AFGE Local 589 officers sent a memorandum to Chief Nurse, Dorothy M. White-Taylor and Center Director, Richard J. Baltz. We requested the Nurse Staffing Plans for all inpatient wards (4CS, 4CN, 2A, Ground Floor Nursing Home, First Floor Nursing Home).

o On February 5, 2004, Center Director Baltz proposed a Pilot Program to address patient falls to start in the GFNH –Ground Floor Nursing Home. The program would utilize log sheets to ensure that patients are observed every hour, and staff are assigned hourly rounds.

o On February 18, 2004, AFGE Local 589 responded to Center Director Baltz, stating the fact that AFGE had more than two years of continual communication with Chief Nurse Dorothy M. White-Taylor and the Center Director in regards to staffing needs, and that the union had repeatedly communicated their concerns about the impact of short staffing on patient falls.

o On March 30, 2004, the union sent emails regarding gross staffing problems in the Ground Floor Nursing Home. We sent these emails to Dorothy M. White-Taylor, Prior Chief of Staff, Kent A. Kirchner, and Rosa T. Garner, (one of the Deputy Chief Nurses).

o On September 16, 2005 I sent emails to Dorothy M. White-Taylor, Rosa T. Garner, Acting Center Director, Rebecca J. Wiley, in regards to inadequate staffing levels and other deplorable working conditions in the Ground Floor Nursing Home.

o On December 29, 2005 @11:03am I sent an email to Associate Director, James Pasquith in regards to the fact that no one from the Chief Nurse's (Dorothy M. White-Taylor) or Center Director's office had contacted Union officials regarding the September 16, 2005 email addressing staffing in the GFNH.

o On June 5, 2005, @05:02pm, I sent an email to GFNH Head-Nurse, Jerrie Williams in regards to meeting with her and GFNH Staff, on June 17, 2005 to discuss staffing and other concerns.

o On January 5, 2006, Union officials filed a 2nd step Grievance against Dorothy M. White-Taylor in regards to unhealthy and unsafe working conditions in Ground Floor Nursing Home and First Floor Nursing Home.

o On February 10, 2006 Union officials received a written response from Chief Nurse Dorothy M. White-Taylor. She stated: "I have reviewed information on the current staffing in the NHCU and shared it with the Center Director. He has also reviewed the information and discussed it with me. And although staff levels have met the required patient care hours, senior management has made the decision to add additional nursing assistants to enhance the current staffing levels. This staff will allow the NHCU Head Nurses to schedule three (3) nursing assistants (rather than 2

nursing assistants) for each hall on the day and evening tours when the patient care activity is high. Licensed staff will also be added to ensure patient care is well coordinated with the additional direct patient caregivers in the NHCU."

o On February 13, 2006 AFGE Local 589 Vice President Nena P. Jackson (then Nena P. Davis) and I sent a memorandum proposing nineteen (19) items that AFGE Local 589 and staff in the FFNH & GFNH, thought would improve employee morale and the working environment. This was delivered to Dorothy M. White-Taylor, and Center Director, Richard J. Baltz.

o On January 24, 2008 I sent a memorandum to Director, Baltz, and Chief Nurse Dorothy M. White-Taylor, requesting to meet to address staffing concerns and other issues.

o On September 22, 2009, during a Labor/Management meeting with Center Director, Linda F. Watson, and Chief Nurse, Dorothy M. White-Taylor, Union officials brought to their attention staffing shortages on Wards 4CNorth, 4CSouth, FFNH, and 3K.

o On October 1, 2009, @1:26pm, I sent an email to Dorothy M. White-Taylor, Center Director, Linda F. Watson, Chief of Staff, Dr. Kent A. Kirchner, and Associate Director, Shannon C. Novotny informing them of inadequate staffing in the ENT Clinic.

o On January 14, 2010, @6:22pm, I sent an email to Center Director, Linda F. Watson, and VISN 16 Network Director, George Gray, in regards to serious understaffing in the Supply Processing and Distribution (SPD) Section of Decontamination. (Dorothy M. White-Taylor managed this area as Chief Nurse).

CURRICULUM VITAE

Charles Jenkins has served as President of AFGE Local 589 at the G.V. "Sonny" Montgomery VA Medical Center in Jackson, Mississippi since 2001. He previously held other offices with Local 589.

Mr. Jenkins started working for the VA in 1995 as housekeeping aide. His other positions at the VA include nursing assistant and medical supply technician.

Mr. Jenkins is a service-connected disabled veteran of the Navy. He was born and attended school in Cleveland, Ohio. Mr. Jenkins has been married for 24 years and has three children.

Mr. COFFMAN. Thank you, panel, for your testimony.

Dr. Hollenbeck, what policies were in place at Jackson VAMC that pertain to the prescription of narcotics?

Dr. HOLLENBECK. In primary care, the bulk of the patients were seen by nurse practitioners. The nurse practitioners do not have individual DEA registration numbers as required by federal and state individual law, licensing laws.

They used an institutional DEA number, which was an umbrella, which also meant you could not really trace, except with a little more investigation, who was prescribing or over-prescribing narcotics. These NPs again also did not have physician collaboration.

When Ms. White-Taylor was arrested, the NPs were suddenly not allowed to write narcotic prescriptions because the DEA got wind of what was happening and swept in. We were then told as physicians, the few of us left, there were three of us at that point, that we needed to sign narcotic prescriptions on patients we did not see.

Email documentation abounds and it was that you are not helping the veterans if you do not do this and you are not a team player. But that is illegal and I immediately had called the DEA and they said it is illegal. So I refused.

The scheme then was to have the residents from the University of Mississippi Medical Center and this was done with the chief of staff, Dr. Kent Kirchner, the then chief of primary care, Dr. James Lochere, and the chief of medicine, Dr. Jessie Spencer, and they assigned residents after hours to look at charts to write narcotic prescriptions.

Those residents actually could have been arrested on the spot by the DEA. I was told that personally by Jeff Jackson, the agent. All of this was illegal. It was one scheme after another.

And also, as we all know, narcotic over-prescribing is a major concern along with mental health brain active chemicals. All of this was a setup for disaster.

Mr. COFFMAN. Thank you.

Dr. Sherwood, when did Jackson VAMC management become aware of the radiology misdiagnosis made by Dr. Kahn and what steps have they taken since then to properly address and correct their effects?

Dr. SHERWOOD. I have been gone for a couple of years, but let me give you the chronology as I know it from the trial transcripts primarily.

Dr. Kahn joined the VA in August of 2003. The first month he was there, he broke a wire off doing an invasive procedure in the femoral artery of a patient. And although it was known, he started to send that patient home.

Two of the invasive procedure room technicians went to Dr. Margaret Hatten to report that the patient was about to be sent home. She intervened so that that patient was taken care of. So this was within the first month that he was there. This was September 2003.

The same week, and he had done a partial neuroradiology fellowship at that point, but he missed a broken neck in a patient during the same month. And at that point, according to the trial, his supervisor, the chief of radiology, was informed that this young man just right out of training was having some problems. Apparently they were told that he would monitor the situation, that the chief of radiology would.

Between 2004 and 2005, departmental radiologists, according to the record, went individually to the chief of radiology to report these errors that were continuing to crop up. Initially, according to the trial record, the chief of radiology continued to say he would monitor the problem.

But towards the end of that period of time, he basically said that the people who were reporting to him were the problem and that they needed to leave him in charge of everything and to leave him alone effectively.

Between 2005 and 2006, there was a flurry of emails from the chief of radiology and the chief of staff about stressing productivity, meaning getting as many RVUs per radiologist as possible in the department. And at that point, Dr. Kahn was held up as a model of productivity to the other radiologists.

February 2007, Dr. Hatten sends the list of 52 names of patients that were major errors and in her opinion showing that Dr. Kahn was outside the norm of expected errors from a radiologist to the Office of Inspector General. This list of the 52 names later became Plaintiff's Exhibit Number 25 in the federal trial.

April of 2007, the hospital director refused to meet with the concerned radiologists over what was going on in their department, the fact that managers were not taking any action as a result of this threat to what they considered patient safety.

However, the chief of staff did meet with the three female radiologists. Actually, I think at that meeting, there were four if my recollection is correct, three who later were plaintiffs in the trial, and at that point, issues a veiled threat to their jobs, basically saying if I had more radiologists like Dr. Kahn, we would not need your three positions effectively.

Sometime during the period between April and June, the Jackson VA Medical Center in trying to respond to these allegations about Dr. Kahn sends a simple small number of cases, 30 cases to the chief of radiology at the Houston VA Medical Center to see if they can find any errors of Dr. Kahn's that were significant.

In my written testimony, I point out, and in my Office of Special Counsel response, whistle blower response, that this is an extraordinarily small number and had no statistical power to really pick up anything.

In fact, the chief of radiology at Houston writes back and said seems to be a competently trained radiologist, but seems to be in quite a hurry when he is doing these interpretations.

Then in June, between the 26th and the 28th of 2007, the OIG has a site visit. They recommended——

Mr. COFFMAN. Dr. Sherwood, I am afraid I am going to have to move on. Just let me ask you one question. The reason why Mr. Kahn was moving so fast through these, through reading these, I guess, radiology reports, these images——

Dr. SHERWOOD. Yes.

Mr. COFFMAN. —there was a financial incentive built in; was there not?

Dr. SHERWOOD. That is correct.

Mr. COFFMAN. Okay.

Dr. SHERWOOD. Yeah. I apologize for the length of my——

Mr. COFFMAN. No, no problem.

Ranking Member Kirkpatrick.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Dr. Hollenbeck, I am a former hospital attorney and I was in charge of the credentialing committees, the peer review quality assurance, and so I am very interested in what is going on with the nurse practitioners at this hospital.

Is there a credentialing, an Allied Health practitioner credentialing committee at the hospital?

Dr. HOLLENBECK. There is. And there is another OSC complaint as I understand about credentialing and privileging. I do not sit on that committee.

I do know that and at the present time, my understanding is that management is scrambling to check off the requirements in the Office of Special Counsel report that there be oversight of the

nurse practitioners as state law requires. And as Major Hearon said, some of them have gotten Iowa licenses where they do not need supervision suddenly.

Mrs. KIRKPATRICK. And with an Iowa license, can they practice in Mississippi?

Dr. HOLLENBECK. This is an open question and I brought it up including to Mr. Battle two weeks ago at a meeting with physicians and other bylaw review.

The Iowa State Nursing Board of Registration says that if you practice in Iowa, you do not need collaboration, that 50 states have a gobbledegook of——

Mrs. KIRKPATRICK. Yes, they do.

Dr. HOLLENBECK. —certifications. So——

Mrs. KIRKPATRICK. Yes. And so what is the requirement in Mississippi?

Dr. HOLLENBECK. Well, in Mississippi, they must have a signed collaborative agreement. They must have a certain percentage of charts reviewed every month, a log kept, and also quarterly face-to-face review. None of that has been done. And one doctor, Dr. Spencer, has 10 to 14 nurse practitioners and the limit is four.

And Iowa has also stated that if you practice outside of Iowa, you should follow the laws of the state you are practicing in. So, again, we need to know.

Mrs. KIRKPATRICK. So the physician to nurse practitioner ratio is very unusual. Why do you think that is——

Dr. HOLLENBECK. Well——

Mrs. KIRKPATRICK. —at this particular hospital?

Dr. HOLLENBECK. —historically, and it is more detailed in my written testimony, my whistle blower comment, Dorothy White-Taylor wanted to have the department of primary care all nurse practitioners.

And she set up the idea that the nurse practitioners did not need supervision, that the collaborative agreements were just a piece of paper. The chief of staff went along with it. And physicians really were pushed.

I was too stubborn and I wanted to be there and I wanted to work with the veterans. You know, our lives were made very uncomfortable by overloading in particular.

Mrs. KIRKPATRICK. Not to push you or interrupt you, but she is not there anymore. Am I right?

Dr. HOLLENBECK. That is correct.

Mrs. KIRKPATRICK. Okay.

Dr. HOLLENBECK. We had——

Mrs. KIRKPATRICK. So——

Dr. HOLLENBECK. Go ahead.

Mrs. KIRKPATRICK. —if you had to name the top three challenges facing the hospital right now under the new leadership team that has been there a little bit over a year, what would you say are the top three challenges, not going back and rehashing the past, but looking toward the future?

Dr. HOLLENBECK. Reorganize the primary care department to have more physicians and when a physician comes as we had someone several months ago, do not ask them to break narcotic law

again, do not overload their schedule as they did with me and several other physicians, and then——

Mrs. KIRKPATRICK. Are you saying physician recruitment is a problem in Mississippi?

Dr. HOLLENBECK. Yes. And it is a problem now because the word is out about the hospital.

Mrs. KIRKPATRICK. Is it a problem just at this hospital or in Mississippi overall?

Dr. HOLLENBECK. I only know about the Jackson VA.

Mrs. KIRKPATRICK. Okay.

Dr. HOLLENBECK. And I moved there to work with the veterans. And the doctor who quit a couple months ago moved from New York City to come and could not stay after two months.

Mrs. KIRKPATRICK. Okay. Mr. Jenkins, thank you for your service to our country.

I just want to ask you a little bit about leadership at the VA. You testified that it has been inconsistent.

If you were going to have the ideal leadership team at the VA, what would that look like?

Mr. JENKINS. It would have to be someone that is familiar with veterans' needs. We are not just regular patients. We have special needs.

I come to the VA myself as a patient and I want to go on record saying that we do have some outstanding workers there. And I do not agree with any part of the VA being privatized.

So we have to have someone that is dedicated to keeping the Federal Government running, keeping our medical center running, but understanding veterans' needs.

Also individuals that do not mind going out and walking around a hospital and finding out what the veterans need, finding out what the staff need, retaining staff, even the lower graded staff. I used to be a housekeeper. I was a WG1. I was a nursing assistant. We need to not have someone there that forgets about those individuals.

That is one of the reasons why I brought out to them and committee Members the nepotism because we had a chief nurse who was allowed to abuse her authority and hire family members, allegedly hire family members and let some of her deputies do that while a lot of the other employees, regular employee was doing their job, dedicated to our veterans, were just in the positions knowing we could not get promoted unless we knew someone or was something special.

Mrs. KIRKPATRICK. And I understand that was a problem in the past. Do you see that as a problem with the current leadership team?

Mr. JENKINS. I see the current leadership team right now. They need to be more focused on doing more for what is going on now. And what I mean by that, ma'am, as far as understanding the special needs of our veterans.

I respect Mr. Battle. I respect Ms. Payton. But they have to have more insight into this and you only can get that by going down and actually talking to staff, talking to patients, and finding out what is going on. You cannot take Band-Aid approaches on situations. I——

Mrs. KIRKPATRICK. Thank you, Mr. Jenkins.

My time has run out. Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Ranking Member Kirkpatrick.

Dr. Phil Roe, Tennessee.

Mr. ROE. I thank the chairman and thank all of you all for your service both at the VA and to our country. Just two days after Veterans Day, so thank you very much for that.

I, too, am a veteran as many people up here are and live within a mile of a large VA medical center in my home town, Johnson City, Tennessee, Mountain Home Medical Center. And I am very disturbed about the potential quality of care issue.

And, Mr. Jenkins, I agree with you. We should be able to provide great care for our veterans. And as the general said, General Hearon said, they have earned those rights. But if we cannot provide it—and I have been sitting here now for five years.

I have spent 31 years practicing medicine, five years up here, and I have become very frustrated in this process because if we cannot provide those services, the backlog of claims—and we can spend the rest of the hour talking about what the VA had not done.

And I agree with you, Mr. Jenkins, there are a lot of great people. Some of my best friends work at the VA medical center at home. They have the veterans' benefits and best interest in their sights every day when they go to work, no question about it.

But I think one of the concerns I have, Dr. Hollenbeck, and certainly as a primary care doctor myself, is this supervision of nurse practitioners. People do not understand and properly used, a nurse practitioner can be very helpful and provide an extender for you as a physician.

But the levels of training are not even close in comparison. When you look at 720 hours of training for something, that is 20 days. That is nothing. And, I mean, that is a very little bit of time. I do not want to minimize that.

But certainly why would the ratio of physicians to nurse practitioners be reversed and why would a veteran go two years without seeing a doctor?

Dr. HOLLENBECK. Mountain Home, Tennessee is where I believe our prior chief of primary care, Dr. James Lochere, is. And I do ask that people look into who gave him the recommendations from our site to go and get another job when he decimated our primary care department with help.

The ratio, I do think, Ms. or Dorothy Taylor-White or White-Taylor, Mr. Jenkins referred to her as the chief of nursing. She had an empire. The empire was enabled by the chief of staff. The VISN leadership did not step in.

Now, there is a culture where a lot of the physicians are afraid to speak up against the nurse practitioners. They far outnumber us. Some of them are very militant and some of them are wonderful. And some have thanked me for coming forward with the things that I have said.

I think there is a large nursing lobby in the VA system and I have been told this many times. And this current proposal to have them unsupervised across the country, there is a large amount of documentation that I hope all of you will read, that push is there. Is it also to save money? I do not know.

Mr. ROE. Well, let me give you just a couple facts that any medical center ought to be aware of is that there are more narcotic overdose deaths in this country than are car wrecks now. It is a huge problem. And to have a group of individuals practicing unsupervised, and, I mean, I am looking at myself, too, my own prescribing habits, should be looked at and evaluated, and exactly the same thing.

And so to have these individuals out there practicing with narcotic licenses that they do not have writing prescriptions, I do not know how somebody did not end up in jail.

And, Mr. Jenkins, I do not know how you as a—I mean, not you, but how me as a practitioner or a hospital that provides care, provider I should say, could look at Mr. Lee's family and to see him because I have used wound vacs for years. And to see that man, to go talk to that family, how you would explain to them the neglect that occurred for that to happen. That is incomprehensible to me.

And back to the radiological things, look, we as doctors rely on adequate and proper radiological evaluations because we make some pretty big clinical decisions based on what those things show. And as a matter of fact, we do some big operations on things for people that they show.

I think that was to me where you looked at 52 cases, if you had a problem, you should have evaluated a far larger sample of that to find out if there was an issue. Maybe there was not an issue.

And the other thing I want to mention before my time runs out is why wouldn't, and we will get this with the second panel, is I do not understand why the medical center, the VA medical center there in Jackson wouldn't go ahead and let the Mississippi Board of Licensure just look at those things.

I mean, that clears you completely. You have got an unbiased second group of people that look and it is not HIPAA and it is not all that. It is nonsense. You should allow them to look at it. If you have nothing to hide, fine. Look at it and you are exonerated.

Any comments?

Dr. SHERWOOD. The only comment I would like to make is to make sure that a mis-impression listening to my colleague's comment to the ranking member was that Dot Taylor is no longer with us. It is true she is not in our hospital facility. If I am not mistaken, and Ms. Payton can correct it, she was promoted to the VISN staff where she is employed today. But I agree with everything Phyllis has said.

Mr. ROE. Thank you.

My time is expired. I yield back.

Mr. COFFMAN. Thank you, Dr. Roe.

Retired Sergeant Major Tim Walz, State of Minnesota.

Mr. WALZ. Well, thank you, Chairman. I want to thank you and the staff for putting this hearing together. This is our most important responsibility.

And I think General Hearon was right as we literally sit in the shadows of Sonny Montgomery who showed us how to do this. It is important we get this right.

And I think Dr. Roe's use of the word incomprehensible is what I see when I read this.

Dr. Hollenbeck, I want to thank all of you for coming forward on this and I know that whistle blowing is a difficult situation and thank you for doing it.

Dr. Hollenbeck, have you been at other facilities, other VA facilities?

Dr. HOLLENBECK. I have not worked at other VAs. I did work in a naval hospital for several years.

Mr. WALZ. So your experience, and I think, Dr. Sherwood, you said the same thing, that unfortunately this has been your only experience and not a good one.

Dr. SHERWOOD. I was on the staff at the University Medical Center in Mississippi for almost three years before I went full time with the VA.

Mr. WALZ. Okay. Well, thank you both for being there.

And I think the next hearing is or the next panel is the one when we hear from VA and we hear some of these things, the things you laid out. They have been collaborated with OSC.

I am deeply concerned. I am deeply concerned with Dr. Petzel's comments after this had already been brought to notice. This is not a kerfuffle. This is an incredible breach of trust and, as Dr. Roe said, we do not throw the term around lightly, potentially criminal.

And that is a very important responsibility that we have to have. And I think by having this hearing, we are making it clear we have to get there.

I am just most concerned with how we get institutional problems that allow this to happen for extended periods of time. That deeply troubles me.

And also, Dr. Hearon, I appreciate your service and your comments, but I cannot leave unstated where you made some assessments and took a long portion of your testimony.

Are you familiar with the comprehensive review of the literature by Hendricks & Nugent on the cost of VA healthcare as opposed to the private sector?

Major General *Hearon.* No, sir. I probably should be and I will be soon.

Mr. WALZ. Did you take pharmaceuticals into your accounting?

Major General *Hearon.* I took everything that was in the VA's budget submission to the Congress.

Mr. WALZ. The reason I bring this up is is that I think your passion for this, and you are absolutely right, I would be furious with Sonny Montgomery, and your service to the State of Mississippi and your veterans deserve better than this.

The only thing I would ask you is if you have not ever been in the Minneapolis VA or the Sioux Falls VA or the Rochester, Minnesota CBOC that sets in the shadow of the Mayo Clinic, they will tell you best care you can receive anywhere.

And I have great concerns, I tell you, when I hear someone say, and I am not against getting the most competition, getting where we can get out of this, but the core mission of the VA when people say privatization, there is a reason that no veteran service organization in this Nation will say privatization of medical services. So I cannot leave that unchallenged.

Major General *Hearon.* I do not blame you for challenging that. It was not a financial reason for suggesting that we look at it. It

was because in the cases of Dallas, Atlanta, Jackson, Pittsburgh, Buffalo, and so on, these problems keep coming up like a big Whac-A–Mole game.

If the VA cannot get their organization under control—and by the way, I meant to mention I think Secretary Shinseki needs to resign. He has failed in his leadership completely.

Mr. WALZ. Well, now we have another line of questioning from me.

Major General *Hearon.* Oh.

Mr. WALZ. But what I would say is are you familiar with the IOM study on the private sector, the 98,000 deaths?

Dr. Roe is right. This is not something that is just inherent to the VA. And I bring this up not in any way because trust me on this. This next panel, they are not going to be dismissed from responsibility. They are not going to be dismissed for questioning.

But I think the reason I bring this line of questioning up is is that I think it weakens our attempt to fix the system when we do a gross generalization across a large spectrum instead of focusing on the inherent problems, as the ranking member said, of how do we move forward and correct this because this story with Mr. Lee, I do not even have words.

How in God's name can any of us look at his family after that? If that is being repeated, there is a problem. But what I can tell you is the incidence of that happening in a Sioux Falls or Minneapolis is remotely different than this situation. So I——

Major General *Hearon.* The Joint Commission reviewed that death of Mr. Lee and they did not find anything wrong.

Mr. WALZ. And that is a problem. And you are right and I think your focus, and I do not want to get on this, I just said it because you are on to something here, Dr. Hearon. I do not want you to go on a track that weakens our argument on this.

I think your point on management on this is where it comes to because I am convinced, and I see physicians there and you heard from these folks there, for the most part, there is quality people, but supervision of removing non-quality people or staffing issues, that is a big problem.

And the thing that concerns me the most is this committee and the American taxpayers have made the commitment to fully funding and having the right people on deck at the time when they need it. And if it is not happening, that is a management issue. That is not putting resources where they need to be in the best interest of the country. And that is a valid point that needs to be found out.

And so I do not want to go too far down that, but I am deeply concerned once we do that and the question of how far up responsibility goes is valid. I will say that. And I just think it is critically important for this committee to find out now and implement changes so this is not perpetuated.

And this situation, if this was a management problem that has now transferred to Mountain Home, that is a huge issue of who is involved here because I do believe this is—this sounds to me very personnel, culture oriented.

I yield back.

Mr. COFFMAN. Thank you, Mr. Walz.

Just let me say very quickly before deferring to Dr. Huelskamp from the State of Kansas that this subcommittee dealt with the issue of infectious diseases, pathogens, and put the VA under state regulation in that area. And I think that after this hearing, I am convinced that there are other areas that they ought to be subject to state regulation too.

Dr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

A question for Dr. Hollenbeck. What was the structure of performance pay and bonuses when you were employed at the Jackson VAMC and were they made contingent on signing collaborative agreements?

Dr. HOLLENBECK. Part of the performance pay, it varies in departments, so in primary care, the chief of staff, who at that time was Kent Kirchner, set in place, and supposedly we voted on it, but we did not, and it was about customer service. And, of course, we do not hire the clerks. We do not control them.

Also, all your diabetics had certain numbers showing they were successfully treated, although we do not go home with the patients. And God bless them. They do not all take care of their diabetes.

Once the nurse practitioners lost the ability to write narcotics and they were all facing—in Mississippi, they all needed to renew their licenses by the end of the year, 2012, Dr. Gregg Parker, Mr. Battle, and the acting chief of staff at that time stood up at a meeting and told us, the physicians, that 50 percent of the possible performance pay was off the table unless we signed collaborative agreements.

And those doctors that did not have Mississippi licenses would have to get them and then not be able to sign the collaborative agreement. So essentially a gun was held at our head. A physician said it is our license. We are putting our license on the line. Dr. Parker and Mr. Battle said it is just a piece of paper, do not worry about it. When one of the physicians said but what if something happens in that nurse practitioner's care and we did not get to oversee them, they may not even be in our department, Mr. Battle and Dr. Parker said, well, you can write a letter to the national practitioner data bank where all these things would be reported forever about our license and that is stunning.

So the lack of ethical understanding, it is patients' lives and it is our licenses which mean everything to us. But they needed to deal with their mess with all of the unsupervised nurse practitioners who needed a collaborative agreement but the hell with following the law about it. And excuse my language.

Mr. HUELSKAMP. Thank you, Doctor. Very troubling on that.

The information that was provided by this Dr. Parker and those discussions, was this all in writing or were these verbal statements to the physicians that if you did not sign these collaborative agreements, we are going to dock your pay or actually remove your bonus?

Dr. HOLLENBECK. There are minutes that curiously did not come out from that meeting for six months. Many, many people were there. I was there. We then received the collaborative agreements or the, excuse me, the agreements about our performance pay and

if you did not sign it and it did say you had to be willing to sign a collaborative agreement, so it was in writing what the deal was.

Mr. HUELSKAMP. And these bonuses, what would be the range of these? Do you know that, Doctor?

Dr. HOLLENBECK. I would say, and, again, I think it varies in department, but I think for most departments it might be up to $10,000. It is not $63,000——

Mr. HUELSKAMP. Uh-huh. Okay.

Dr. HOLLENBECK. —like some management.

Mr. HUELSKAMP. Yeah, I know. Thank you, Doctor.

One follow-up. Mr. Jenkins, this thing is very troubling, particularly with the group that you do represent. Your thoughts on these types of ways to, I think, manipulate employees of the VA.

Mr. JENKINS. I think it is extremely disturbing because, like I said earlier, the employees that we represent coming to the VA, they come to do their job. A lot of those employees are veterans. And, you know, when you have management in certain positions that abuse that authority, the employees are basically held hostage. You cannot make them do what is correct.

Just like Dr. Hollenbeck being here as an employee and bringing out some information, the same thing as myself. I am an employee. I am a veteran. And we want to see change. We want to see leadership change our medical center for the better.

And I agree with committee Member Walz that, you know, we should not privatize. We have to be committed to fixing the system. And we know it can be done. I believe it can be done.

Mr. HUELSKAMP. Are these physicians members of your organization in general or not?

Mr. JENKINS. I do not represent the physicians. I represent the licensed practical nurses and some of the other so-called nonprofessionals.

Mr. HUELSKAMP. Do they have similar stories or evidence that they were being manipulated as well by the VA on the basis of their performance pay?

Mr. JENKINS. I am unable to answer that question, to give you the full documents because they are represented by NFFE. So I cannot give you the——

Mr. HUELSKAMP. The folks that you represent, though, Mr. Jenkins.

Mr. JENKINS. Yes, sir. Yes, sir. Some of the folks I represent have brought me some situations as far as manipulation of when I mentioned my healthy vet situation. Like a veteran, I am just going to use my retired general here, if you come in for treatment and you have an option. My healthy vet is voluntary. You do not have to sign up for that system. That system was set up for veterans. It is set up to try to streamline your checking it. You may be able to go home and look on——

Mr. HUELSKAMP. Mr. Jenkins, I am not talking about the patients. I am talking about the employees that you represent.

Mr. JENKINS. Yes.

Mr. HUELSKAMP. Have you submitted complaints to the VA on the basis given what we are hearing, at least for the physicians——

Mr. JENKINS. Yes, sir.

Mr. HUELSKAMP. —the use potentially of the performance pay and bonuses to manipulate perhaps at a criminal level activities by those employees? That sounds something right down the line of folks that you represent and defend.

Mr. JENKINS. I sent documents in, sir, regarding nepotism. But as far as specifics with physicians' pay, I have no knowledge on that. Even though some of my employees may work side by side with the doctors, I do not have specific knowledge on that.

Mr. HUELSKAMP. I understand. You do not represent the doctors. But the folks you represent, so complaints about similar attempts on manipulating their pay or you have not heard that?

Mr. JENKINS. I have not heard that because my folks do not receive retention bonuses.

Mr. HUELSKAMP. They do get bonuses, though, don't they?

Mr. JENKINS. They do not. They get regular, you know, performance awards and stuff like that, but they do not receive retention bonuses. It is a different——

Mr. HUELSKAMP. They get performance bonuses, though, correct?

Mr. JENKINS. Yes, sir.

Mr. HUELSKAMP. Okay. And that is part of that bonus. All right.

Yield back. I apologize for taking too much time, Mr. Chairman.

Mr. COFFMAN. Thank you, Dr. Huelskamp.

Dr. Benishek, State of Michigan.

Mr. BENISHEK. Thank you, Mr. Chairman.

Thank you all for being here this morning.

Like the rest of the committee, I am, you know, frankly pretty much shocked and amazed by the level of incompetence in the management it seems in many aspects of the hospital because we have touched on, you know, wound care, radiology, family practice. It seems as if the whole hospital was a mess.

Let me ask a question. What exactly is a ghost clinic? I mean, I could not quite figure that out from reading the testimony.

Dr. HOLLENBECK. I baptized the idea of these vesting clinics. You will see reference to vesting clinics. Basically there was a morning report and it would show where the lack of providers were in the primary care clinics.

And then veterans had waited months and they would have an appointment. And they would come in and there was no provider there. They were either moving nurse practitioners around where they did not have enough doctors or people called in sick.

So the veteran would be there. They would be told there is no provider to see them.

Mr. BENISHEK. So, in other words, they were scheduled for this clinic knowing that there was no provider for that period of time?

Dr. HOLLENBECK. That appointment was left on the books. Your hairdresser does not do this to you.

Mr. BENISHEK. And that scheduling, is that a physician responsibility?

Dr. HOLLENBECK. No.

Mr. BENISHEK. Who handles that department?

Dr. HOLLENBECK. No. And that was overseen, you know, higher than the level of the clerks in the clinics.

Mr. BENISHEK. You know, this is the problem that we have run into time and time again. And I kind of appreciate that Whac-A–

Mole analogy that one of you guys made there because it seems as if nobody seems responsible in the end for the lack of management and, you know, the horrible testimony we have had here this morning.

Are any of the people that were responsible for this, are they still out working at the VA, do you know? I mean, we will ask——

Dr. HOLLENBECK. Well, Dr. James Lochere is not. The chief of staff stepped down, although he is still involved in some of the, you know, issues going on. That's——

Mr. BENISHEK. Is he still employed at the VA?

Dr. HOLLENBECK. That is correct.

Mr. BENISHEK. Yeah.

Dr. HOLLENBECK. We have just had a revolving door of acting chiefs of primary care and acting chiefs of staff.

Mr. BENISHEK. It just seems to me that there is sort of a culture of, you know, transferring somebody to a different VA, you know, after they have had performance reflected here——

Dr. HOLLENBECK. Correct.

Mr. BENISHEK. —which has been inadequate.

Dr. HOLLENBECK. Right. And——

Mr. BENISHEK. And, you know, does anyone here have a suggestion for the institutional repair of, you know, how do we fix this institution so that there is better accountability at the management level for this seeming incompetence?

Dr. HOLLENBECK. Well, the thing I would speak to as far as the medical centers, the center director should have medical experience. You need to have someone who understands how clinics run, what it means to walk in and——

Mr. BENISHEK. Does the chief of staff have input as to how clinics are run?

Dr. HOLLENBECK. I am sorry?

Mr. BENISHEK. Does the chief of staff have input as to how clinics are run or is that——

Dr. HOLLENBECK. The ultimate responsibility, but it is usually the service or department chief. So the primary care chief answers to the chief of staff and they answer to the director.

Mr. BENISHEK. So then the chief of staff would be aware that there is no staff available for that clinic?

Dr. HOLLENBECK. Oh, yes. And I have voluminous documentation of the emails I sent for years.

Mr. BENISHEK. Let me just go on here because I do not have much time. Is there a monthly morbidity or mortality conference at the hospital?

I mean, at my hospital where I work, if there was an incident where somebody had an alleged care problem, that would come up at what we call the morbidity and mortality conference where the physician responsible had to take responsibility for the problem.

So we would have, you know, reviewers who would review charts, review x-rays, review the situation so that, you know, in a learning, collegial, peered setting, you know, we could improve care over the long term.

Did that occur at this hospital?

Dr. HOLLENBECK. Well, I do not know about the inpatient side.

Mr. BENISHEK. But you never went to a morbidity or mortality conference?

Dr. HOLLENBECK. No. I was pretty much until nine o'clock at night in primary care. Dr. Sherwood could answer that question for you.

Mr. BENISHEK. Dr. Sherwood, did you ever attend a morbidity and mortality conference at the hospital?

Dr. SHERWOOD. We regularly had them on the surgical service and it was highly selective how these were followed up on. I could give you one instance, but for the sake of time, I won't unless you want the specifics.

Mr. BENISHEK. Well, I am a surgeon as well and I am used to, you know, in surgery, you know, having morbidity and mortality conferences so that we can improve care over the long term or, you know, address an individual who was, you know, chronically coming up with poor results.

Dr. SHERWOOD. I think——

Mr. BENISHEK. So that was a process in the surgery department?

Dr. SHERWOOD. I think the service itself tried to accomplish that, but I think for the overall facility, making sure your performance numbers were up and good was the principal goal of everything.

Mr. BENISHEK. All right. I think I am out of time. Thank you.

Mr. COFFMAN. Mr. Palazzo, State of Mississippi.

Mr. PALAZZO. Thank you, Chairman Coffman, for having this hearing and thank the Members for allowing us to participate.

Being from Mississippi, being a marine veteran, serving in the Mississippi Army National Guard, you know, I take these complaints extremely seriously. I have been in Congress for two and a half years and it seems like 90 percent of our caseload back home is dealing with VA issues and veterans' benefits.

Over 2,500 people my office has served. I have a wounded warrior fellow who does this probably 60 hours a week. I have my director of case work is a former army officer married to a retired colonel. Our number one focus because—it is not just because my district is extremely populated with military retirees and active guard installations, but it just seems like we are breaking one of our fundamental promises to the men and women who serve our Nation and that is not providing the care that they deserve, that they have earned.

I am shocked, I am sick, and I am disgusted that we are even having this and that this is a VA medical center that bears the name of Sonny Montgomery is not in keeping with his legacy of service not just to the Mississippi National Guard but to the Nation. He was a consummate supporter and fighter for the military.

Dr. Sherwood, you mentioned in your statement that during the past 15 years, the Jackson VA Medical Center has had a diverse leadership who all share a common trait, a progressive failure of their moral compass.

Can you tell me, I mean, 15 years, do they come here and become morally corrupt or is this systematic throughout the upper echelons of management through the VA system?

Dr. SHERWOOD. My first 15 years, the organization really had no problems. I think patient care was first. Once I saw the change in

the compensation model, we began to see the system gamed after the first couple of years when managers understood it.

But when that became paramount, we started to get in these situations where patients who deserve to be told the truth are not told the truth. I am referring specifically now to the trial of 52 people who I cannot speak—you know, I have not seen their medical record completely. I know what is in the trial.

But Dr. Hatten certainly has and she certainly believed after seeing their complete medical record that these were egregious errors.

I also think that you begin to see the erosion of cooperation with agencies like the State Board of Medical Licensure in our state that does have investigative authority and has a right under exemption, as I understand it, I am not a lawyer, but I understand they are exempt under the privacy laws which the current administration of our hospital and the VISN are hiding behind not to give over the records under the subpoena from the State Board of Medical Licensure.

And I would hope that one of the results of this committee today would be to shake those loose for some cooperation with the State Board of Medical Licensure.

Mr. PALAZZO. Thank you, Dr. Sherwood.

And I think Dr. Hollenbeck pointed out briefly that Dr. or Dorothy Taylor-White is still employed by the VA?

Dr. HOLLENBECK. It was a colleague of mine.

Mr. PALAZZO. Okay.

Dr. HOLLENBECK. I believe Dr.——

Mr. PALAZZO. And Dr. Kirchner is still employed by the VA?

Dr. HOLLENBECK. Yes, he is.

Mr. PALAZZO. And I am looking here. The former director, Linda Watson, she basically misappropriated funds at another VA and she was transferred to the Jackson VA.

And this sounds like not just the—can we not only talk about the executive compensation changes, but is this when the problems really began at the VA in Jackson as well or was there leadership issues even before that?

Dr. SHERWOOD. I can only say that it is an apparent reward system for people who get good performance measures and do whatever is necessary in their job. When they get into trouble for that, then they are taken care of even if it is at some later date.

I will give you one example. The latest information I have out of the building, and this is not firsthand, it is secondary, is, for instance, that Dr. Kirchner has now appeared at a surgical staff meeting presenting on behalf of the VISN and the chief of surgery told one of my colleagues that Dr. Kirchner is now the consultant to the VISN for physician productivity.

So, again, he appears to be being groomed for a position at the VISN level. That is——

Mr. PALAZZO. That just sounds like the good old boy network. You know, you are either transferred or you resign and you become a consultant somewhere within the system. There seems to be some serious issues with the VA and I do not just think it is Jackson. I think there are management issues all across the Nation.

And I hope bringing attention to this one that we can fix it so no other veterans have to endure the nightmare that they are going through at Jackson, the fact that Mr. Jenkins lost a friend.

And thank you for your service as well. You lost a friend, a fellow employee and a veteran because of gross incompetence and the people are not in jail? I would like to know everyone that was involved in that. They should have been fired immediately.

So we really do in the essence of taking care of our veterans and also maximizing taxpayer funding for the VA, which is something we promised to do for our veterans, is that I would like to think that there are some areas that we could privatize. And it needs to be explored and maybe dismissed or accepted.

But we have to look at making sure that your employees, Mr. Jenkins, the ones that are performing are taken care of and the ones that are not worth anything, they go find another job, not in the VA, but in the private sector.

Thank you, Mr. Chairman, for allowing me to be here.

Mr. COFFMAN. Thank you, Mr. Palazzo.

Mr. Harper, State of Mississippi.

Mr. HARPER. Thank you, Mr. Chairman. It is an honor to be here.

And I want to thank each of you for taking the time to come, give us these insights.

And, General Hearon, good to see you again. And I know you have been in my office in D.C. and thank you for your service to our state, to our country.

And you know on my coffee table in my office is a signed copy of Sonny Montgomery's autobiography. And he held that seat for 30 years and, you know, this is something that I know would make him most unhappy.

And it is something that we want to keep in mind. Our goal here is we have got a lot of water under the bridge. We have got a lot of past problems. And the key is what do we do to make sure that we correct this, we do not deal with this in the future, and we provide the patient care and remember that the patients' care is paramount to everything that we do.

And so I want to thank you for your concerns, bringing these issues to our attention.

And, you know, I think something that Congressman Palazzo mentioned was the previous director. It appears that many problems existed when Linda Watson was there, but she had problems in Georgia, came to Jackson, and the problems were obviously documented very seriously.

Does anyone know where she is currently? General Hearon.

Major General *Hearon.* I think I heard that she went to Texas and then retired.

Mr. HARPER. Okay. Went to Texas in the VA system and then retired?

Major General *Hearon.* I believe that is right, but I think the VISN director would know for sure.

Mr. HARPER. All right. Well, we will follow-up on that as we go forward.

But, Dr. Sherwood, if I could ask you a question. How long was Dr. Kahn employed by the Jackson VA system?

Dr. SHERWOOD. 2003 to, I believe, 2008.

Mr. HARPER. Okay. Is there a documented time period during his tenure when he was overlooking images in radiological studies?

Dr. SHERWOOD. Overlooking them, he was, yes, according to the federal trial, yes, including his own statement to that effect.

Mr. HARPER. Well, approximately how many radiologic studies do you believe Dr. Kahn reviewed during his time at the VA medical center?

Dr. SHERWOOD. It is unknown. The estimates were between 15 and 25 thousand depending on his read rate. It is unknown. I mean, it could be easily found out.

Mr. HARPER. There has been much discussion about the 52 individuals, these lives that have been impacted.

And are you telling me then that all 52 have not been notified of these problems as of today?

Dr. SHERWOOD. I have no knowledge of what has been done exactly. I know that two at the time of trial who had litigation pending, the VA did, yeah.

Mr. HARPER. And, General Hearon, would you add some insight on that?

Major General *Hearon.* I was told that when we first inquired about this and it was on the basis in addition to the medical issues, but to the ethical issues involved in having allegations about 52 and not bringing it to their attention that some of these people probably had a very painful unnecessary death.

And they said the case was closed. They were not going back and reviewing those at all. But we insisted on it. The OSC helped a lot on this. And two additional institutional disclosures were made I was told which means that at least they confessed, you might say, to two additional people. We think there are more than that.

But a lack of accountability, lack of transparency are some of the key issues that led to the suffering and death of some of those patients. And at the time, in the trial, they estimated the cost would be $300,000 to go back and review all those records instead of just 100th of one percent. And they said that it was not worth it.

Mr. HARPER. Do you believe that every one of those patients or their families have a right to know if their images in their studies were overlooked?

Major General *Hearon.* Absolutely. And the problem is that by the time some of them got aware of their serious health issues, it was too late to do anything. And sometimes the cancers had been—I have talked to some of the veterans—had nothing to do with that study, but some of them did not know about it until they went to outside physicians and were told about it.

And all the processes were in place at the VA or overlooked like the guy I met last Wednesday. They did blood tests or blood draws, but they never did what I believe is called a CA125 test to show that he had had cancer for some time and they just did not pick up on it even though they were doing the blood draw.

Mr. HARPER. Dr. Hollenbeck, do you believe it is possible to locate all of these individuals, locate all of the studies and reevaluate them or at least make the patients aware of the issues?

Dr. HOLLENBECK. It is Dr. Sherwood's area of expertise as far as that case, but, yes. There were records, some computerized permanent records.

Mr. HARPER. It can be found?

Dr. HOLLENBECK. Absolutely.

Mr. HARPER. Okay. All right. Thank you.

And I yield back.

Mr. COFFMAN. Thank you, Mr. Harper.

We will do a second round of questions with this panel.

General Hearon, what measures are you aware of that VISN 16 and Jackson VAMC have in place to promote accountability, proper training of officials and information sharing to ensure significant medical errors are prevented and not repeated?

Major General *Hearon.* Sir, I wish I could tell you I knew of some. I am sure they will be offered by the other panel. But what I see is like you and I and Command Sergeant Major Walz—thank you, both of you all—but saw where you send a message to your troops, so to speak, or your employees, the veterans every time you do something or you do not do something and the message is that if you really mess up, you will not be fired and there is also a good chance you will be promoted to the VISN office or to another VA medical center or maybe your highest rank will be removed, maybe temporarily, but there is no real accountability.

There's no clear punishment and people just looking around and say why should I be the one to point out the issues. And thankfully Mr. Jenkins has been doing that for years and others have been keeping notes. But why should I go through all of that if nothing ever changes. And the culture of the VA has just gotten abysmal I am sad to say.

Mr. COFFMAN. Okay. Mr. Jenkins, how many requests have you made with Jackson VAMC officials to ask for an independent external investigation into the alleged wrongdoings at the facility and what responses have you received?

Mr. JENKINS. From 2012 to the present, I have made more than 12 requests, 12, and I got three responses that said it is ongoing. They are looking into my complaints and it is ongoing.

Mr. COFFMAN. Okay. And no responses, but you have never had a response that brought about a solution or a conclusion?

Mr. JENKINS. That is correct, sir. That is correct.

Mr. COFFMAN. Okay. Very well.

Ranking Member Kirkpatrick, Arizona.

Mrs. KIRKPATRICK. Thank you, Mr. Chairman.

Dr. Sherwood, what is important for this committee to know is if there is an adequate accountability structure at this hospital. By that, I mean credentialing committees, medical staff bylaws, peer review, quality assurance all the way to the director.

And so just looking at it structurally, do you think there is an adequate accountability structure? Let me just clarify——

Dr. SHERWOOD. I missed——

Mrs. KIRKPATRICK. —a little bit. It sounds from the panel's testimony that most of the issues had to do with particular personnel within that structure, but I want to look just at—take the personnel out of it, just look at the structure.

Do we need to make some recommendations to the VA regarding the accountability structure?

Major General *Hearon.* May I just suggest that the VA has a core values of I care including integrity and respect and so on. They need to review those and start following them.

Mrs. KIRKPATRICK. Thank you, General. I would like to hear from Dr. Sherwood too.

Dr. SHERWOOD. Structural changes only the degree of absolute power that directors and VISN directors have in the institution to ignore the processes as they see fit. The processes themselves, we do not need any more layers of processes. We need people at the top who have a conscience to look in the mirror every day and say I want to treat my fellow person that I am responsible for in this, my job, as I want to be treated.

Mrs. KIRKPATRICK. Thank you for clarifying that. I appreciate that.

But what would be your recommendations to make sure that we got that proper person at the top?

Dr. SHERWOOD. I am going to defer to my colleague.

Mrs. KIRKPATRICK. Okay.

Mr. JENKINS. Thank you.

Double standards right now is an issue that is hurting accountability because on one side, you have top leaders that is not being held accountable such as like Dr. Hollenbeck mentioned about our prior chief of primary care being allowed to go somewhere else or our prior chief of nursing being allowed to go to the VISN and continue her pay.

The employees that I represent, they are held accountable. They have progressive discipline. I have had employees removed for doing things. I have had a number of employees removed.

In my 18 years as a government employee, I have only seen two low level managers, only two, and they were supervisors who were removed. But as far as center directors, network directors, they are moved.

So I feel that double standard need to stop. The same accountability that the regular employees are held to and they can be disciplined and fired, that needs to be for the top.

Mrs. KIRKPATRICK. Thank you very much.

Dr. SHERWOOD. I agree completely.

Mrs. KIRKPATRICK. Thank you, Dr. Sherwood, and thank you, Mr. Jenkins. Thank you to the panel and thank you, Mr. Chairman.

Mr. COFFMAN. Unites States Army veteran, Dr. Phil Roe, State of Tennessee.

Mr. ROE. Thank you.

And just a couple of quick questions. I am going to focus on what I did my entire career, 31 years of practicing is quality of care.

And one of the things that has disturbed me here is, first thing is how long does it take to get a primary care visit at the hospital? How long? If I am a veteran and I move to Jackson, Mississippi and I call up, when can I get an appointment?

Dr. HOLLENBECK. I think that they keep——

Mr. ROE. Let me back up. When can I be seen?

Dr. HOLLENBECK. As opposed to in a ghost clinic?

Mr. ROE. Yes.

Dr. HOLLENBECK. Well, I would say that they would tell you maybe a month, but I know that when I was in primary care, it could be five to six months. Again, if you wanted a doctor, it could be even longer.

Mr. ROE. And that was my second question. When would I get to see the doctor?

Dr. HOLLENBECK. It could be six to nine months depending on how many doctors were there.

Mr. ROE. Would I establish a relationship with that doctor and continue with that doctor or would I be assigned to a nurse practitioner typically?

Dr. HOLLENBECK. No. There is no team work. There is all silos of care so that if your doctor has been pushed out—I had people for four years and there was continuity of care and I tried to do everything that I was trained to do and hold myself to a high ethical standard.

But in the last year, there has been eight different physicians taking care of my panel of patients. And some of my elderly veterans come up and see me in compensation and pension and say who will take care of me now.

Mr. ROE. And the second thing, let me just unequivocally say that there is no way on this planet that I would sign a narcotics prescription for somebody I had never seen. I mean, there is just absolutely no way I would ever do that.

Dr. HOLLENBECK. That is correct. And I think that when the VA report tried to say that Dr. Kirchner, Dr. Spencer, and Dr. Lochere only found out that was illegal and as soon as they found out a couple months later, they changed the policy, that is bologna. You know, DEA agent Jeff Jackson said when did you first learn about that being unethical and I said I knew that as a medical student.

Mr. ROE. Yeah, you know that. And secondly I certainly think, as I have stated before, that proper supervision of nurse practitioners is a way to extend quality of care to veterans and to anybody. I mean, I use nurse practitioners in my practice, but we have some very rigid guidelines of which they were able to practice. And one was not to write a narcotics prescription without direct supervision.

Dr. HOLLENBECK. Correct. That is what I am used to in other places.

Mr. ROE. And I think the other one that was a little disturbing to me was the—two things. One was the Medicare. I mean, typically you have to have—I know how Medicare is and we have dealt with Medicare patients in my practice. That is very clear what those Medicare guidelines are. And if you do not follow those, then you have basically created fraud.

Dr. HOLLENBECK. Correct. And I was asked repeatedly and I refused. They wanted us to co-sign. The nurse practitioner only would be seeing these patients. I would never see them. The bottom of the form says I certify they are under my care and I refused. And each time you sign a piece of paper, each paper is an instance of fraud.

Mr. ROE. Well, just to give you an example, this has been almost 40 years ago, I did remedial OB/GYN training. It took me six years

to do what most people do in four because I had a little drafted status in between. I got two years of service in between.

And when I came back out of service, Medicaid had gotten started and you had to have a faculty member present when you delivered a baby to bill for that. You could not even bill for it. And so there are ways to do that now without being fraudulent and convincing yourself that you are providing good care without proper metrics and supervision.

So that was one. And then I guess the last question and I will cease is spending all of my career as an OB/GYN doctor, women's health is very important to me. And to see the women's clinic there have only not even a nurse practitioner.

It is not to say that the nurse there was not a competent nurse. Probably is a very competent nurse. But that nurse needed supervision if you are providing birth control pills, are you going to be able to take care of someone if they have phlebitis, a pulmonary embolus, and so on. So just a comment.

Dr. HOLLENBECK. That was a nurse practitioner under the grandfathering of VA rules, but she did not ever have a license as a nurse practitioner. And you are absolutely right. She ran the women's clinic forever and she still does alone. There is no doctor fully overseeing her.

Mr. ROE. I yield back.

Mr. COFFMAN. Thank you, Dr. Roe.

Mr. Walz passes. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chair.

Just for the record, I would like to indicate that I have toured the hospital there in Jackson on a number of occasions. And, actually, Mr. Jenkins and I and others there have had significant conversation. There is a history at this hospital of not following VA procedure.

What I have been led to believe is since new administration has come some of the things have gotten better, but nonetheless it should not have gotten to the point that it did.

And the over-reliance on nurse practitioners rather than doctors and writing of prescriptions by people unauthorized to do it, those kind of things are most egregious in my review. And I would hope that this hearing will put some of those issues to rest, that they have corrected some of them. There are some issues around patient management and other things that I would like to hear, too, but nonetheless I appreciate the opportunity to sit in on the hearing today.

Thank you.

Mr. COFFMAN. Thank you, Mr. Thompson.

Mr. Harper, further questions?

Mr. HARPER. Thank you, Mr. Chairman.

I, too, have had the opportunity to tour the VA medical center and I certainly have been much more impressed with at least the opportunity to visit with Joe Battle. And the comment was just made that some things are better. Other things are not taken care of.

Would you agree with that, and I will ask each of you? Let me ask this. Is there anything that is better that you are aware of?

Dr. HOLLENBECK. Not in primary care.

Mr. HARPER. Okay.

Dr. HOLLENBECK. And not——

Mr. HARPER. And may I——

Dr. HOLLENBECK. —in having permanent—there is no true team in place.

Mr. HARPER. And may I ask this of you, Dr. Hollenbeck? The shortage of primary care physicians is not just a VA problem. It is not just unique to the VA. It is a problem that we see around the country.

But specifically for the VA, if you could map out any type of strategy or plan, what would you do to attract primary care physicians to the VA medical center in Jackson? What could you do to do that? What would you do if you could call the shots?

Dr. HOLLENBECK. Well, I would clean house from the top down and I do think from VISN down. And then the medical center trains physicians. It trains primary care physicians in family medicine and internal medicine.

Now, some people are going on to subspecialties, no question.

Mr. HARPER. Right.

Dr. HOLLENBECK. But if you showed that the people in charge, the director of primary care was somebody they respected, who wanted to have true teaching go on there, you would have a supply of physicians and you could show that as a place that people who are in the VA system and may want to move, you could come to Jackson and there is an excellent department because the wheel has been invented how to run primary care.

Mr. HARPER. Dr. Sherwood.

Dr. SHERWOOD. Let me just add that the director and the VISN director have the authority to offer retention bonuses and recruitment bonuses on top of the salaries of these direct patient care providers. To my knowledge, it is not being used.

We have seen where apparently it is being used for the senior executive service on a regular basis is the impression I have been given. It certainly could be given if you want to attract direct patient caregivers, they could use that authority.

Mr. HARPER. Give me a number. If you had the ideal number of additional primary care physicians that the Jackson VA Medical Center needs, how many would that be ballpark?

Dr. SHERWOOD. It is above my pay grade. Ask Dr. Hollenbeck.

Mr. HARPER. All right.

Dr. HOLLENBECK. Well, you have four clinics and I would like to see actually four to five physicians in every clinic.

Mr. HARPER. Additional than what exists?

Dr. HOLLENBECK. Well, there is a few more. I think there is five to six, although we still have temporary physicians coming and going. But I think it should be primary care teams and then all nurse practitioners assigned with a physician and strict protocols.

Mr. HARPER. For direct oversight?

Dr. HOLLENBECK. Directly assigned, right.

Mr. HARPER. General Hearon, you attended the hearing in Pittsburgh that Chairman Miller conducted there and primarily it was obviously not about the Mississippi VA system, but it was mentioned. And so I know the Jackson VA Medical Center was mentioned in that hearing.

Have you seen any improvements or anything that has taken place that you have seen in a positive light since that hearing that you attended?

Major General *Hearon.* Well, that was September the 9th, I think. Dr. Hollenbeck did a fine job of testifying. I was there for moral support, I guess, and to observe the audience. Dr. Petzel who I was pleased to see is retiring next year, I made an offer to help him pack.

But in any event, he was there and made a similar showing in Pittsburgh I would say to what he demonstrated in Jackson on April the 3rd at that town hall meeting which I provided a video of to the committee, two copies in case you all did not have it.

But I have not noticed and, of course, in government terms, it has only been two and a half months. I think Mr. Battle's heart is in the right place, but I do not think he gets the kind of support both by his staff who I think try to keep him in the dark on many issues, but at least they have for sure, and I do not know if he has turned that corner or not, but from above.

And I think just like in the military, I am convinced that the clearest leadership should be coming from the secretary and it is not.

Mr. HARPER. I thank each of you for being here and I yield back.

Major General *Hearon.* Thank you.

Mr. HARPER. Mr. Chairman, thank you.

Mr. COFFMAN. Thank you, Mr. Harper.

Our thanks to the panel. You are now excused. Thank you very much for your testimony today.

Our second panel, we will hear from Mrs. Rica Lewis-Payton, network director of VISN 16. She is accompanied by Dr. Gregg Parker, neurologist and chief medical officer of VISN 16, and Mr. Joe Battle, director of Jackson VA Medical Center.

The complete written testimony will be made part of the hearing record.

Ms. Lewis-Payton, you are now recognized for five minutes.

STATEMENT OF MS. RICA LEWIS-PAYTON

Ms. LEWIS-PAYTON. Chairman Coffman, members of the committee, and other members in attendance today, I am very pleased to see our congressional delegation from Mississippi, thank you for the opportunity to participate in this oversight hearing and to discuss the policies and response of the Department of Veterans Affairs in the wake of allegations concerning the G.V. (Sonny) Montgomery VA Medical Center in Jackson, Mississippi.

I am accompanied today by Dr. Gregg Parker, Chief Medical Officer for the South Central VA Healthcare Network; and Mr. Joe Battle, Director of the G.V. (Sonny) Montgomery VA Medical Center.

The Department of Veterans Affairs and the Jackson VA Medical Center are committed to consistently providing the high quality care our veterans have earned and deserve. In delivering the best possible care to our veterans one of our most important priorities is to keep veterans safe from harm while receiving care in our facilities. I, too, knew Mr. Johnny Lee and was saddened by his death. I am deeply saddened by any adverse event a veteran expe-

riences while in or as a result of care at the Jackson VA or any medical center.

I am proud of the hardworking and dedicated employees at the medical center that are committed to delivering on President Lincoln's promise. I was there when the medical center was named for Mr. Veteran, Congressman Sonny Montgomery. I understood then, as I clearly understand now, there is no more noble mission than serving the men and women that stood and took the oath to protect this country and the freedoms we hold so dear.

The Jackson VA has a history of exemplary performance. The medical center is at or above target on many performance metrics and was recognized by the joint commission as among top performing medical centers in this country on cardiac care. We are rebuilding the executive leadership team and have had an associate director and assistant director, and are currently recruiting a chief of staff. Other key leadership positions, such as chief of surgery, chief of pharmacy, and women veterans health director have been recently filled.

Over the last year several veterans center care projects have been completed, including construction of the mental health unit, renovations to the oncology unit, the surgical intensive care unit, and the women veterans clinic. We look forward to completing more renovation projects for more private rooms, as well as the community living center addition.

Compensation and pension exam times have improved from over 30 days in fiscal year 2012 to 14 days in fiscal year 2013. Our vigorous homeless veterans program has housed 242 veterans in Mississippi and provided valuable medical care and employment counseling.

Shortly after his arrival Mr. Battle developed a plan to transform Jackson's nurse practitioner driven primary care model to one with an equal number of physicians and nurse practitioners for its 20 medical center based primary care teams. I am extremely pleased to announce that nine of the ten physicians for primary care are on duty and the tenth is completing the credentialing and privileging process. In response to concerns at Jackson consultative program reviews, site visits, and external surveys, including unannounced visits from the joint commission, Office of the Inspector General, Office of the Medical Inspector, and the Occupational Safety and Health Administration have been completed.

Jackson continues to be accredited by the appropriate oversight agencies, including Joint Commission, and has developed robust action plans to address our recommendations. Actions are being closely monitored to ensure completion.

So far I have provided information regarding what we are doing at the Jackson VA Medical Center as a system. Please be assured we understand that it is also about individual veterans getting the healthcare they need when they need it. Our goal is that each veteran will have an exceptional experience every time they enter our facility. They deserve no less. We are striving everyday to achieve this goal. When we do not achieve this goal we reach out to those veterans and their families in an effort to make it right for them and to improve our systems and processes for other veterans.

Various allegations have been thoroughly investigated. We are working aggressively to identify and correct errors and we are adopting a series of reforms to improve. When appropriate to do so we hold people accountable. 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. I welcome the opportunity to discuss details in a private setting with congressional members as allowed by law.

Mr. Chairman, we appreciate your interest in identifying and resolving challenges at the G.V. (Sonny) Montgomery VA Medical Center. I feel a great sense of duty to the men and women who have served, and our efforts to improve will continue. I thank you for the opportunity to appear before you today and my colleagues and I are prepared to respond to your questions.

[THE PREPARED STATEMENT OF RICA LEWIS-PAYTON]

Chairman Coffman, Members of the Committee, and other Members in attendance today, thank you for the opportunity to participate in this oversight hearing and to discuss the policies and response of the Department of Veterans Affairs (VA) in the wake of allegations concerning the G.V. (Sonny) Montgomery VA Medical Center (hereafter Jackson VA Medical Center) in Jackson, Mississippi. I am accompanied today by Dr. Gregg Parker, Chief Medical Officer for the South Central VA Health Care Network, and Mr. Joe Battle, Medical Center Director of the G.V. (Sonny) Montgomery VA Medical Center.

VA and the Jackson VA Medical Center are committed to consistently providing the high quality care our Veterans have earned and deserve. In delivering the best possible care to our patients, one of Jackson VA Medical Center's most important priorities is to keep our patients safe from harm during their time at our facility. I am saddened by any adverse consequence that a Veteran might experience while in or as a result of care at the Jackson VA Medical Center.

Let me discuss recent events at the Jackson VA Medical Center and what we are doing in response. Be assured that we have thoroughly investigated various allegations. We know that a number of issues have been raised about this Center, and we take those concerns seriously. We work aggressively to identify and correct any errors, and we are adopting a series of significant reforms to improve the center. When appropriate to do so, we hold people accountable. 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.

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.

At the time the March 18th letter was received, VA had appropriately responded and corrected the issues cited in the three whistleblower allegations related to the Sterile Processing Department.. These issues are all closed. , Jackson VA Medical Center has implemented stringent oversight processes to ensure reusable medical equipment is cleaned and sterilized according to manufacturers' instructions before every use. The facility has also invested more than a million dollars into state-of-the-art reprocessing equipment to ensure proper cleaning and sterilization and transitioned to the use of more disposable devices when these are available. After receiving the March 18th letter, VA initiated a quality of care review of sterile processing services at the facility. The review found that the VAMC utilizes effective systematic processes to safely perform the re-processing of all critical and semi-critical reusable medical equipment in the facility. The Jackson VA Medical Center continues to monitor and evaluate the Sterile Processing services.

The other two complaints discussed in the March 18th OSC letter had been referred to VA on February 29 and March 5, 2013. The February 29th complaint involved the Primary Care Unit at the Jackson VA Medical Center, and the March 5th 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, a review team outside the Veterans Integrated Service Network (VISN), chartered by the Deputy Under Secretary for Health for Operations and Management (DUSHOM), conducted 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, 2013. The OSC sent a follow-up letter, dated September 17, 2013, concerning those reports. Therein, OSC reported the Department had substantiated some of the whistleblowers' allegations and recommended follow-up actions, but OSC indicated the status of the recommended actions was unknown.

Efforts to implement the recommendations in VA's July 2013 reports are well underway by the facility and the VISN, with active monitoring by the Office of the Medical Inspector (OMI). Specifically, in September 2013, the Under Secretary for Health directed the OMI to oversee implementation of the action plan at the Jackson VA Medical Center. OMI conducted a site visit on October 22–23, 2013, and both reviewed and concurred with the facility's action plan. OMI and the DUSHOM will continue to monitor implementation of the action plan and keep Veterans Health Administration (VHA) leadership apprised of the progress in implementing the reports' respective recommendations and the sustainability of the recommendations. On May 24 and June 12, 2013, OSC referred two additional complaints to VA for investigation. These referrals con-

cerned pharmacy operations and the credentialing and privileging processes at the Jackson VA Medical Center. VA's report on the credentialing and privileging matter was delivered to OSC on August 15, 2013. The facility revised its credentialing and privileging processes to ensure it is consistent with National VHA policy. The Jackson VA 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 Medical Center Director for approval. The report concerning pharmacy operations was delivered to OSC on August 27, 2013.

Jackson has undergone many consultative program reviews, site visits, and external surveys, including recent unannounced visits from The Joint Commission, the Inspector General, OMI, and the Occupational Safety and Health Administration. Jackson is accredited by all appropriate agencies, including The Joint Commission. During the past 12 months, subject matter expert teams have been deployed to conduct assessments of primary care and assist in the development and implementation of actions to address deficiencies. Additionally, staff from across the VISN have been deployed to fill key leadership vacancies. These activities are in addition to the standard annual reviews of quality and safety, financial operations, and environment of care.

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. Mr. Battle has personally addressed participant comments provided on comment cards at the town hall meeting and met with all interested parties who desired a meeting with him as follow up.

Given the issues raised concerning the Jackson VA Medical Center, I have provided intense oversight of facility operations. This includes weekly calls with the Medical Center Director, monthly operational calls with the Executive Leadership team, and site visits to the facility to include all employee town hall meetings.

Conclusion

Mr. Chairman, we appreciate your support and encouragement in addressing issues at the Jackson VA Medical Center. VISN 16 and the Jackson VA Medical Center will continue to work hard and improve the high quality of care to our Nation's Veterans. Thank you for the opportunity to appear before you today, and my colleagues and I are prepared to respond to any questions you may have.

Mr. COFFMAN. Thank you, Ms. Lewis-Payton. Since the death of Johnny Lee in April, 2011, what efforts have been taken to improve supervision and personnel shortages to stop further preventable deaths?

Ms. LEWIS-PAYTON. Thank you, Mr. Chairman. I will tell you that that death has saddened all of us. And therefore we had thorough investigations by external review bodies to look at the circumstances under that death and those investigations were complete and actions taken as needed were completed as well. We con-

tinue to provide oversight in terms of the care that is provided at our facility. That oversight takes a number of forms. There is a very robust performance management system in the Department of Veterans Affairs. In addition to that the VISN does site visits routinely at least on an annual basis. We have the joint commission survey that has occurred. The Office of the Inspector General also does a comprehensive assessment program of the VA on a routine basis. So there are a number of systems and processes in place to address it.

I must also say, sir, that despite our best efforts healthcare is complex and errors will inevitably occur. But what I can also tell you is when they do occur that we take the actions to address those errors to make it right for veterans and to improve our systems and processes for veterans in the future.

Mr. COFFMAN. Thank you. Just a point, you had mentioned the joint commission. You have referenced that and I want to remind you that the joint commission does not investigate allegations of negligence, they only assess compliance with their own requirements. Also the FDA released a safety report in February, 2011 warning of the bleeding risks associated with wound vacs and advising of the need for frequent monitoring. And as recently as September 17, 2013 the Office of the Special Counsel wrote a 22-page letter to the President explaining how VA was not taking adequate action to correct problems and not taking these issues seriously at your facility.

Mr. Battle, Jackson has had other preventable deaths and occurred recently. For instance, a patient in 2010 who suffered a diabetic coma and died in the intensive care unit, and another patient who died after having both legs amputated due to the misdiagnosis of a protein deficiency. Will you provide us with the records associated with these cases?

Mr. BATTLE. We will be happy to provide you records, sir.

Mr. COFFMAN. And when can you have those to us?

Mr. BATTLE. I will get those records to you within 30 days.

Mr. COFFMAN. Very well, thank you very much. Dr. Parker, it was a uniform practice at Jackson to redirect veterans to "vesting clinics" that did not exist which resulted in double booking and in many cases veterans being turned away without care. What efforts if any have you taken to end this practice?

Dr. PARKER. Thank you, Mr. Chairman. I had the privilege of serving 28 years in the Navy uniform as a combat surgeon in two war theaters. I use that experience to guide me as I provide the oversight for the ten facilities in the VISN. That experience alone does not allow me to by itself look at the issues and address the concerns when they arise. I rely on data and I rely on the data sources. But I personally receive all of my care at the Jackson VA as a veteran. Since 2005 I have received all of my primary care from a nurse practitioner——

Mr. COFFMAN. Can I go back to the question, please? Dr. Parker, it was a uniform practice at Jackson to redirect veterans to "vesting clinics" that did not exist which resulted in double booking and in many cases veterans being turned away without care. What efforts if any have been taken to end this practice?

Dr. PARKER. The primary care clinics at Jackson have evolved and we have fully implemented PACT. In the VA terms that is a patient aligned care team. That ensure——

Mr. COFFMAN. And when did you implement this?

Dr. PARKER. It has been fully implemented in Jackson, which was slow out of the gates, and fully implemented as of August of this year where they met all of the metrics that we hold them to.

So currently there are no vesting clinics. We expect that the provider, nurse practitioner or physician, will manage their panel of 1,200 patients at an average of about three visits per year, because that is what the national average is. So that practice——

Mr. COFFMAN. Were you aware of the vesting clinics?

Dr. PARKER. I was not.

Mr. COFFMAN. But it was your responsibility to know, was it not?

Dr. PARKER. Yes.

Mr. COFFMAN. Very well. Sergeant Major Tim Walz, State of Minnesota.

Mr. WALZ. Thank you, Mr. Chairman. Thank you all for being here today. And after listening to the first panel, and now hearing this, and I want to say I am very appreciative of all of your service. And Ms. Lewis-Payton, I am very appreciative of the point you brought up on due process, and some of the things that are there. But due process should never endanger veterans. And I am fearful that we, at times there is a fine line there. I hope we stay on the right side of what we are willing to give and do but with the best interest. And I know your hands are tied on certain legal matters.

But one of the things in this job I have had the privilege and the responsibility of is visiting many different centers. And they are all slightly different. The commitment of the folks who are working there is never in question. But their outcomes, like so many things, do vary. And I think after listening, and I am going to hear some responses to some specific questions, this one appears to me that there is a bit of a cavalier attitude being put forward and I daresay almost dismissive of the reports. Because there has been a paper trail here and a review that has gone. The only other time I saw this maybe at this level was in Miami and we have seen these things.

So I would ask you this. The concerns you heard brought up from staffing to undue pressure being put on by two physicians, how do you account for that? How do you account for that pervasive and I would say cancerous attitude that was in amongst some of the staff? And any of you can try this. And I know, Mr. Battle, you have not been there a long time. But I myself have seen these things as being cultural and they tend to extend beyond directors at times. So let me.

Ms. LEWIS-PAYTON. Yes, Mr. Congressman, thank you sir for the question. Let me first say that I come to work every day with a sense of duty and responsibility to the men and women that we serve, and I am honored to do so. I take these allegations and these concerns very seriously.

Major General Eric Hearon can tell you I have had numerous conversations with him. When he brings those concerns, we may disagree on the approach to address them but he cannot say that I did not address them.

I will also say to you that I absolutely agree with you that at no time can we as leaders put people, put veterans in harm's way. So I can assure you, sir, that when there are, when we have information to suggest that harm is being done to a veterans, yes there are due process requirements that we are obligated to complete. But what we do is to remove those persons from that environment while we complete the investigation——

Mr. WALZ. Were all veterans notified as soon as you found out on the misreadings on the radiological exams and things? Were veterans notified in writing and given an opportunity? Were they also told what their legal obligations were assuming that there was negligence here, possibly bordering on criminal? Were all those, was every veteran notified of their rights?

Ms. LEWIS-PAYTON. Sir, there are some complex issues. And so not all of the information that is currently in the public domain is correct. So——

Mr. WALZ. So it is possible that a veteran who was misserved by this went home and still to this day does not know that there was a problem and that they have some legal recourses?

Ms. LEWIS-PAYTON. I can tell you for those cases where it was confirmed that an error was confirmed that caused harm to a veteran, an institutional disclosure was done. And Dr. Parker can speak more specifically to the systems and processes in place associated with that and the radiology cases were followed in that process too. There is some additional work because of the concerns that have been expressed to go back and take a second, a third, and even a fourth look. But I can assure you when there is a confirmation that an error occurred that caused harm to a veteran, an institutional disclosure either has been done or will be done.

Mr. WALZ. So the situation at Jackson, Dr. Parker in your assessment, was just a couple of bad folks who just did not do what they were supposed to do?

Dr. PARKER. The individuals at Jackson that are practicing there are all good individuals. They go there with the intent to provide good care. There are on occasion some errors that occur. I have not run across a provider yet who intended for those errors to occur. But errors do occur. And when they——

Mr. WALZ. That is the role of processes.

Dr. PARKER. Correct.

Mr. WALZ. Whether it is sterilization processes on medical equipment, and to know that there is a checklist that you follow, and then someone is in charge to make sure the checklist was followed. Is that where the breakdown was?

Dr. PARKER. Yes, in part. In part the processes needed to evolve to keep up with the standard of care and the standard of medicine. For example, sterile processing. You used to, when I started practice back in the seventies and we used a scope, which was a flexible scope, we wiped it down with alcohol. That was the accepted standard then. Now it has to be, go through a highly decontamination process——

Mr. WALZ. I am very familiar with this issue——

Dr. PARKER. Yes.

Mr. WALZ. —because of the colonoscopy scopes. And I have had them set in front of me on how we do it. The problem there was we did not have a process in.

Dr. PARKER. Correct.

Mr. WALZ. It was instituted systemwide and since that time for the most part we have reduced those errors. My question is is that some of the policies that were not being followed in Jackson were being followed in other places where they did not have this process occur. And that to me seems to be the critical issue, of who is responsible for making sure that those things happen. And I have gone over my time. I appreciate the chairman's indulgence. We will come back around. Thank you.

Mr. COFFMAN. Let me just say quickly, Ms. Lewis-Payton, that this report by OSC to the President of the United States on September 17th contradicts your testimony today and states that you are not serious on the date of this report and prior in terms of addressing these issues. Mr. Palazzo?

Mr. PALAZZO. Thank you, Mr. Chairman. I appreciate you letting me join this important hearing today, especially for the second panel. And it is fitting just a few days after Veterans Day that we are having this hearing. And before I begin I want to note that this hearing has a special meaning for me since we are specifically discussing the Sonny Montgomery VA Medical Center. Many of us in Mississippi and around the nation remember very clearly the work Sonny Montgomery did on behalf of our nation's veterans. So it is heartbreaking and quite frankly makes me angry that the VA has so completely screwed up a medical center with the name of such a great supporter of our veterans. In fact, it is disgusting.

Now I am not on the VA Committee but I am a veteran. Veterans have to wait more than a year to receive benefits and when they do it is painstakingly problematic. Now I have had my issues with the VA Medical Center in Biloxi and we are working through those. I have been assured those issues are going to be handled. But the complaints keep coming in. My office is regularly called upon to interface on simple yet frustrating matters for veterans. Some examples include failure to give proper notice of appointments causing scheduling difficulties for aging veterans; veterans being turned into collection agencies due to billing errors by the medical center; unnecessary hurdles to fill regular prescriptions; and long, excruciating, all day waits at the medical center only to find out you are waiting to see a nurse practitioner and not a doctor.

And now we have these stories from our veterans coming out of Jackson. Those that we have heard this morning, those from my constituents from across the State of Mississippi. While I am thankful that my office has not experienced a tragedy like the incident of Mr. Lee, a VA employee and Army veteran, I must ask why does a veteran have to call their congressman for assistance on what should be routine matters performed by the medical center? If you cannot get the simple matters right it strikes utter fear in me when I hear the horror stories described earlier.

I am appalled because our veterans deserve better. These men and women fought for our country, came back, and they deserve better. They deserve better from a Veterans Administration that

for years has said do not worry, we will fix it. Do not worry, we will fix the claims backlog. Give us a little more time and we will fix the problems at our medical centers. Provide a little more funding, and it will all be okay. Well guess what? It is not okay, and it has never been okay. It is a problem from the top down.

But I want to focus briefly on those of you here before us today. Veterans are literally dying at the Jackson VA because the VA cannot fix their problems. I mean, those reports I am reading are sickening. Veterans left to die because they were forgotten about. Bad prescriptions, illegal prescriptions, patient overbooking, the list goes on. So I want to know on behalf of the veterans of Mississippi, Mr. Battle, what are you doing to personally fix these issues? And what are you going to do? What are you doing now, what are you going to do? And I do not want to hear political jargon. I want to hear you tell this committee, tell me, and tell the State of Mississippi, what are you doing to fix these problems that are facing our veterans?

Mr. BATTLE. Well thank you, Congressman Palazzo, for your question. I appreciate the opportunity to speak before the committee today. More specifically to your question, sir, you mentioned benefits to start with I think. One of the things that I have done in Jackson and continue to focus on is processing medical evaluations for veterans. When I got to Jackson the average processing time was a little over 30 days, the standard for VA was 30. Today we are processing in the 14- to 15-day range on average. So we have cut that in half and, you know, we are very happy that we are able to do that so when the claims do come to us we turn them quickly.

MR. *Palazzo.* Let me, I appreciate that, and I do not mean to interrupt. I have just got a few more questions. How does it feel to know that your colleagues, they were not terminated, they were not fired for their gross incompetence and possibly illegal behavior? That they are still amongst your ranks in the VA system? Does that make you proud of the service that you do? And I do not, I hope that I am not overstepping. But I know if I worked a career in the industry, and I know you all have sacrificed for our veterans, and you are here, you are not 100 percent responsible. And I know you have good employees. Mr. Jenkins mentioned that you have good rank and file employees. You have got good doctors at the VA medical system. But does that make you all proud? That the system that you have grown up in is just transferring people from one place to another? Mr. Battle, let us start with you.

Mr. BATTLE. Well thank you for the question, Mr. Congressman. I have over 30 years of service with the VA and I am very proud of that service. And it has been my life and my passion. And it continues to be today and it is everyday that I get up, because I do not think there is any greater job to have in the United States than to take care of our nation's veterans. And any time that we have an incident or something occur, where something did not go like it should, that takes a little bit out of me and it is my job to make it better. And that is what I concentrate on each and everyday when I go to the office.

MR. *Palazzo.* Mr. Battle, my time is up. And I hope you are the last director in Jackson for a long time and that you personally

oversee fixing the problems and paying for the mistakes that have been made, especially to the veterans. I think they need to be immediately notified of the possibility that their results were erroneous, or were not read at all. And I appreciate your passion. Because I know for a fact, my wife started out in the VA medical system in Houston, she worked in the VA medical system until Hurricane Katrina took that, pretty much that whole facility. So I understand. And sir, thank you for your service. And Ms. Payton, I thank you for yours. But please do not every write this off, or call this kerfuffles. I am with Chairman Coffman. If you use a word like that in the military, you are probably not in the military, you are just passing through. But please, do not dismiss this. Work hard. Make us proud. And most of all, let us make Sonny Montgomery proud. Because wherever he is, he is looking down, he had got a heavy heart.

Mr. BATTLE. Yes.

MR. *Palazzo.* So we owe it to him, but we owe it to the veterans. That is the first and foremost, number one priority. Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Mr. Palazzo. Mr. Thompson of Mississippi?

Mr. THOMPSON. Thank you very much. Ms. Payton, when, if you have the information, can you provide this committee with a timeline from the notice of Mr. Lee's death to how it was investigated? You know, the question I think in a lot of our minds is it was not taken seriously. And I think the timeline can clear up a lot of that.

I guess the other question in light of some of what I heard earlier is what part of the system failed the veterans in Jackson so that so many of these errors kept occurring and reoccurring? It appears that some standard of checks and balances just was not adhered to, and were being overlooked. Can you shed some light on that?

Ms. LEWIS-PAYTON. Yes, sir. Healthcare as you all know if a very complex operation. And when I look at my network as an example, which includes ten VA medical centers, 60 community-based outpatient clinics, in all or part of eight states, 20,000 employees. At the Jackson VA Medical, Mr. Battle can quote the specific number, 1,500 employees. You have a large number of outpatient clinics. A lot of opportunities in a large complex system for errors to occur.

When you say that there are systemic issues clearly over the last several years there have been significant concerns and media attention surrounding the Jackson VA Medical Center. What I can tell you today, and this has been the case since I arrived at this position, as was mentioned before I also knew Sonny Montgomery. And the naming of that facility, that you have my commitment, ongoing commitment to address the issues and to make that facility better. And that is what I work on each and every day and will continue to do so.

Mr. THOMPSON. And there is no question about it. But I think some of us are concerned that the culture of the facility allowed certain things to go on that those situations are inconsistent with good medical practice. And I just, I want——

Ms. LEWIS-PAYTON. There is no question that organizational climate and culture makes a difference. As was mentioned, we have

had a significant turnover in the leadership positions at Jackson and we are rebuilding that facility from its foundation up.

Mr. THOMPSON. Well——

Ms. LEWIS-PAYTON. It has taken us some time to fill those vacancies.

Mr. THOMPSON. Well——

Ms. LEWIS-PAYTON. Because we want to make sure that we have individuals that like Joe and I, and Dr. Parker, are also committed to making it better.

Mr. THOMPSON. Right. Right. Well you know, I toured the facility last June, and I have been up a couple of other times. But the OSC letter causes me great concern. Because some of those things we talked about a year and a half ago have been brought up in this letter. And what prevents you from fixing a problem when you find it?

Ms. LEWIS-PAYTON. Sir, I would say that we are addressing the issues. And I agree that the complaints in the OSC letter, they are those complaints from 2003 and 2007. The primary care complaint is different. But those are the same complaints. If you look at the supply processing, for example, there have been subsequent reviews and significant investment in that area since 2010.

Mr. THOMPSON. Right. I——

Ms. LEWIS-PAYTON. And that complaint has been——

Mr. THOMPSON. Well if it has been ongoing I think some of us are saying what stops the complaints from being fixed? If you have been rolling them for ten years, that is a problem. And I think you are aware that OSC disagrees with your response?

Ms. LEWIS-PAYTON. Yes, sir.

Mr. THOMPSON. And you are preparing a response to them?

Ms. LEWIS-PAYTON. Yes, sir.

Mr. THOMPSON. Has a peer review been conducted by Dr. Khan in Dr. Khan's case?

Ms. LEWIS-PAYTON. There have been several. Dr. Parker, do you want to speak?

Dr. PARKER. In the 2007 time frame there were several peer reviews that were conducted for Dr. Khan. What you are referring to now is the Office of Special Counsel and some requirement or mandate to review more of his films. That is under review at the highest level here at the VA and the response will be afforded to Office of Special Counsel.

Mr. THOMPSON. There is a 60-day turn around on a response to the OSC report. You have got to be pretty close to it now. Do you know when it will——

Ms. LEWIS-PAYTON. Yes, sir. It is my understanding that it was submitted today. But since that is an active and ongoing issue with VA and OSC we are not at liberty to discuss it here.

Mr. THOMPSON. Thank you.

Mr. COFFMAN. Thank you, Mr. Thompson. Dr. Benishek, State of Michigan?

Mr. BENISHEK. Thank you, Mr. Chairman. Dr. Parker, this guy that had these problems with the radiology reviews, you have not reviewed his films that he did then? I mean, you are planning on doing that?

Dr. PARKER. There are two issues there, Dr. Benishek. One of them has to do with the 52 cases that were talked about in the testimony here, and the other has to do with a request to review more films of Dr. Khan that were read from 2003 to 2007. The 52 films, actually there are 58 cases at this point, that have been thoroughly reviewed by at least three external reviewers all to substantiate whatever the claims were. And that has gone to the Office of the Medical Inspector last week so that they can finally bring to closure any concerns about those 52 cases, we think there are 58 that we will need to review. The other issue has to do with a peer review of X number of charts from Dr. Khan.

Mr. BENISHEK. The other question I had is, I had mentioned it earlier, you may have been here for that, you know, the Morbidity and Mortality Review Panel within, you know, each medical center.

Dr. PARKER. Right.

Mr. BENISHEK. You know, I am very familiar with that. Because you have to get up there and, you know, tell about your failures. So you are the Medical Director for the VISN, right? Or the Chief Medical Officer?

Dr. PARKER. Yes, sir.

Mr. BENISHEK. So then are you involved in making sure that kind of happens throughout your VISN?

Dr. PARKER. Yes, sir. There are several places where that can occur, several places where it must occur. You are, as a surgeon, familiar with the Morbidity and Mortality Conferences. And that is a very lively discussion among surgeons and others. Each facility is expected to do that, although it is not technically a requirement. There is also a peer review committee where everything must be reviewed that hits a certain category. When untoward events happen, you know, hospitals take care of disease and unfortunately there are patients that die. That is expected on occasions and unexpected on others. Every one of those get reviewed at the facility and it forwards up to me, usually in an institutional brief or an issue brief so that I can see it. It comes up in a different way for any cases that were seemed to be outside the norm, where there should be disclosure. I review every single one of those.

Mr. BENISHEK. Let me ask a question about the organization of the clinics and that, because I know in my experience and in my Subcommittee on Health in the VA Committee, you know, we are concerned about, you know, physicians not having the input to manage the clinics and that they end up being sort of the worker bees, and then the nurses or the administration is sort of managing the clinic. And we have run into circumstances where physicians end up doing their own blood pressures and, you know, wasting physician time. Can you expand on that? Is it completely separate from the physicians? I mean, is the Chief Medical Officer organized a clinic, or is there a chief of staff in each individual hospital? Or do they just sort of go to their assignments?

Dr. PARKER. As a clinician, there are two basic models. One is the product line and one is a non-product line, if you will. But as a clinician I always took the responsibility myself. You know, I was responsible for the patients. In the primary care arena, the PACT teams, the patient aligned care teams, are specifically designed to do exactly what you say. There are supposed to be three support

staff for each provider. That provider and those support staff, which is——

Mr. BENISHEK. So but does the physician have the determining, I mean, who determines how that all works? Is it the administrator? Is it the director of nursing? Or is it the medical staff——

Dr. PARKER. It should be the service chief, sir. They are they, healthcare is delivered one on one, face to face. And the service chief, which is the Chief of Ambulatory Care, or the Chief of Primary Care, or the Chief of Surgery——

Mr. BENISHEK. A physician?

Dr. PARKER. A physician.

Mr. BENISHEK. That is the complaint I hear most often amongst VA physicians, is that, you know, the way the thing is managed is not to their liking and they seem to have little input.

Dr. PARKER. Well and I will say, as a physician I think I can say this, all physicians are not great managers and they need the assistance of other professionals. It should be a team. But——

Mr. BENISHEK. Well absolutely. I understand there is other input there. Because I know when I had my own practice, you know, I tended to want to manage it most efficiently for my time, for my patients' time——

Dr. PARKER. Right.

Mr. BENISHEK.—but sometimes when you get to the, you know, the VA, I did not have much input as to how my clinic was run. You know, being a fee for service physician coming in on a——

Dr. PARKER. Yes, sir.

Mr. BENISHEK. —whatever day it was. Sometimes we could have improved it if we could allow more patients to get in there, to make effective use of staff and the patient time. And I just get kind of concerned over many of the situations that we heard here, you know, the most egregious was, you know, a ghost clinic, where people were coming into a clinic and there was nobody staffing it. I mean, it is pretty shocking to have heard that that went on.

Dr. PARKER. Yes, sir.

Mr. BENISHEK. How can we fix this, Dr. Parker? I mean, how do we instill the need or the management goal of having good patient care rather than, it seems to me that these guys were motivated by having to produce some statistic.

Dr. PARKER. Yes, sir. I think when I was in the military for 25 years the military had a nice cessation planning and a gradual progression of responsibilities and you learned it. I think what the VA lacks in comparison is that progression. We promote leaders into positions without the support, without the education, without the training, without the structure that would allow them to be successful. In particular for physicians. I mean, the training piece of it is phenomenally detailed, as Ms. Payton says, it is a very complex system. I think that we provide a disservice for our providers and our service chiefs, and I am not talking just physicians here, that we should have better mechanisms to train them.

I recently started my own training for the chiefs of staff because, in part because of Jackson. There is a phenomenal amount of responsibility and accountability and things that you must understand, credentialing, privileging, to get it done. So we now have a once a quarter, face to face, that is about a day and a half or two

days. That is about all we can package together, especially for the travel requirements right now. But personally have put that together and trained the chiefs of staff so that they understand the responsibility. And hopefully that will go down to the service chiefs level.

Mr. BENISHEK. So there is no general VA system for that to be done? You just had to institute it on your own, basically?

Dr. PARKER. Correct.

Mr. BENISHEK. All right. Thank you. Sorry I am overtime.

Mr. COFFMAN. Thank you, Dr. Benishek. Mr. Harper of Mississippi.

Mr. HARPER. Thank you, Mr. Chairman. And I thank each of you for being here. And it is good to see some of you again. And I do want to say, Mr. Battle, I appreciate your hospitality on the occasions we have had to visit. I know there is a lot that has been done, but still it appears there is a lot that still needs to be done. And we want to make sure that we equip you to make sure they are done, keeping in mind that patient care is paramount at the VA. And the commitment that we have to our veterans is just critical. And that we do not ever want to look like we are not fulfilling that.

Now one thing that I had, was concerned about is we have obviously in the, among our patients at the VA, we have a lot that need orthopaedic care. Do we have any orthopaedic surgeons on staff currently?

Mr. BATTLE. Yes, sir. We have one orthopaedic surgeon on staff today.

Mr. HARPER. How can one orthopaedic surgeon, I assume it is a full time position?

Mr. BATTLE. It is full time.

Mr. HARPER. How can one orthopaedic surgeon take care of all the orthopaedic needs in our VA patient population at the Jackson VA Medical Center?

Mr. BATTLE. Well thank you for the question, Congressman Harper. One cannot. And normally we would have three. And we lost two of our orthopaedic surgeons last fall. We have been aggressively looking to recruit new ones.

Mr. HARPER. So that has been a year ago? Fall, so we are a year?

Mr. BATTLE. November, yes, sir.

Mr. HARPER. Okay, sorry.

Mr. BATTLE. And as you know, Mississippi is a medically underserved state and recruiting physicians is difficult. But we want to make sure that who we hire is someone who can be collaborative with the University, our medical affiliate next door, ourselves, and take care of our veterans the way we want them done.

In the meantime what happens is we feed (use of Non-VA care) those cases out to the community, is how we handle it presently.

Mr. HARPER. I have been told by some that getting outside orthopaedic care is difficult because of the delay in payment from the VA. Is that accurate or not?

Ms. LEWIS-PAYTON. We have certainly had some challenges in that regard. And we are working very closely with our vendors in order to continue to provide that care. In addition we have instituted a number of actions to address our fee processing times. These are not simple things, as I mentioned. Our network is ten

VA medical centers across eight states. And our fee unit is centralized. So that is a lot of claims going through a system. We are improving our IT infrastructure, going to two shifts, and doing some other things to increase that.

The other thing I will mention as it relates to recruitment of specialty physicians, particularly in Mississippi that is underserved. And Dr. Sherwood mentioned it, we are using all of the recruitment and retention incentives available to us in order to attract. But it is a challenge.

Mr. HARPER. All right. Let me ask both of you right now. We have been basically, I assume, one orthopaedic surgeon for almost a year, or approximately a year. What kind of time frame are we on? When will we see that in house, where we will have three? Do we have any leads?

Mr. BATTLE. Yes sir, we do. We are vetting two candidates right now.

Mr. HARPER. Okay, thank you. Dr. Parker, if I may ask you Linda Watson was the subject of a 2006 OIG report that found she misused funds, did not cooperate with investigations, and created a very, for lack of a better word, a very stressful environment during her role as the VISN 7 Director. So why was she hired as the Director of the Jackson VA Medical Center after that?

Dr. PARKER. Thank you, sir. I am not sure if I can answer your question completely. She was transferred to the VISN 17 staff in Dallas, Texas, and after a period of time was moved to the Jackson VA as the Medical Center Director.

Mr. HARPER. Well how do we make sure that our future problem children are not just moved to another location? I mean, this is a problem that we have got to address and we have got to stop. And that is we cannot continue to reward bad behavior. So what is the answer there, Ms. Lewis-Payton?

Ms. LEWIS-PAYTON. Sir, I would agree with you. And what I will also tell you is one of the things about this wonderful country that we live in is that people get due process and all of those sorts of things come into play as well. So when there are findings as you know all of that is assessed relative to the overall performance of a person, and then there are decisions about what actions there are to be taken associated with that. And all I can tell you is that I am sure that that process was followed as it relates to the person you mentioned.

Mr. HARPER. Well then the process needs to be changed. So thank you very much. I appreciate your time. I yield back.

Mr. COFFMAN. And we will do a second and final round for those members that have questions. Ms. Lewis-Payton, why is VHA now pushing to amend its nursing handbook? Does that designate an nurse practitioners as independent practitioners without regard to state licensing restrictions?

Ms. LEWIS-PAYTON. Sir, as you may be aware VA does follow the state requirements as it relates to licensure. The thing that is different about perhaps the VA is that a person can have a license in any state and then be able to practice at a VA facility. But the full requirements associated with that state, those are, those are followed.

As was previously mentioned by one of the congressional members of this committee, a physician, that in this country there are areas where we have, we have underserved areas where it is difficult to recruit physicians, particularly specialist physicians. And so nurse practitioners are used as physician extenders, if you will. But the oversight responsibility is still there in terms of collaborative agreements and those sorts of things associated with it.

As it relates to specific questions about the VA's policy in pursuit of a certain policy, I am not in a position to answer that.

Mr. COFFMAN. All right. Well let me remind you that on June 21st VHA recommended that Jackson leadership should stop designating nurse practitioners as licensed independent practitioners unless their licensing state permitted them to do so. So let me leave you with that.

Mr. Battle, how many different people have served as Acting Chief of Primary Care in the last year?

Mr. BATTLE. In the past year? Three.

Mr. COFFMAN. I think Dr. Hollenbeck in her testimony stated that there has been one every three months since March, 2013. Would you say that that is a very high turnover rate?

Mr. BATTLE. Well we have acting associate chiefs of staff for primary care, sir, as we are searching for a new permanent Associate Chief of Staff for Primary Care. And we have brought one person in from detail. We had one person within house do it. And now we have another person from in house acting as we continue that search.

Mr. COFFMAN. Ms. Lewis-Payton, in 2012 you received a bonus of $35,940. Why was this information not included on the disclosure from VA to this subcommittee with the rest of the 2012 bonuses?

Ms. LEWIS-PAYTON. Sir, I am not aware that it was not included. It is a matter of public record.

Mr. COFFMAN. Thank you. Mr. Walz from Minnesota? Passes. Mr. Thompson?

Mr. THOMPSON. Thank you. I think I am concerned with how we are presently handling situations, too. Mr. Battle, Mr. Jenkins mentioned that a number of patients have fallen in the month of September. Are you aware of that?

Mr. BATTLE. Yes, sir. I get a report on falls. And I am aware that there has been some falls and we have a group looking into that.

Mr. THOMPSON. So is 14 people in the month of September considered a high number? About average? Or what?

Mr. BATTLE. I think it depends on where the falls are, sir, and as to whether it is a high number or not. Let me just say that I consider falls an important issue that we are looking at and we want to make sure whenever possible that no veteran would fall in our care.

Mr. THOMPSON. So are you looking into the fall? Are you looking into whether or not is a shortage of nursing, or support personnel for the patients?

Mr. BATTLE. Yes, sir. We look at all of it. We look at when the falls occur, what the staffing ratios are, and for any other causal factors that may have been contributory to them.

Mr. THOMPSON. Thank you. Mr. Jenkins also referenced the practice of nepotism, and managers hiring family members into nursing positions. Are you aware of that?

Mr. BATTLE. Yes, sir, I am aware of his allegations in that regard.

Mr. THOMPSON. Are you looking into it? Or have you looked into it?

Mr. BATTLE. Yes, sir. In regards to the Nurse Executive, there are administrative activities going on.

Mr. THOMPSON. So it did happen?

Mr. BATTLE. I am not at liberty to discuss it because it is an ongoing personnel issue, sure.

Mr. THOMPSON. So—okay. But it is against VA regulations to hire a relative at a certain relationship?

Mr. BATTLE. Under VA regulations it depends on where they work in the facility and whether there is a direct relationship or not.

Mr. THOMPSON. Can you repeat that for me again?

Mr. BATTLE. Sure. Relatives may work at the same facility.

Mr. THOMPSON. Sure.

Mr. BATTLE. But they should not be in a direct, under the direct supervision of that person that they are working, where they are working.

Mr. THOMPSON. Direct supervision, nor should they participate in the hiring of the individual?

Mr. BATTLE. Correct. Correct. That is correct.

Ms. LEWIS-PAYTON. That is a violation of VA policy for an individual to hire their relative.

Mr. THOMPSON. And your testimony before us is that you are aware of the complaint and you are investigating it?

Mr. BATTLE. We are looking in—yes, sir.

Mr. THOMPSON. Well I——

Mr. BATTLE. There has been an administrative activity going on in regards to the Nurse Exec. And that is an ongoing situation from a personnel perspective.

Mr. THOMPSON. Well Mr. Chairman, I am not certain but I think since you are an Oversight Committee it might be proper for you to ask for whatever findings those are. And I would recommend that you, that this committee would look at any of those nepotism allegations.

Mr. COFFMAN. Very well, Mr. Thompson. We will do that. And thank you very much for your recommendation. We will follow through on that.

Mr. THOMPSON. Thank you. I yield back.

Mr. COFFMAN. Mr. Palazzo, State of Mississippi.

Mr. PALAZZO. Thank you again, Mr. Chairman. Quick question for Ms. Lewis-Payton. When were you informed of the alleged wrongdoings of Dorothy White-Taylor? And what actions have you taken since then to end these prohibitive narcotic prescription practices at the VA in Jackson?

Ms. LEWIS-PAYTON. I think it is important to note that we, the leadership at the medical center and at the VISN, requested an OIG review of concerns that have been brought to our attention. As you are aware, the criminal investigation has been completed. And

as was mentioned, an administrative investigation is underway and we are not at liberty to discuss it in this public hearing nor any actions that are in process or may result from it.

Mr. PALAZZO. So you kind of knew something was going on and so you asked for the OIG investigation, correct? Or the investigation? And that is when you actually learned of these behaviors. And now she has been on suspension, indefinite suspension since 2013? February, 2013?

Ms. LEWIS-PAYTON. Sir, I will be happy to discuss personnel issues related to individuals in a private setting. It would not be appropriate to do so in this public hearing.

Mr. PALAZZO. All right. I appreciate it. And again, I do not want to, I mean, we have to recognize that there has been some serious mistakes made in the past before we can begin the process of moving forward so that these, this culture, this institutional culture is changed, turned upside down on its head so we can do what our number one mission is. And that is to serve our veterans. Every one of you said you have a passion for serving veterans. I know I mentioned my wife. She loved it. She, I mean, she shot out of the house. You know, she would stay late. I mean, I think she would pick up any veteran that came in, she would just work them in. And she loved it. And it was something that I know many, many VA employees do. The doctors behind you have that passion. So this, I mean, there are so many other agencies, so many other jobs you could pursue. But people are drawn, because they are naturally caretakers. And we have to have a way to weed out these bad apples. Because they do not need to be anywhere near our military veterans. I mean, the military has a way of weaning out bad apples as well. And I hope, and I know this is, we are talking about the VA center in Jackson. And I hope we emulate, Congressman Walz mentioned, you know, stellar model VA medical centers. There is no, with the number of veterans in Mississippi we should be that number one, that number two ranked in the best hospital system for the VA in America. I mean, I want a competition. I mean, that should be you all's charge everyday. We are going to be number one. And it is not, you know, a decade from now. It is within arm's reach.

So I mean, I could go on about the oversight. I could go on about the accountability. I look forward to personally meeting with you all outside the committee setting to see what your benchmarks are, where you are going, and then to help kind of monitor it. Because as I mentioned, 2,500, I have been in office two and a half years, 2,500 case files have been opened in my office dealing with veterans and veterans' benefits. Not all with the medical center. But, and they say, you know, I want to be patient, I want to be kind about this, but I cannot. Because patients in some regards when we are talking about veterans that are 70 or 80 years old, they do not have time. They need the care that, and they need it immediately. Because they have earned it and they deserve it. And I just know that you all are going to work hard. And know that if there is anything that we can do, let us know. And I appreciate again the chairman for allowing, you know, some non-VA Committee members. Many of these issues are probably, you know, they are

aware of the VA inside and out. This is new to us. But I look forward to learning a lot more about it. So thank you.

Ms. LEWIS-PAYTON. Yes, sir. And I thoroughly enjoyed working with your office in addressing the concerns. I have become personally involved in that. And just so you know, the motto in VISN 16 is the pursuit of perfection in veteran driven care. We may not achieve perfection, but we will catch excellence. So we are going to continue to work this. Because we too think that this medical center should be the beacon of what VA medical centers are across this country.

Mr. PALAZZO. I yield back.

Mr. COFFMAN. Thank you, Mr. Palazzo. Mr. Harper, State of Mississippi.

Mr. HARPER. Thank you, Mr. Chairman. And again, thanks to each of you for being here and to give us an opportunity to discuss these issues. And it is, you know, perception is reality. But a lot of the reality has created the perception. And so we have to make sure that we equip you to turn things around. Because the way it has been in the past number of years is not acceptable, we would all agree with that. We have got to do better. And you mentioned, Mr. Battle, 14 falls in September. Just curious, was every one of those examined by the orthopaedic surgeon on staff after the fall?

Mr. BATTLE. I do not know that I can give you that answer off the top of my head, Congressman Harper. But I would be happy to provide that information.

Mr. HARPER. I am just curious, when a patient falls, it is reported.

Mr. BATTLE. Right.

Mr. HARPER. That is how you keep up with it. And is the family notified if a veteran has a fall? Is the family notified?

Mr. BATTLE. Yes, sir. Typically a couple of things will happen. If someone falls there is an assessment done right away of any injury or anything of that nature. If there is any speculation of head trauma, for example, they go get a CT scan right away. And the family is, or next of kin, is typically called and told of the incident.

Mr. HARPER. I am still concerned about the radiological studies. And you mentioned, did you say potentially 58, Dr. Parker?

Dr. PARKER. Yes, sir. On rereview when it came up through the radiologist——

Mr. HARPER. Yes, sir.

Dr. PARKER. —at Jackson they gave us 52 names, and then they gave additional names. It ended up being 58, yes.

Mr. HARPER. And of that 58 how many of those patients, or the patients' families, are aware of this?

Dr. PARKER. Well the allegation was that all 58 of the studies were misread. And under independent review we were not able to confirm that. But two families have been notified where there were misreads that resulted in harm to the patients. And there is an ongoing review.

Mr. HARPER. So two out of 58——

Dr. PARKER. Correct.

Mr. HARPER. —means 56 have not been notified?

Dr. PARKER. Yes, sir.

Mr. HARPER. Is that what you are saying?

Dr. PARKER. Yes, sir. Specifically there was no reason to notify them because the allegations were not proven to be true.

Mr. HARPER. I see. So you are saying that all 56 of those are, there are no problems?

Dr. PARKER. We asked an outside agency to completely review those and that has been turned over to the Office of the Medical Inspector so that again, back to perceptions and realities, we have asked them to make that determination if there is anything else?

Mr. HARPER. Have they completed that yet?

Dr. PARKER. It was given to them last week and they are under review now.

Mr. HARPER. How long will it take to review it? Ballpark, best guess? I will not hold you to it, just best guess?

Dr. PARKER. I would imagine within a couple of weeks we will have a specific answer.

Mr. HARPER. And Dr. Parker, Dr. Hollenbeck stated that the threat of withholding performance pay was made to encourage or extort physicians to sign collaborative agreements. What effort has been made to terminate this practice?

Dr. PARKER. Dr. Hollenbeck mischaracterized the pay. So let me just briefly, there is, physicians are paid, there are three elements to their pay. There is basic pay, there is market pay, and there is performance pay. And that is to be able to compete in the private sector for orthopaedic surgeons or primary care physicians.

The performance pay is specific to a maximum of $15,000 per year or 7.5 percent of whatever their annual salary is. So the primary care physicians would be eligible for a certain amount. That performance pay is specific, has to be a signed contract that you will do something above and beyond, an achievable measurable outcome. And there was discussion about those physicians in primary care who went above and beyond and agreed to collaborate with nurse practitioners. I am not sure that it has been enacted. It was a discussion.

Mr. HARPER. All right. I would certainly like any additional information on that that you can share with this committee, if I guess that is not my request to make but I would appreciate the chairman taking a look at that. I would like to see if that was available.

And then Mr. Battle, my time is almost up, a quick question. Does Jackson continue to use temporary physicians or any that did not maintain a direct supervisory role over nurses to sign collaborative agreements?

Mr. BATTLE. I think, well thank you for the question, Congressman Harper. I think to try to answer your question is right now in primary care we do not have any locum tenens working in primary care so we do not have them signing collaborative agreements.

Mr. HARPER. Thank you. My time has expired.

Mr. COFFMAN. Thank you, Mr. Harper. Panel you are now excused. Today we have had a chance to hear from many different accounts of the problems occurring at Jackson VA. I am not convinced that VA has taken the appropriate steps to correct these problems and I believe it is apparent that the veterans served at Jackson have borne the brunt of these inadequacies. This hearing

was necessary to accomplish a number of items: to identify the effects of overbooking, understaffing, lack of supervision, and prohibited narcotics prescription practices on the veterans served by Jackson VA Medical Center; to require VA officials to explain their inadequate response to these obvious deficiencies to determine what steps are being taken to correct these problems; and getting answers for the preventable deaths that occurred at Jackson as a result. Within 30 days I expect VA to provide this subcommittee with a detailed written account on what has been done to fix the many problems addressed today that continue to occur at Jackson VA.

I ask unanimous consent that all members have five legislative days to revise and extend their remarks and include extraneous material. Without objection, so ordered.

I would like to once again thank all of our witnesses and audience members for joining in today's conversation. With that, this hearing is adjourned.

[Whereupon, at 12:38 p.m., the subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

Submission FTR, not testimony

Phyllis A.M. Hollenbeck MD, FAAFP
Whistleblower Comments
August 2013

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. It should be noted, however, that the team stated they would not be able to interview all of the witnesses on the list I gave them. 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.

As the team knows, I "lived" Primary Care at the Jackson VAMC for four years, and continue to be an eyewitness. The reality of the situation in Primary Care at the Medical Center is one I experienced in person, including knowing the medical and psychological effects on the Veterans and committed staff. Heartaches can be palpable and visible.

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.*

Phyllis A.M. Hollenbeck MD, FAAFP
Whistleblower Comments
August 2013

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 cross-over 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 how the people who run the Medical Center operate, and 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 overnight. 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 quit 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?

The investigative team asked me if "anything had changed"—and the answer is no. The paramount problems remain. The overuse and abundance of

completely unsupervised nurse practitioners in Primary Care is the same; the delivery of care to the Veterans in their "medical home" is still from 16-18 nurse practitioners and 3-4 physicians. The Veterans often still do not know whether or not they are assigned to a physician's panel of patients, or seeing a physician that day—and what happens to them in Primary Care is the mainstay of their health.

Even if a nurse practitioner is licensed in a state that requires a collaborative agreement with a physician and an agreement is signed, that physician is not doing the mandated reviewing of nurse practitioner charts, or doing the also mandated quarterly face-to-face meetings with the nurse practitioner. Thus, these nurse practitioners are not legally licensed. For those nurse practitioners who suddenly obtained licenses in Iowa because Iowa does not require collaborative agreements, there is still an open question as to whether they are legally licensed (and thus whether they can get individual DEA numbers and prescribe narcotics). The Iowa State Board of Nursing regulations require the nurse practitioner to follow the policies of whichever state that NP is practicing in—and this may mean that even Iowa-licensed NPs who work in Mississippi, even at a VA hospital, still need collaborative agreements when they work in Mississippi. And—VHA polices/medical staff bylaws do still state that the employee must have at least one *valid* state license. A valid state license for a medical professional means conforming to *any and all* state board licensing rules. The claim of "Federal Supremacy" does not trump this.

We still have unsupervised (and some not-legally-licensed) nurse practitioners with the "point and click" ability to order addicting, and potentially fatal medications—especially in combination with other psychotropics, depression, and traumatic brain injuries in patients. The simultaneous taking of these kind of

"centrally-acting" (meaning in the center of the nervous system, the brain), and often coupled with other street drugs, including alcohol, is toxic and potentially combustive; the Veterans continue to walk around with the same chemical weapon risks in their brains.

The overload of certain physicians and nurse practitioners continues: the new Blue Clinic doctor was scheduled for 14 patients, including a double-book at 0800 hours, on his first day—and he had *no* computer access and no training yet on the computerized medical record system. Veterans are still being continually cancelled and rescheduled, and cancelled and rescheduled; some elderly patients are going over a year without being seen, having labs and diseases checked and monitored; and there are not infrequent physician absences. The care of these human beings is clearly compromised and endangered. One clerk told me she has twenty pages, with sixty Veterans' names per page, of patients who are now considered "lost to follow-up" (not seen in the last twelve months)—and she has nowhere to put them on already overbooked schedules. Any walk-ins on an already overbooked schedule means the physician will end up *de facto* triple-booked. A physician can still only see one patient at a time according to the rules of physics for our universe.

There have now been *seven* physicians and one nurse practitioner in my prior office in Primary Care—a stream of temporary help—and whoever fills in stays overbooked and overloaded, with multiple "loose ends" to try to fasten or connect.

Two memos of "surveys" of Veterans (10 patients per survey) echo the concerns about medicine refills not being done, including non-narcotics, due to provider turn-over and unavailability; appointments repeatedly pushed out; and not

enough doctors. The American patient, including Veterans, is getting sicker and sicker younger and younger; each patient is a walking "chemistry experiment" of a unique recipe of all kinds of drugs and interactions. On top of that our Veterans have the more specific wounds of wars.

With regards to signing of Medicare Home Health Certifications on patients of nurse practitioners, it is unclear which physician(s) is doing these, as we have had continual turnover (or no) of a ACOS (Associate Chief of Service) for Primary Care as well as Acting Chief of Staff (COS). Dr. Kirchner may still be signing these forms, and/or Dr. Spencer, who was Chief of Medicine (COM) then Acting COS while someone else was Acting COM, and she is now back to COM. Our "Weekly Bulletin" continues to show 16-18 "acting" chiefs. It defies logic to consider this as a stable environment for the Care of the Veteran. An ugly type of chaos is still the norm. And even though he mismanaged Primary Care and put the care of Veterans at risk, broke federal law regarding signing both narcotic and Medicare Home Health forms on patients he never saw, and put in writing instructions telling the physicians in Primary Care to break federal narcotic laws, Dr. James Lockyer was somehow able to get recommendations from the Jackson VAMC and is allegedly now in a leadership position in primary care at another VA facility (Mountain Home in Tennessee). We hope that the rumor he got a bonus when he arrived is not true.

The epidemic problem of the ease and frequency of overprescribing of narcotics to Veterans has been reported on nationally; it is vital that the privilege to order such narcotics is carefully determined, and the appropriateness (or not) of use reviewed in an ongoing fashion. And at the Jackson VAMC the Pain Clinic often sends the Veteran right back, noting in the chart that the primary care physician or

nurse practitioners will write the narcotics. So we end up with many young Veterans being started on an addiction course—or quite truly, a "dead end".

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.

I have also identified the following nurse practitioners who recently worked at or still work at the Medical Center, many of them having spent time in Primary Care, whose credentials files were *not* addressed by the investigative team. They are:

1. Elizabeth Goodwin
2. Rena Beal
3. Debbie McFadden
4. Kathryn Chambliss
5. Carol Smith
6. Susan Fletcher
7. Jean Melton
8. Nancy Thomas
9. Shelah Teeters
10. Debbie Lowe
11. Jodi Stubbs
12. Jennifer McCaffery
13. Leigh Langford
14. Linda Watkins

15. Tatonja Jones
16. Gwendolyn Adams-McAlpine
17. Charlotte Magee
18. Brenda Smoot
19. Lorraine Martin
20. Ramona Strong
21. Eileen Fisher

I also think it is important to highlight that one of nurse practitioners that Dr. Kirchner collaborates with is in Women's Health—and Dr. Kirchner has not done *any* "women's health" in decades. He is a nephrologist who spent the recent years of his career in medical administration.

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.

Phyllis A.M. Hollenbeck MD, FAAFP
Whistleblower Comments
August 2013

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.

O+I 11/13/13

QUESTIONS FOR THE RECORD
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives

"Correcting 'Kerfuffles' – Analyzing Prohibited Practices and Preventable Patient Deaths at Jackson VAMC"

November 13, 2013

NOTE: The material below is sensitive – either because it contains personally identifiable information, protected health information, quality assurance documents, or because disclosure might impede the Department's ability to determine accountability and take corrective actions. VA protects this information carefully consistent with statutory and regulatory requirements and knows that the Committee will protect the data and treat this information with the same degree of sensitivity. This information is being provided under the Congressional Oversight exception to the Privacy Act and the Committee's oversight authority as articulated in the August 13, 2013, hearing notice.

Question 1: The Administrative Investigation Board (AIB) recommended a random sample of 3,000 of Dr. Majid Khan's studies to conduct a statistically valid review of his error rate. Which medical center and VISN officials participated in the decision not to carry out the recommended sample size review recommended by the AIB and why was that decision made?

VA Response: On January 31, 2008, the Medical Center Director convened a Special Professional Standards Board (PSB) to review information concerning Majid Khan, M.D., in order to obtain the most qualified and impartial judgment available to make a determination. The PSB included members from Medical Service, Neurology, Radiation Therapy, Mental Health, Surgical Service, Physical Medicine and Rehab Service, Anesthesia Service, and Pathology and Laboratory Medicine Service. The Director of Quality Management and the Chief, Chaplain Service also participated as expert staff support to the Board.

The PSB unanimously agreed that there was a lack of quality evidence to conclude that Dr. Khan's clinical practice failed to meet generally accepted standards of clinical practice. The Board also determined that the facility performed a comprehensive review of Dr. Khan's work and felt no further review was indicated. Additionally, the Board determined that the evidence presented did not conclude that Dr. Khan's clinical practice failed to meet generally accepted standards of clinical practice.

In March 2008, the Medical Center Director made the final decision, following due process, to uphold the recommendation of the PSB.

Question 2: A Special Professional Standards Board (PSB) was convened in February 2008 which reversed the December 2007 AIB's recommendation to review at least 3,000 of Dr. Khan's imaging study interpretations. Why did Ms. Rica Lewis-Payton and Dr. Gregg Parker accept the final PSB finding which said no review of Dr. Khan's studies were needed, when the PSB had no radiologist member?

VA Response: After questions arose regarding decisions of medical center leadership from 2008, in 2013, the new Medical Center Director and Network Director reviewed the 2007/2008 file related to this matter. The Network Director referred the file to the Office of Quality, Safety and Value to determine whether further actions were necessary. However, after the Office of Special Counsel (OSC) complaint was filed, this review was suspended and incorporated as part of the review conducted by the Under Secretary for Health's appointed team to investigate the Jackson OSC complaints.

Question 3: The chief of radiology position at the Jackson VAMC has been vacant since 2008 when Dr. Patel stepped down. The position has been advertised three times since 2008. Two plaintiffs in the 2010 federal trial, Dr. Brighid McIntire and Dr. Margaret Hatten, have applied each time. Are they unqualified for the position? One or the other has been acting chief of radiology for the past five years; why hasn't one of them been hired for the position?

VA Response: The recruitment process is still underway. The Jackson VAMC anticipates completing the recruitment process in the second quarter of 2014.

Question 4: After Dorothy White-Taylor, the former Associate Director of Patient Care Services, was arrested on a narcotics violation, why was she transferred to a VISN position instead of being dismissed?

VA Response: There are due process requirements that must be followed prior to the dismissal or termination of a Federal employee. The Medical Center Director, in coordination with the Network Director, decided to remove Ms. White-Taylor from her position as Associate Director of Patient Care Services and detail her to Veterans Integrated Service Network (VISN) 16 while an Office of Inspector General (OIG) investigation was initiated. During the course of that OIG investigation, Ms. White-Taylor was arrested for overlapping narcotics prescriptions. She was indefinitely suspended without pay after her indictment and brought back only after the criminal charges were dropped. After all criminal charges were dismissed, an Administrative Investigation Board convened. Disciplinary actions have been proposed.

Question 5: What is Dorothy White-Taylor's current position title and what duties and responsibilities does she have in that position? Who was her predecessor in that position?

VA Response: Ms. White-Taylor's current position is Associate Director of Patient Care Services (AD/PCS) at the Jackson VAMC. Her predecessor as AD/PCS was Ms. Linda Moore. Ms. White-Taylor is currently detailed from her AD/PCS position to VISN 16 to perform "unclassified duties including special projects." She has been assigned tasks associated with analyzing VISN performance data.

Question 6: Was an internal investigation into the allegations of substance abuse by Dorothy White-Taylor ever undertaken by VA? If so, what were the results of that investigation?

VA Response: No. The Administrative Investigation Board, which completed its investigation in September 2013, was specifically charged to conduct a thorough investigation into any and all circumstances surrounding the prescription of controlled substances by facility providers to the Associate Director for Patient Care Services.

This charge was not related to substance abuse allegations but specifically assessed prescriptions of controlled substances by facility providers to Dorothy White-Taylor.

Question 7: Physicians at the Jackson VAMC were ordered to sign narcotics prescriptions for patients of nurse practitioners that they had never seen, which was illegal. Some of these physicians were allegedly University residents in training, who were intentionally misled about the appropriateness of this unprofessional activity. At the VISN level, this was Dr. Parker's oversight responsibility. What disciplinary measures, if any, were taken against Dr. Parker about this issue? If no measures were taken, why was that decision made?

VA Response: OIG, in coordination with the Drug Enforcement Administration (DEA), referred this case to the U.S. Attorney in Louisiana, as there was a conflict for the U.S. Attorney in Mississippi. The local Jackson OIG Agent in Charge informed the Medical Center Director that there would be no criminal charges as a result of the investigation. However, there were misinterpretations of the law.

In response, VA has taken action to ensure that staff members at the Jackson VAMC are aware of and comply with State and Federal prescribing requirements. Specifically, medical staff bylaws have been revised and the ratio of physicians to nurse practitioners (NP) has increased. In addition, NPs who are required by their licenses to work under a scope of practice have a collaborative agreement with a physician. Furthermore, NPs who have not yet received their individual DEA certificates do not write prescriptions. The facility also monitors prescriptions requiring DEA certification. In October, the Medical Center's Pharmacy Service reviewed prescriptions requiring DEA certification for the preceding 3 months and did not find any unauthorized controlled substance prescriptions.
As Chief Medical Officer for VISN 16, Dr. Parker has broad oversight and responsibility for clinical issues across the network. However, at this time no administrative actions

against Dr. Parker have been taken in regard to the appropriateness of physicians signing narcotics prescriptions for patients.

Question 8: Would you please provide us with the names and medical record numbers of any patients who were overmedicated, suffered injury, or died related to prescriptions that were made by nurse practitioners or physicians who were improperly prescribing narcotics?

VA Response: A review of 30 medical records for each primary care provider, a total of slightly over 2,000 records, has been completed. This review found no evidence that any Veterans were overmedicated, suffered injury, or died related to narcotic prescriptions that were written by nurse practitioners or physicians. The complete review of overall clinical care in these cases is ongoing.

Question 9: If there are adversely-affected patients in Question 8, what are the names of the responsible nurse practitioner or physician and what actions has VA taken against them?

VA Response: Since there were no adverse clinical events related to narcotics prescriptions, no action was taken.

Question 10: Has Dr. Kirchner had a pay panel to reduce his pay since stepping down from the Chief of Staff position because his duties are now considerably reduced in scope?

VA Response: Yes, a pay panel was conducted and his salary is commensurate with his current position.

○