A CONTINUED ASSESSMENT OF DELAYS IN VA MEDICAL CARE AND PREVENTABLE VETERANS DEATHS

HEARING

BEFORE THE

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U.S. HOUSE OF REPRESENTATIVES

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A CONTINUED ASSESSMENT OF DELAYS IN VA MEDICAL CARE AND PREVENTABLE VETERANS DEATHS

Wednesday, April 9, 2014

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

The committee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Bilirakis, Benishek, Huelskamp, Coffman, Cook, Walorski, Jolly, Brown, Brownley, Titus, Kirkpatrick, Negrete-McLeod, and O'Rourke.

Also Present: Representative Cohen.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. The committee will come to order. Before we begin, I would like to ask unanimous consent that when he arrives, our colleague from Tennessee, Congressman Steve Cohen, be allowed to sit at the dais and participate in today's proceedings. Hearing no objection, so ordered.

Ladies and gentlemen, welcome to today's full committee hearing, a Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths.

Today's hearing is the fulfillment of a promise I made in early January to follow-up on delays in care at Veterans Affairs' Medical Centers in Columbia, South Carolina and Augusta, Georgia that together resulted in nine preventable veteran deaths.

I had hoped that during this hearing we could be discussing the concrete changes that VA had made, changes that would show beyond a doubt that VA had placed the care of our veterans first and that VA's commitment to holding any employee who did not completely embody a commitment to excellence through actions appropriate to the employee's failure to be held accountable.

Instead today we are faced with even more questions and an ever-mounting list of evidence that despite the myriad of patient safety incidents that have occurred at VA medical facilities in recent memory, the status quo is firmly entrenched at the Department of Veterans Affairs.

On Monday, shortly before this public hearing, VA provided evidence that a total of 23 veterans have died due to delays in care at VA medical centers. Even with this latest disclosure as to where the deaths occurred, our committee still does not know when they

may have happened beyond the statement that they most likely occurred between 2010 and 2012.

These particular deaths resulted primarily from delays in gastrointestinal care. Information on other preventable deaths due to consult delays remains unavailable.

Outside of the VA's consult review, this committee has reviewed at least 18 preventable deaths that occurred because of mismanagement, improper infection control practices, and a whole host, of maladies that plague the VA healthcare system all across this great Nation, yet the department's stone wall has only grown higher and more nonresponsive.

There is no excuse for these incidents to have ever occurred. Congress has met every resource request that VA has made and I guarantee that if the department would have approached this committee at any time to tell us that help was needed to ensure that veterans received the care they required, every single possible action would have been taken to ensure that VA could, in fact, adequately care for our veterans.

This is the third full committee hearing that I have held on patient safety. And I am going to save our VA witnesses a little bit of time this morning by telling you what I do not want to hear.

I do not want to hear the rote repetition of, and I quote, "The department is committed to providing the highest quality care which our veterans have earned and that they deserve. When incidents occur, we identify, mitigate, and prevent additional risks. Prompt reviews prevent similar events in the future and hold those persons accountable," end quote.

Another thing I do not want to hear is again, and I quote from numerous VA statements including a recent press release, "While any adverse incident for a veteran within our care is one too many," unquote, preventable deaths represent a small fraction of the veterans who seek care from VA every year.

What our veterans have truly earned and deserve is not more platitudes and, yes, one adverse incident is one too many. Look, we all recognize that no medical system is infallible no matter how high the quality standards may be. But I think we also recognize that the VA healthcare system is unique because it has a unique, special obligation not only to its patients, the men and women who honorably serve our Nation in uniform, but also the hard-working taxpayers of the United States of America.

When errors do occur, and they seem to be occurring with alarming frequency, what VA owes our veterans and our taxpayers in that order is a timely, transparent, accurate, and honest account about what mistakes happened, how those mistakes are being fixed, and what concrete actions are being taken to ensure accountability.

It seems to me that my staff has been asking for further details on the deaths that occurred as a result of the delays in care at VA medical facilities now for months. And only two days before this hearing did VA provide any information that we have been asking for. Even then, that information is far from complete in what VA's effort is to prevent future deaths.

It concerns me even more than that at a briefing that VA provided on Monday and the testimony that is provided today, include

very few details about what, if any, specific actions have been taken to ensure accountability for 23 veterans who lost their lives and the many more who were harmed because they did not get the care they needed in a timely fashion.

The VA witnesses' testimony that is provided for today is ridiculous. It answers no questions. It provides no new information. And I am tired of begging the Department of Veterans Affairs to answer this committee's questions.

On our first panel today, we are going to hear from a veteran who sought care through the William Jennings Bryan Dorn VA Medical Center in Columbia, South Carolina, a facility that I visited earlier this year.

That veteran, Mr. Barry Coates, is going to tell us that, and I quote, "The gross negligence and crippling backlog epidemic of the VA system has not only handed me a death sentence but ruined my quality of life."

Mr. Coates waited for almost a year and would have waited even longer had he not personally persistently insisted on receiving the colonoscopy that he and his doctors knew that they needed. That same colonoscopy revealed that Mr. Coates had stage IV colon cancer that has metastasized to his lungs and his liver.

Maybe that is why VA does not want to define accountability in terms of employees who have been fired. The department is going to testify this morning that instead we should focus our accountability efforts on correcting system deficiencies in order to prevent adverse events from occurring again.

There is nothing wrong with fixing the system, but Mr. Coates deserves better than that. His adverse event already has happened and for him, there is no going back.

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

With that, I yield to the ranking member, Ms. Brown, for her opening statement.

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN. Thank you, Mr. Chairman, for calling this hearing today.

We can all agree that veteran safety and quality of care issues at the VA health facilities are the utmost concern for this committee. However, it is unfortunate that we must continually call these hearings to make sure that our Nation's veterans are receiving the care for which they have already paid dearly for on the battlefield and in service to protecting the freedom we all hold most dear.

I also find it disturbing that just two days before this hearing, the VA has released findings that its healthcare personnel are not fully trained in the importance of timely consulting when treating a veteran.

The definition defined a consultant as the act of seeking information or advice from someone with expertise in a particular area. The system the VA set up to make these consults easy obviously broke down and it is possible that at least five veterans died in

Florida because the right information was not shared with the right health professionals.

I am concerned that in the five years after the colonoscopy debacle in the Miami VA nothing has changed. To refresh your memory, in 2009, staff members at a number of VA facilities noticed improper reprocessing of episcopes contrary to the manufacturing instructions.

The VA properly ordered all facilities to step up and get retrained on the procedures. We want employees to feel free to report questionable issues and procedures without fear of retribution for trying to save lives. It seems that from the new consultant problems that the retraining stopped at this one procedure.

The fact sheet your office put out regarding consults talks a lot about procedures and adverse events. However, I have heard that before and again our veterans are suffering. And I am looking forward to hearing the testimony today and explanations for this lack of proper care and accountability for these mistakes.

I yield back the balance of my time.

The CHAIRMAN. Thank you very much, Ms. Brown.

[THE PREPARED STATEMENT OF CORRINE BROWN APPEARS IN THE APPENDIX]

Joining us today for our first panel is Mr. Barry Coates. Mr. Coates is a disabled veteran who served in the United States Army and currently resides in the Palmetto State. As I stated earlier, he is going to share his very personal story of attempting to receive needed care from the Department of Veterans Affairs.

Also on the first panel is Daniel Dellinger, national commander of The American Legion. The commander is accompanied by Edward Lilly, senior field officer.

Thank you all for your service both in and out of uniform.

Thank you in particular, Mr. Coates, for being here today and for agreeing to share what I know is a very painful story. This committee is honored to have you here before us today, and you are recognized for your statement, Mr. Coates.

STATEMENT OF BARRY COATES

Mr. COATES. First of all, I would like to thank Chairman Mr. Miller, Ms. Brown, and other Members of the committee for the opportunity to be able to come in front of you today and give you my testimony.

I would like to start, first of all, with the first part of my paragraph of my testimony, and I think each one of you all have that.

My name is Barry Lynne Coates. And due to the inadequate and lack of follow-up care I received through the VA system, I stand here before you terminally ill today.

I joined the army in February of 1991 anxious to serve my country. Near the end of basic training, an injury to my back derailed this plan and I was discharged around the 1st of May of the same year.

After five years of fight to obtain service-connection status of my injury and treatment and pain management requirement as a result of it, I finally became eligible for medical treatment through

the VA system. That was the start of the long, painful, emotional, and unnecessary journey that brings me here to you today.

First of all, I appreciate the opportunity to be able to stand here and testify in front of the committee, one for the veterans who have died because of this unnecessary tragedy that occurred that should not have ever occurred to start with. Also, for the families that have lost those veterans and for the veterans who have suffered and are still suffering because of this like myself and their families, I want to be a voice to them and an advocate to them.

Hopefully this testimony will prove to the VA system the lack of knowledge or the lack of care that they gave to myself and to other veterans that need to be changed. Something needs to be created to change the policy of the way this is done.

I talked to numerous veterans since all this occurred and a lot of them, I hear the same story like my story, you know, why didn't we receive help, why didn't I get care earlier, why didn't it get outsourced. And outsourced is probably a good thing that needs to be put into policy if it is backed up to a part they cannot control.

Another thing also that needs to be done for the veterans that are struggling, for the ones that have lost their husband or wife, it is hard to even get care and medical.

Another thing, too, to look at, if I am serving in the military today and I look at what happened to veterans outside of the VA system and their care and I see what is going on there like what happened to myself and other veterans, what is a member of the military service going to think? They are going to think one thing. Well, they are not taking care of the veterans outside of this. Well, one day, I will be a veteran also. Are they going to be there to take care of myself, my family?

And that is a big question that probably servicemen who are serving now, they are going to ask the question, why would I need to serve my country if they are not going to look at me and protect me after my service and become a veteran?

And I think that is something we need to focus on because military service is really volunteer. If you look at time and history dating back to the Revolutionary War, it was all voluntary. And if it had not been for that voluntary service, we would not have what we got today in this country. And without that, we would not be here today and be able to talk to you all and deal with this matter.

So something needs to be done. Someone needs to be held accountable for it. And I understand from other sources that no one has been held accountable for it. And I think someone should be held accountable for it, whether it be a director of the Dorn VA Hospital or it be the secretary of the Veterans Affairs or even the President of the United States.

Thank you.

[THE PREPARED STATEMENT OF BARRY COATES APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, sir, for your testimony.

And before we go to questions, I do want to ask Commander Dellinger if he would please proceed with his statement.

You are recognized for five minutes.

STATEMENT OF DANIEL M. DELLINGER, NATIONAL COMMANDER, THE AMERICAN LEGION, ACCOMPANIED BY EDWARD LILLY, SENIOR FIELD SERVICE OFFICER, THE AMERICAN LEGION

Mr. DELLINGER. Thank you.

As the Nation's largest wartime veteran service organization, The American Legion dedicates significant resources towards working with and observing the work of the VA.

Through the Legion's System, Worth Saving medical facility visits, Town hall meetings with veterans and the feedback we receive from the thousands of American Legion certified Veteran Service Officers across the Nation, we are able to provide you with the specific details in our written testimony that you have before you. I will highlight just a few of those details to you now.

Chairman Miller and Members of the committee, on behalf of the two and a half million members of The American Legion, I want to thank you for inviting The American Legion to share our research and position on the important topics of delay in medical care and patient deaths.

I am here today because The American Legion has no greater priority than ensuring that veterans receive timely and quality healthcare as a result of their service-connected illnesses.

It seems a day cannot pass without a news report about the problems and challenges the VA faces with delays and quality of care issues. While we wait for things to get better, hundreds of thousands of veterans are waiting for their initial disability claim or appeal which prevents them from receiving VA healthcare.

While we wait, transitioning servicemembers are falling through the cracks due to DoD and VA's inability to create a single interoperable medical record.

While we wait, officials in the VA central offices are preventing hospitals from being transparent during crisis. While we wait, veteran suicides continue to plague our Nation at 22 per day with no clear strategy from VA on addressing suicides proactively.

And while we wait, veterans are being over-prescribed medications for pain, TBI, PTSD with reluctance toward looking at complementary and alternative medicine because giving out pills is faster than providing veterans the therapy sessions they need.

In January, The American Legion went to Jackson, Mississippi where a veteran died as a result of when all the blood was drained from his body because he was not properly monitored during a medical procedure.

When our task force members asked the facility director for a copy of the action plan they were using to address their problems, the director refused to give them a copy.

Last November, we visited Pittsburgh. At that time, we believe the Legionnaire outbreak that left six dead and more than 20 sick was due to equipment failure. The neglect on the part of the VA to notify local health officials, veterans, and patients was bad enough, but then later, we learned that CBS news reported that senior officials at the Pittsburgh VA actually knew that human error was behind the outbreak and not equipment failures as officials had suggested to this committee.

Our System Worth Saving Task Force went to Atlanta in January where two veterans died of an overdose and one committed suicide which was attributed to mismanagement and an inability to get the mental healthcare they needed in a timely manner.

Last night, there was a daughter that missed her dad saying goodnight. Today there is a wife who misses her husband. Tomorrow a father will still regret that he was able to outlive his son because someone at the VA did not do their job.

Patient deaths are tragic. Preventable patient deaths are unacceptable. But failure to disclose safety information or worse, to cover up mistakes, is unforgivable and The American Legion will not sit quietly by while some VA employees cover up the truth and the VA should not either.

We need to continue to ask the hard questions. What is VA doing to fix these problems and are they concerned about keeping me informed? How is VA holding their leaders accountable for these errors? And, finally, why is the VA reducing inpatient long-term care beds, ICU, emergency rooms, and closing hospitals such as Hot Springs, South Dakota?

The American Legion will not stop asking the hard questions and we hope you won't either. The American Legion looks forward to working with this committee as we work together with the VA to ensure that VA provides the best healthcare anywhere.

Thank you.

[THE PREPARED STATEMENT OF DANIEL M. DELLINGER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Commander.

Mr. Coates, in the more or less year that it took for you to receive a colonoscopy through the Department of Veterans Affairs, did anybody at any time ever tell you that you could be authorized to receive the procedure that you needed done through a private provider in the community enabling you to get a diagnosis sooner?

Mr. COATES. No, sir. I never was advised during that time period. During that time period, I seen from January of 2011 when I first complained about it till the day of my colonoscopy which was December the 9th of 2011, I seen four different doctors that was in the VA system.

One was Rock Hill Clinic outpatient, Dr. Verna. She was my outpatient clinic doctor I had in Rock Hill, South Carolina. I presently moved to the location I live now. I transferred. It takes roughly anywhere from four to six months to get a transfer to a different location for outpatient care which would have been the Florence Clinic.

Upon that, I seen Dr. Verna on January, March, and I think May of that same year and each time, my problem got worse. And she made notes in her comments because I retrieved copies of those from the VA. And she made note of those saying may need colonoscopy. Never set a consult up for it.

Upon getting transferred to the Florence Clinic in June of 2011, if I remember correctly, Dr. Naumann was my clinic doctor there. And being a new patient, he done a full exam, looked over information from Dr. Verna prior to treating me. And he kind of got upset because she did not have me on a certain prescription because of

taking pills for pain would cause certain problems and that I should have been on something already from that from being on those for quite a few years.

But he immediately set me a consult up with a GI surgeon which I did not ever get an appointment with her until probably either around the eighth month, maybe the ninth month, if I remember correctly, Dr. Kim.

And upon seeing her, I seen her twice, she delayed it another two to three months and I went back to her again around the tenth month. We did not have a good communication ability between each other because she kind of made me mad from my first appointment because of things that she could have done then that would have resulted earlier and set the consult up for a colonoscopy earlier if she would have done a couple other procedures other than a physical exam.

I learned that she could have done a CT exam or a CT scan. She could have done a lithoscope exam which would have found the tumor that was only five inches in the area, in the lower rectum area.

After that appointment with her on the 10th, she set me up for a consult for the colonoscopy to be done which I received the appointment in the mail two weeks later. And it was actually scheduled for April of the following year. We are talking six more months out and I had already been in pain for eight months already and suffering because of this. But I did not let that stand in front of me, so I called the department that scheduled that appointment and they told me that is the normal time is usually around six months before you can get a colonoscopy. There was nothing that she could do to get it done earlier, that the only way you could get it done earlier is request your physician to write the chief GI surgeon or either the gastroenterologist to get it done sooner or you could call each day and see if anyone dropped off from the appointment schedule.

And I asked her could she write my name down and call me if someone dropped off. She said she could not do that. But, fortunately, due to the Lord's grace, she called me the next morning at 9:30 and asked me could I come to an appointment around 2:30 that day which I did. And then that is when I was set up for the colonoscopy done at the Fort Jackson Military Hospital on December the 9th.

So from January to December the 9th was a whole year.

The CHAIRMAN. One other question. Do you know what an institutional disclosure is? Have you ever heard that term before?

Mr. COATES. No, sir.

The CHAIRMAN. It is where VA notifies a patient when there has been an adverse event such as a consult delay that ultimately resulted in the failure to diagnose an issue.

So you are saying you never received an institutional notice?

Mr. COATES. Not to my knowledge, no, sir.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you.

I think I will ask the first question to The American Legion, Mr. Dellinger.

During your System Worth Saving visits outlined in your testimony, did you encounter common themes throughout the VA medical center and how long have you all been doing this?

Mr. COATES. We have been doing these System Worth Saving for the last ten years.

Ms. BROWN. ten years?

Mr. COATES. Yes, we have.

Ms. BROWN. Yes, sir.

Mr. COATES. And we go in. We do a town hall meeting the day before with the local veterans to learn their concerns and then we go into the hospitals and we review their procedures and do visit the hospital.

Ms. BROWN. Since you have been doing it for ten years, and I have been on this committee for 22, have you seen any improvements over the last ten years in the system?

Mr. COATES. I would say yes, we have seen improvements. There are still areas that need improving dramatically, but for the overall system, yes.

I was actually in Salt Lake City a couple months ago and the director, first thing she had in her hand was a water quality test to show that she had done it. So they have started knowing when we are coming to be prepared and they do a better job.

Ms. BROWN. Okay. Thank you very much.

Mr. Coates, let me ask you a couple of questions.

First of all, I want to thank you for your service.

Mr. COATES. Thank you, ma'am.

Ms. BROWN. And you are serving today being here. And I also want you to know that no one can determine when we are going to leave here. That is in the hands of the Lord. And they have a lot of new technology and equipment. And I know someone that they released him, said that you are going to die right away and four years later, they are still living. So we got to continue to work to make sure you get the best treatment that is needed.

When you were going through this process, did you ever talk to any top officials? You were getting the runaround with the system it seems, but did you ever try to talk to the head of the VA at the particular hospital or anything like that?

Mr. COATES. No, ma'am, I did not, which I probably should have been more aggressive like I was trying to get an earlier appointment.

Ms. BROWN. Uh-huh.

Mr. COATES. And not to discredit what you said, you should not have to do that.

Ms. BROWN. No, you should not. But we do not want you to be a victim either.

Mr. COATES. No, ma'am.

Ms. BROWN. Yes, sir.

Mr. COATES. No, ma'am. And nobody wants to be a victim and no one wants to be pointing a finger, too, but I should have but I did not. But a lot of times, you learn from hard things you do and mistakes that you make and give that advice to other vets and which I do.

I represent a lot of other veterans around my community and my state that I help with VA compensation claims and also tort claims.

I help with them also and get them filed, how you file things, how you get things started because the VA system does not volunteer any information a lot of times. And a lot of times, you ask questions and you ask other veterans on how you get that.

But to answer your question fully, no, ma'am, I did not ask anybody which I was, I guess, ignorant to that.

Ms. BROWN. Let me just ask you one other question. You indicated that maybe the VA should not farm out, but you could go to outside—outside the system and that might be more efficient.

Most of the times when we have testimony, let's say women veterans, they say, well, we want to be served in the VA, but we do not like this and that.

So do you think that we should consider maybe giving, particularly in some areas, an opportunity to go to the outside? I mean, I know you can, but making sure you know that you can.

Mr. COATES. Yes, ma'am. I would say I think you should be able to give more opportunity. I think it should be put in a form or documentation when you are being treated, as common knowledge, same way as the handbook, the handout. I think that should be probably wrote in there somewhere you have options due to the VA system or you can request outsourced services.

Presently now I have been dealing with the VA system for a little over two years now going to the oncology department at the Dorn VA.

Ms. BROWN. Yes.

Mr. COATES. I am well satisfied with my doctor I have and I give him credit. It is Dr. Babcock. He retired from private practice after 30 years. And I guess he wanted to serve veterans or either work somewhere that dealt with veterans. And he goes three days at the Dorn VA and works there as oncology.

When I first started, I actually got him the first week he came into the system which I think that was something the Lord had planned all together. And he is a real good Christian man. He said there is not a night that he does not go to bed at night and pray for me.

But after all his works and what I have learned through the VA system medically, they have to request and get certain medication or certain different treatments to be done for cancer. I asked what he is doing.

Recently I'm inquiring now after I have been there working for two years and now from my last scan I had a couple weeks ago spots on my lungs, liver, and a new spot has came up now in the abdominal area that they have grown and multiplied.

And I am presently getting ready to go back on chemo in the next week, but I am looking for outside services now. I have acquired information now through the MSU—well, the MUSC out of Charleston which is another cancer research. They have ability to do—a lot more scientists to research different cancer and be able to offer more availability to treat me a lot better than what the VA has.

And I have applied and checked on it and hopefully I can get payment due from the VA to be able to go to that hospital and try something new, you know, because I am talking about my life.

Ms. BROWN. Yes.

Mr. COATES. And like you said, no one knows the exact moment that the Lord is going to call you home.

Ms. BROWN. Uh-huh.

Mr. COATES. But you also got sense enough to know that try your best while you are here and stay as long as you can. And I am at the process now where I am getting information together to them so they can look at my case and see what they can do. And it is always good to have another option because, you know, I am talking about myself and my life and my family.

Ms. BROWN. Yes.

Mr. COATES. And I am sure each one of you all here in this room now would do the same thing if it was you in my shoe. You would look for other things because I have been doing this for two years now and it has worked pretty good, but I think I am at the end of the line of where I am at now with the VA system.

Ms. BROWN. Yes, sir.

Mr. COATES. And I am having to go outside of that.

Ms. BROWN. Thank you.

My time is up, but let me just say I want to recommend a couple of the hospitals in my area. I have a couple of good ones. Shands and Mayo, they have some excellent work. So let me yield back the balance of my time, but I will make sure I get you that information.

Mr. COATES. Yes, ma'am.

Ms. BROWN. Thank you.

Mr. COATES. Thank you.

Ms. BROWN. Thank you, sir.

The CHAIRMAN. Mr. Huelskamp, you are recognized for five minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate the opportunity to participate in this hearing today.

And, Mr. Coates, I would like to apologize on behalf of the failed system that has created such pain for you. And I know words probably do not mean much, but I mean that from the bottom of my heart. Thank you for coming here today. This probably was not easy.

But in your testimony, I do note you do mention four different doctors, Dr. Verna, Dr. Naumann, Dr. Kim, and a Dr. Sarbah.

Do you know if any of these doctors or related staff have faced any punishment or discipline for the failures in this situation?

Mr. COATES. Thank you for the compliment.

And as far as I know, there has not been any discipline. I would say out of two doctors in that four I mentioned would be one Dr. Verna. She had three occasions to set me up a consult, January, March, and May.

Upon seeing Dr. Naumann my first time in that same year, he immediately looked over the information, set me a consult up with Dr. Kim, the GI surgeon, which I think he should have set me up with probably a different department that handled the colonoscopies. I know it is something to do with gastroenterology department, but he should have set me up with someone other than a GI surgeon.

But he did make effort and I give him credit for that because he is the only one on the first initial meeting.

Dr. Kim was the GI surgeon I mentioned. She could have done a lot better than what she did if you missed my prior information about that as far as the procedure she could have done on my first visit with her and delayed it further.

The last doctor was the one who actually done the colonoscopy and he done a real good job. And he was the chief doctor that done that and he was very sensitive to me and my family about that. And after that, he would see me in the hospital getting treatment and he would come up and talk to me and ask how everything is going, you know, everything.

But now I have learned that he has left the system and they have lost a great man from that down at the VA, at Dorn. He called me a couple weeks before he left and he said, Barry, he said I just want to let you know that I am leaving the system here at the VA. He did not mention where he was going, but he asked me how I was doing which is very fortunate, you know, for a doctor to give a rapport like that, but——

Dr. HUELSKAMP. Mr. Coates, your interaction with other VA staff other than the doctors, can you describe that and was that simply taken up with the appointments or were there any visits with them, any attempts to help you move through the morass of bureaucracy and can you describe that as well for the committee?

Mr. COATES. You are referring to appointments as far as what, set up the consults?

Dr. HUELSKAMP. Well, any other staff. I mean, you have mentioned the doctors and those that really went above and beyond the call of duty and those that perhaps did not.

What about other staff at this center? I mean, were they helpful? You had to fight your own way through the process? Can you describe that a little bit more?

Mr. COATES. Well, I will say yes and no to that answer. There were ones who were helpful, but they only had a limited source. And the ones that was not trying to be helpful, they really did not care. And I can say that from knowledge of a record that I received from the VA upon the GI surgeon from filling her notes after she learned of the result from my colonoscopy.

I had a meeting with her that same day at 1:00 or 1:30 and she came into the office. And that is the same woman that I had words with on the first initial meeting. And the only thing she could say was, Mr. Coates, I am so sorry, I did not expect that. I looked at her and I told her, I said, see there, I told you I was hurting. I said from now on, you need to start listening to your veterans and doing more for them on their first initial visit.

And that way, you know, when you can look back and say I done the best thing I could do because I told her the same thing, that I looked up things that she could have done and she did not do it. And if she had done, it would have been a little sooner. And the only thing she could say I am sorry. Well, sorry does not change that. And nothing happened to her. No punishment came upon her.

Learning from other surgeons in that same department, I cannot reveal their names, but because they work in that department and they told me that her policy changed after that to where now if any veteran comes in that has any bleeding or pain in the rectum area, that she immediately sets them up for consult for the colonoscopy.

So I am thankful that, I had to be the one to suffer to get that done, that other veterans that won't suffer now. But she has been there. She was a seasoned doctor. And I think the lack of her ability, not her knowledge because she had the knowledge to know what was going on, but the lack of care it might be. I do not really know what it was, but there was a lot of things that she could have done more than what she did and she did not do it.

Dr. HUELSKAMP. Thank you, Mr. Coates. I appreciate it.

I yield back.

The CHAIRMAN. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I really want to thank you for holding this hearing today. It is clearly a very important one.

And, Mr. Coates, I want to thank you for your testimony this morning and truly on behalf of this committee and our Nation, I really want to apologize for the care that you received or the care that you did not receive.

And clearly you agreed to serve our Nation and we agreed to take care of you when you came home, and we did not hold up our end of the bargain. And so I truly want to apologize to you.

And I am the ranking member on the Health Subcommittee here for veterans. And when I learned of this, I actually wrote a letter to Dr. Benishek who chairs the Subcommittee on Health and was very obviously saddened by what I had learned about nineteen preventable deaths.

And I even question nineteen preventable deaths. I mean, really, nineteen? I am sure I believe in my heart of hearts that there are probably more than nineteen, but nineteen that we know about.

So I am, you know, very, very grateful that we are having this hearing today and it is incumbent on all of us here to make sure that the VA is held accountable for what has happened and is accountable to you, Mr. Coates, and to the other men and women who have served our country and who have not received the proper care.

I just wanted to ask you, we have already asked a lot of questions around this, but during the time that you have gone through, were you aware of any recourse that you could take or did anyone suggest to you that there is someone in the VA that you could reach out to, a patient advocate, anything like that during the course of these delays?

Mr. COATES. No, ma'am.

Ms. BROWNLEY. And I know that you mentioned just in your last answer that Dr. Kim ultimately apologized to you for her lack of diagnosis and care.

But have you had any formal apology from the VA?

Mr. COATES. None.

Ms. BROWNLEY. And in your experience, again, how would you describe, I guess I want to say sort of the bedside manner in terms of how you were treated? Clearly there were these delays, but did you experience from any VA employees or doctors that you encountered any sensitivity or concern about your frustration?

Mr. COATES. Yes and no answer to that. No to a couple of the physicians that I had and yes to a couple of physicians that I had.

I mentioned, I think, briefly those ones that I mentioned. The lack of concern, I look at this way, and I have been going to the VA for quite a few years now since early 1990s, same hospital, and you see a lot of different things going there from different physicians and things like that.

You got physicians that care about people and you got physicians that look at it as just a job to do. You got nurses and other officials there that look at it the same way. You got some that cares for the veteran themself and enjoy what they do. And then you got some that does it for a job.

And I think that is what happened to a lot of people in America today. They do not look at the honor of having something and appreciate it anymore. I am not saying that anybody does not, but a lot of people do not. They come and go to work and go home. They want it for one thing and one thing only and they do it for their self.

And I think if everybody worked together and do something for each other like it is supposed to and originally was set up, then we would probably be a lot greater Nation today.

Ms. BROWNLEY. Thank you, Mr. Coates. And, again, I thank you for your testimony today and it means a great deal. And I hope that through your testimony today, it will pave the way for other men and women who serve our country, that they will not be treated as you were through this process. So I am very grateful to you. Thank you very much.

Mr. COATES. Thank you, ma'am.

Ms. BROWNLEY. I yield back, Mr. Chair.

The CHAIRMAN. The gentle lady yields back.

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

Mr. COOK. Thank you, Mr. Chair.

Mr. Coates, thank you very much to come here. I know this is tough on you and your family and everything like this.

Last year, I lost my sister with colon cancer and it is horrible for the family and everything else. She was much older than you are.

Can I ask how old you are, sir?

Mr. COATES. Forty-four.

Mr. COOK. You do not have to tell me.

Mr. COATES. Forty-four years young.

Mr. COOK. Okay. And obviously you are expected to live much longer and that is why this is so tragic.

I want to ask the commander, you know, Commander, you said that you think the VA has improved in certain areas, but the culture of the VA in terms of taking care of patients like Mr. Coates, it seems as though that is lacking.

And do you share my concern about the culture, quite frankly, taking care of our veterans, taking care of the troops and that?

And I am not trying to preach here and everything, but, you know, I spent a long time in the military. We have all had stories when people that where a grenade was thrown in there, somebody would land on a grenade, get killed, and save five, six people for the unit or going out on a battlefield and somebody was wounded and take them back under fire.

And we have all heard these horror stories and very, very frustrating. And it seems as though the culture of the VA is such that

there is not a sense of urgency or, hey, we have got to take care of this veteran. You know, this is general orders.

And if you could just comment. And maybe it is just me, but I have reached the breaking point on this where, you know, excuse after excuse after excuse after excuse.

The gentlewoman from Texas talked about, I believe, or Julia talked about we expect more for somebody that has signed up to do their duty, the veterans, and return. That is what they are there for. That is their mission.

So I finally got around to my question. Sorry.

Mr. COATES. That is all right.

You know, it is continuity. As I go around the country visiting these hospitals, you can tell the ones that are the caring ones just as Mr. Coates stated. You know, you have where they are there really for the patients and others are there to get a paycheck. And that is the difference.

And I think it comes from the top down. VA needs to be accountable from the top down through the secretary, through the under secretary, all the way down to the directors and to the chief of staff. I have seen some great chiefs of staffs and other ones that are just there biding their time until they retire.

Mr. COOK. You know, this is probably the most bipartisan committee, I think, in Congress. And I chaired the Veterans Committee in California and it was very bipartisan. And I do not think it is a democrat or republican. I really, really think it is culture that is not ingrained. You know, all talk is cheap.

But in terms of actually talking about the suicides, we talked about all these, and we go on and on and on, and it is like business as usual and we cannot tolerate that. And maybe, you know, maybe we do have to fire people, but we certainly should not give them merit increases and all those things that go along with it, particularly in the IG investigations and everything else.

If somebody is not doing what they are supposed to do in terms of, as I said earlier, taking care of our veterans, not just on the battlefield, but after they come back, then somebody deserves to be replaced or fired and have somebody in there that understands that is the primary mandate.

If you could comment briefly. I know we have a lot of——

Mr. COATES. I agree. I mean, just as in the military, you disobey an order, you get court-martialed.

Mr. COOK. That is right.

Mr. COATES. Here we have seen instances where there have been some reprimands, but they are still on the job.

Mr. COOK. That is right.

Mr. COATES. And others are allowed to resign and then there is nothing. There is no——

Mr. COOK. That is right. You have a rank structure, but that rank structure, your primary responsibility is to take care of everyone under you. And if you do not, that is why you are the first one out the helicopter if you are in command. You are going to get drilled. That is just the way it is and I am afraid that it is not carried over.

The CHAIRMAN. Thank you much, Mr. Cook.

Mr. O'Rourke, you are recognized for five minutes.

Mr. O'ROURKE. Thank you, Mr. Chair.

And for Mr. Coates, your testimony and the answers to the questions posed so far has been so powerful, so clear, so honest, really the questions that are left that I have are really for the VA, for ourselves, for this committee, for this country.

What are we going to do now that we know the consequences of lack of access, delay, and ultimately denial really is what we are talking about in care and lack of accountability?

So I just will use my time to personally and on behalf of the veterans that I have the honor of representing in El Paso thank you for your service, for your courage, for your testimony, and being here today and focusing our attention on something that we desperately need to fix. So thank you very much.

Mr. Chair, I yield back.

The CHAIRMAN. Thank you very much.

Ms. Walorski, you are recognized for five minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman.

And, Mr. Coates, I sit here and I think you are an example of the finest America has to offer. And it seems so petty to sit here and apologize on behalf of a bureaucratic system that is broken, but I do apologize. I am so sorry to you and your family sitting here of what you have gone through and that you are going to have to stand and be an advocate for the rest of these veterans.

And I promised my veterans in my district when I ran for Congress that they answered the call, they did what this Nation asked them to do, and it was my turn to fight for them. That is what we do on this committee. We fight for the right of veterans to get the benefits they were promised, to be treated with the best care.

I sit here as a freshman lawmaker so frustrated that there is a bureaucracy that is out of control. And if this happened in the civilian world where negligence was proven time and time again, we would be in the streets with signs saying shut them down. It is an outrage is what it is. This is an outrage.

And so I just join the rest of my colleagues here. This is not a partisan issue. This is an American disaster that we have sat here and witnessed for me probably 16 months. And if I could change your circumstance, I would. I would do it in a heartbeat.

Mr. COATES. Thank you.

Mrs. WALORSKI. My dad was a veteran that died of colon cancer. This is so personal to me. And as a committee, I can tell you right now what the VA is going to say when they sit here. They are going to say what the chairman read in his opening remarks. They are going to give us long dramatic answers and nothing is going to change unless we in this Congress on the House and the Senate side decide to stand up and take on one of the biggest issues in this Nation which is this negligence toward taking care of the people that fight for freedom, fought for liberty, and allow us to sit and serve in a place called the U.S. Congress.

And I just want to say today I hope that your testimony, I hope that your advocacy, and the truth of what you are saying changes the culture. It has changed the culture in this room. I can tell you that. But my prayer is for you and your family——

Mr. COATES. Thank you.

Mrs. WALORSKI [continuing]. And that together we can stand and change the culture in this country and say that today was a different day in the history of this VA. I do not know how they sleep at night, I really do not. But I can tell you that we are your brothers and sisters to stand and fight for you in every way that we possibly can.

Mr. COATES. Appreciate it. Thank you.

Mrs. WALORSKI. And to The American Legion, sir, you guys come in here faithfully every single time there are hearings, you and the many other advocacy organizations for the VA and for our veterans, and I just want to commend you for consistently coming, consistently telling the story, consistently being eyes and ears for all of us that have decisions to make and hopefully can improve a failed system. I so much appreciate what you do in your world and standing consistently for veterans.

But, you know, this is so personal to me today because I had to advocate for my dad and I could and I did. And we did everything we could possibly do all the way down to the wire. And that is what I am going to do for you, Mr. Coates, and for the veterans in my district. I am going to stand here and continue to fight every day until we change a broken system.

So God bless you.

Mr. COATES. Thank you.

Mrs. WALORSKI. And together, let's change this system so no other veteran ever, ever has to do what you are going through and your family as well. And you are in our thoughts and prayers. We will stand with you through this as you continue to go through this process. But God bless you for being here today.

Mr. COATES. Thank you, ma'am.

The CHAIRMAN. The gentle lady yields back her time.

Dr. Ruiz, you are recognized.

Dr. RUIZ. Thank you very much, Mr. Chairman.

First, Mr. Coates, I apologize again for the missed diagnoses that occurred in your case. Thank you for your strength. Thank you for your honor, your dignity. Thank you for being a voice for all those other missed diagnoses that has occurred.

I am an emergency medicine doctor, and I see here that the ER doc recommended a colonoscopy. That was the right thing to do. It is unacceptable, and as someone who pursues excellence in medical care, it is very infuriating to know that a gentleman who comes in with rectal bleeding at any point did not have a rectal exam or an endoscopy or any other diagnostic study that would have detected your rectal nodules.

I think that what we need to do now and, you know, I look at my colleagues, Mr. Cook and Ms. Walorski, and I thank you for your passion and I am sorry to hear about your father as well. And Mr. Cook, I can only imagine your memories of those soldiers who have given up themselves and their lives to protect others and I thank you for your service. It is very strong, coming from the heart.

And I believe this to my—I say this to my colleagues, is that in this individual case we have missed a diagnoses and I hope that our committee does not miss the diagnoses that we must pursue in order to remedy this, to determine systematically whether or not we have more medical errors, more complaints from patient care

and more litigations that were found successful to the VA versus any private healthcare system that we would consider the gold standard because we not only expect the gold standard, we expect our VA system to be beyond the gold standard because our veterans are beyond the gold standards of our citizenry in our country.

And so if there is a study or if there is a commission that we would be able to start as a committee to compare and contrast, to determine if there is a systematic increase of maltreatment, misdiagnoses, then I would be very much inclined to look at that diagnoses and take adequate treatment because we missed a diagnosis in this individual case. I want to make sure that the rectal nodule and cancer of our VA system gets removed as well.

Thank you. I yield back my time.

The CHAIRMAN. The gentleman yields back.

Mr. Bilirakis, you are recognized for five minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it so very much. And sir, thank you very much for your service. You are an extraordinary individual. Thank you for coming today and sharing your story.

I wanted to ask, sir, the VA has an ethical and legal obligation to disclose to patients adverse or potentially harmful events that have been sustained in the course of the patient's VA care. I know the gentle lady touched on this and I want to ask once again, sir, were you notified and informed of your rights and recourse?

Mr. COATES. To my knowledge, no, sir.

Mr. BILIRAKIS. Say that again, sir. I am sorry.

Mr. COATES. To my knowledge, no, sir.

Mr. BILIRAKIS. No, sir, okay. And I know in your statement, in your testimony you may have mentioned this in your opening statement, and forgive me, I was a little late for the meeting, but you state and I quote, "The gross negligence of my ongoing problems and crippling backlog epidemic of the VA medical system has not only handed me a death sentence, but ruined by quality of life."

That is simply heartbreaking to hear. So would you like to elaborate some more? I want to give you the opportunity to, if you will.

Mr. COATES. As far as ruining the quality of my life?

Mr. BILIRAKIS. Quality of life, yes.

Mr. COATES. Yes, sir. Thank you for the opportunity. Yes, it has dampered my quality of life to a great deal. Other than what I mentioned earlier about still having to go on with the chemo treatments and for now over two years now, and looking for other avenues but, you know, I have other family members other than myself to look at and like any one of us here, you know, you have children and you have grandchildren. I have children and I have grandchildren.

The question is, and you don't never know how much longer you have. You better enjoy them and them enjoy you. You take one day at a time. That is my philosophy. You live every day as it is going to be your last day. And once you do that, then the next day will come and you start again and you live that like it is your last day.

And this has dampered a lot of what I can do, a lot of enjoyment. You know, I am 44 years old. I will be 45 in May of this year, but I am fairly young and a lot of things I can't do. I can't get out and

enjoy playing with my grandchildren. I can't enjoy doing things that I could as a normal 45-year-old man.

A lot of things has been taken from me because of that. I wanted to do things as far as—an example, if I want to get out there and play baseball with my grandchildren and do running or anything, I am not capable of doing that. I can't lift but so much weight because I have a ostomy from that.

If I decided I wanted to—at my age, you know, you probably look at me and say I am crazy—if I want to have another child, I can't do that now. That option there is gone. And there are a lot of other things that, you know, I enjoy doing that I use to do that I can't do now, and it has affected my life a lot and my family's life a lot and now I look at what my children and my grandchildren look at me and they probably look and think, well, why can't my—why doesn't my dad, can't enjoy himself. And my grandchildren say, well, why can't you come out and play with me and do things like the other dads or other granddads do with them. And so that is something I am going to have to live with and deal with the rest of my life and hopefully my being here today, that maybe I am saving another father or another mother from having to go through the same tragedy that I went through and have a better quality of life for doing it.

Mr. BILIRAKIS. I will tell you, sir, you are a tremendous role model for those children and grandchildren. I know they are very proud of you.

I have one question for Mr. Dellinger, if I may, Mr. Chairman.

I understand from your written testimony that The American Legion has been waiting for five months to receive a report from VA regarding the Jackson VA Medical Center. Is it common for your organization to experience lengthy wait times to get information from the Department?

Mr. COATES. Yes, we do see lengthy delays with the fact that everything is centralized in Washington, D.C. They try to do everything out of Washington. We think it is very important that they empower the medical centers and the directors to be able to address crisis in a timely and quick manner.

Mr. BILIRAKIS. Thank you very much. We got to do something about that, Mr. Chairman.

Thank you very much for your testimony and I appreciate it. I yield back the balance of my time.

The CHAIRMAN. Ms. Negrete-McLeod, you are recognized for five minutes.

Dr. Benishek has not returned.

Mr. Coffman, you are recognized for five minutes.

Mr. COFFMAN. Mr. Coates, thank you so much for your service to our country. Which branch were you in again?

Mr. COATES. Army.

Mr. COFFMAN. Fantastic. And again, on behalf of the American people, I certainly apologize as so many other members of this committee have to you for the treatment that you got from the VA system. Let me ask you this question. Do you think, if you were given an option to be able to go outside the VA system and have it compensated through the VA for medical care, would you have taken that option?

Mr. COATES. Knowing what I know now, yes, I would.

Mr. COFFMAN. Do you think other veterans ought to have that option that if there are such delays in the system, if they are unable to do proper diagnosis and something as simple as blood in the stools, that veterans ought to have choices?

Mr. COATES. Yes, sir, I think they should and the reason for that is, if you get in a situation like that when you approach somebody's health and their quality of life or life or death situation, and even under civilian medicals, you have a choice of what doctor you want to go to. And under the VA system, I think you should have the same opportunity there, what health care you want to use, what physician you want to use, what specialty physicians you want to use. And especially when you get in a situation where you have a backlog like there was and the bad and the sad part of it and I think this comes from Mr. Miller, I remember hearing, I think there was money allotted to the VA system at Dorn back in 2011 and it was misused.

The CHAIRMAN. It was over a million dollars.

Mr. COATES. Correct. And no one has asked for that yet. I don't know where it went. They say it was misappropriated. Well, what happened to it and who is responsible for that? Why didn't it go where it went? We can't answer that, but we can find out why and make sure it doesn't happen again.

Second of all, that was to help the backlog of those patients and the sad part of it is that was during the time I was going through that in 2011.

The CHAIRMAN. Let me ask you this. The reality is you are the victim of the system that did not care as much as they should have about their patients. Do you think that culture or that system exists because of the fact that they don't see themselves competing, that you are their only choice, that they don't see themselves competing with anybody else, so that if you had an option to go outside the system and they would have to pay for that and that was your freedom to make that decision, do you think that they would have handled your case any differently?

Mr. COATES. I think they probably would have. Any time it comes down to—and I am not the only one who probably knows this and anybody across America has known this—when it comes to spending government money, there are a lot of things that they like to spend it on and there are a lot of things that they pinch pennies about. If it is for national defense and it needs to be done, why, they jump on it. If it something saving somebody's life, they get in a big debate about it, why does it need to be spent, where does it need to be spent at, and we have run across this and here recently in the past year, debates in the House and debates in the Senate, the debt ceiling being raised and allocated money for where it goes.

But reality and you look into it, and you look at what we spend for different small items and you can probably request this information from somewhere, and I have heard this from other sources, what we pay for little small things like a hammer, a toilet seat, you know, $150, $350, when you can go to anywhere and buy it for $10, $12, we spend money where we think it needs to be at and where it not needs to go.

And the sad part of it is, we don't get choices like that of knowing where it goes and where it doesn't go. There are the people who have the authority to rest upon where it goes at.

Mr. COFFMAN. Well, Mr. Coates, I again am sorry about your advanced rectal cancer as a result of substandard medical care by the VA, and I just want to say that they have received, the system has received a higher appropriation every single year. And so it is the question of how that money is utilized.

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

The CHAIRMAN. I have a bunch of questions, but I am not going to ask them. You have given of your time today. Your story is more than compelling. I, like the other members of this panel, want to say thank you for your service in and out of uniform.

Ms. BROWN. Thank you. My question is really for the commander. My question is, you know, I have been on this committee for 22 years as I have mentioned and you have been here, well, I believe, almost as long as—more than ten years. But my question, some of the members say that the VA system is broken. I don't feel like it is broken. I feel like we need to do what we need to do to fix it.

But I have traveled to, I can't tell you how many hospitals. I was in one that's going to be one soon yesterday, all day. But the point is, my feeling is that the VA people that I met with and talked to, I think they really care and it can't be just my district. It can't be just those areas in Florida or Tampa that I have been to or Jacksonville or Gainesville or Lake City. I mean, I have been to California and, you know, I have met with the people there and when I went out there I found out we had 400 units that just was sitting there and people could be using them.

So the point is, on a one to ten, if you are going to evaluate the system, and I know we got problems. We are sitting here listening to the problems and I really think we need to be able to go outside the system to get certain services.

How would you evaluate the system?

Mr. COATES. It is a great question. I really believe I need to break that into two aspects. First, being the medical care that you receive at the medical centers and at the community-based outreach clinics. I think that is an eight to a nine because as you mentioned, they really do care. They really want to help.

But what I think is broken is when you talk about the oversight and the works of the VA central offices and regional offices, I would rate that at about a five. They need a lot of improvement. Where we see most of our problems are at the regional and the central offices, not at the medical facilities themselves.

Yes, there are instances just like Mr. Coates, but the overall system there, I think they are wanting to do better and just as a director tried to do, you know, wherever you see blood at this point, you get a colonoscopy. They are addressing these.

Ms. BROWN. That is common sense.

Mr. COATES. It is common sense. But when you have a failure at the—just like during the Legionella in Pittsburgh when they had a statement ready to go out and they had to send it back to Central Office so that they would evaluate the statement. It never got released. It is such a bureaucracy.

Ms. BROWN. Okay. So you are saying the part of the problem with the culture is that it is too—you don't have enough responsibility on the regional level?

Mr. COATES. I think regional, central area, yes, across the area.

Ms. BROWN. Okay. Okay. But I really find that this, you know, maybe in this particular case, the person, it could have been cultural differences as far as—I mean I just can't imagine somebody not caring. I mean, I serve on this committee because I care. And I think the people working in the VA, to just say that they work for a check is way beyond me because these people have served us, and what we are doing is giving back. This is the other opportunity to serve.

Mr. COATES. Ms. Brown, I have with me Field Service Officer Lilly and he is out there every day. He goes to the System Worth Saving, he goes to the regional and central offices. I would like for him to make a comment on this also.

Ms. BROWN. Thank you. Thank you.

Mr. LILLY. Thank you, Commander, and thank you, Ms. Brown. I wanted to comment on what you said earlier about employees coming forward and trying to address the problem before it escalates and I completely agree with you there because what happens is there is this negative stigma of whistleblowers. That is what those employees become or they are former employees.

So the local facilities on the local level need to be empowered to address crises when they happen, and that is not how it is right now and that is what our commander was referring to when he was saying that it takes a long time for these facilities to address what has happened because they have to get approval from Washington, DC. And that is what we have seen in Pittsburgh, Jackson, Atlanta, all these different trips.

The veterans are scared. They are nervous. They are afraid to go to their own healthcare system because they just don't know what steps the VA is taking to address the issue.

Ms. BROWN. Well, thank you very much, and thanks again, thank all of you for your service.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Brown. Thank you, Members, for holding your questions until the next panel.

And thank you very much, Mr. Coates, for being here.

Commander, thank you and you are excused.

Members, we are going to switch up the witnesses and we will take VA next instead of waiting until the third panel, so we will be preparing the table for the second panel.

Members, joining us at the second panel is Dr. Thomas Lynch. He is the Assistant Deputy Under Secretary for Health for Clinical Operations and Management.

Dr. Lynch is accompanied this morning by Dr. Carolyn Clancy. She is the Assistant Deputy Under Secretary for Quality, Safety and Value.

Dr. Lynch, you are recognized for your testimony.

STATEMENT OF THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY CAROLYN M. CLANCY, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR QUALITY, SAFETY, AND VALUE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF THOMAS LYNCH

Dr. LYNCH. Mr. Chairman, let me begin by saying that we have heard a compelling story. I need to recognize the fact that what we have heard is a sad story.

Before I walked up here, I apologized to Mr. Coates. I told him that I am sorry for what happened. If he did not receive an institutional disclosure, I initiated that by extending my apology on behalf of VHA.

I also commit that we will look into what happened so that we can understand and he can get a better explanation and the explanation that he deserves.

I was looking around. It appears that he has left the room. I did and I want to publicly thank him for his service. I want to thank him for reminding us of what we are here for and for the people that we are serving through VHA and our healthcare system.

I am going to go pretty much off script. I want to let you know that Dr. Clancy and I are here because I think we share a common value with you, sir, and with the committee, and that value is to provide quality care to our veterans.

I would also suggest that we are here because we share common concerns and those are concerns regarding harm that has occurred to veterans in our healthcare system.

I think it is good that we hear these stories, that we not ignore when harm has occurred. They are powerful. We need to learn from them and we need to do better.

I think also I would like to acknowledge publicly that I think the relationship between VA and Congress has been a constructive relationship in the past. I think many good things have occurred in VHA healthcare because of the concerns you have expressed and because of the actions we have taken.

In the late 1980s there were significant concerns about the quality of surgical care in the VA. The VA developed what was then called NSQIP, the National Surgical Quality Improvement Program. It is now called VASQIP. It gives us a risk adjusted model to assess outcomes in our surgical programs.

It is so powerful, it has been adopted by the American College of Surgeons. It is now used to provide oversight and evidence to healthcare systems and to physicians to allow them to improve the services that they provide.

In the mid-1990s, there were concerns expressed on behalf of Congress regarding the quality of our healthcare system. In response, the VA developed the electronic medical record. This is an advance that has now been adopted by the private sector.

The VA has also moved towards looking at the way we deliver care and how we focus care with respect to prevention; preventing

illness, not necessarily treating illness. This means that we don't necessarily have to put people into hospitals. We can treat them as outpatients. It is a model that is now being adopted in the private sector.

I want to go back and make one point from what had been my prepared statement, Mr. Chairman, and that is that over a third of our employees are veterans and the fact that everyone in VA is constantly striving to eliminate the clinical and administrative errors that may occur.

We strive, sir, to be transparent in disclosing what has happened. As a system, we have taken a lead in being transparent, we have taken a lead in clinical disclosure. We are not perfect, sir. We are a learning organization.

When errors occur, we do try to express apologies to the involved patients and to their families. I think I will close with a statement from Ralph Gabarro. He is the former CEO of the Mayo Regional Hospital in Dover-Foxcroft, Maine. I think he has said it best, sir.

To paraphrase, preventable patient deaths are a nightmare for our entire medical community, but our feelings, what we are going through, pales in relationship to what the families are dealing with and we understand that, sir.

We are now prepared to take your questions.

[THE PREPARED STATEMENT OF THOMAS LYNCH APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Dr. Lynch. Your recent National Consult Delay Review disclosed two deaths in Arizona, but committee investigation show that it appears that it could be much worse than you know or if you do know that it is worse than what the committee has been told, so I want to tell you about some information that we have received here in the committee as it relates to Phoenix.

I have been made aware of internal emails from within the VA that suggest that Phoenix VA may have been using an unofficial electronic waiting list where veterans were placed on that unofficial list until an appointment became available.

These lists were supposedly designed to give the appearance that veterans were only waiting for appointments for 24, 25 days or less and they potentially contain thousands of names. In cross referencing the two lists, it appears as though there could be as many as forty veterans whose deaths could be related to delays in care.

Were you made aware of these unofficial lists in any part of your look back?

Dr. LYNCH. Mr. Chairman, I was not. And Mr. Chairman, I would say that I have tried to work with your committee. I have visited with your staff. I was in Atlanta. I was in Columbia. I was in Augusta when you made those visits. I have tried to share the information that we have gained as we are obtaining it. I know it is not perfect information, sir, but I know there is a desire on your part to know that information as we obtain it.

I am more than willing to meet with your staffers and take their information so that I can use it, sir. If I don't have that information, I can't act on it.

The CHAIRMAN. So your people had two lists and they kept it from your knowledge. So my question is, does that make you even internally question the validity of the information being utilized in your look back or your review?

Dr. LYNCH. At the moment, sir, it does not, but I am open, I am happy to meet with your staffers, I am happy to look at the data so that we can understand it and see what the issues and the problems are.

The CHAIRMAN. I want to provide you with a request for a preservation order for all potential evidence at Phoenix VAMC and I would also ask the Inspector General for Health care, Mr. Daigh, to look into this issue as soon as possible. I will be putting a letter to you quickly, but I make this as an official request on the record and we are ready to assist by providing our evidence and any assistance that Dr. Daigh may need as he goes forward.

It has been mentioned a couple of times in here about Dorn being awarded a little over a million, 1.02 million or some number like that to help in the backlog of fee-basis colonoscopies and money was provided in September of 2011. I have still not been able to get a solid answer where that money went, so I am hoping that you might be able to provide an insight this afternoon.

Dr. LYNCH. Mr. Chairman, I know that that information has passed through VHA. I took the opportunity to listen to the Deputy Secretary's hearing the other day. I know he has committed to increasing the communication with Congress and with this committee, and I support his efforts and will do what I can to get you the information that you need, sir.

The CHAIRMAN. So, again, another piece of information the committee awaits. I specifically asked for a complete accounting of those dollars when I was at Dorn earlier this year.

On the 22nd of February in a Health Committee hearing, Dr. Benishek asked Dr. Petzel to provide a list of circumstances surrounding the removal of six SES employees over the last two years. Dr. Petzel promised at that hearing that he would provide that information at the end of that week.

This is April 9th. It has been six weeks since the committee asked for the information. We have not received it. This information was referenced in a subcommittee on economic opportunity hearing that was chaired by Mr. Flores and, by the way, Mr. Flores is absent today because he is at the memorial for Fort Hood Texas, and the committee staff has made numerous requests.

So I would also note that this statistic was also noted in your written statement for this hearing. So why is VA keeping this information from the committee when it was an entirely reasonable request?

Dr. LYNCH. Sir, I wish I had an answer for you that you would find acceptable. I could only repeat that I support the Deputy Secretary's efforts to get you the information.

The CHAIRMAN. I have a bill right now, Dr. Lynch, that gives the secretary additional flexibility to fire SES employees. Out of the 320,000 employees at the Department of Veterans Affairs, we are only talking about 450 individuals. The secretary is pushing back saying that he has the tools and that he has, in fact, taken the necessary steps and we are talking about six people and we have been

waiting months now to get that information, and I just—as the chairman and subcommittee chairman and the ranking members sit here just wondering why in the world it takes so long.

In January, following my visit to Columbia and Augusta, which you were at, to follow up on the delays in care, I wrote a letter to the secretary asking for specific information regarding consult backlogs at those facilities and others in general. And though I requested a response be provided within thirty days, I have yet to receive a response, an answer from the department, so I ask you again, as somebody who should be intimately involved in the preparation of the secretary's response, when can the committee expect to receive that information?

Dr. LYNCH. I don't want to sound like a broken record, sir. I realize that you take this seriously. I realize that your committee takes the responsibility seriously, and I accept the fact that there can be a constructive relationship between the committee and the VA, and I hope to be part of that solution, sir, and not the problem.

The CHAIRMAN. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chair. And I wanted to ask, I know we skipped over a panel, but I wanted to refer back to some of the testimony that I reviewed from Dr. Daigh who spoke specifically around the problems in Columbia, around the consult backlog, and one of the indications that he gave was the availability of fee-based care, that it had been reduced.

I wanted to just hear your comments on that and why fee-based care was reduced in Columbia.

Dr. LYNCH. I don't have the full explanation for that, Congresswoman. I believe the facility felt at the time they had the resources to solve the problem. In retrospect, they did not. I think, however, Congresswoman, that in the process of looking back over what happened, we have developed a tool that gives the facility, that gives the network and it gives VA Central Office eyes on delays and helps us ask critical questions of a facility in terms of should they be using fee-basis care.

We have improved our fee-basis process. We have implemented the PC3 process which helps us interact with the community to obtain services. I think we have the ability to identify where our demand exceeds our capacity, to understand why that may be occurring, and as we move forward, to effectively use fee basis.

Ms. BROWNLEY. Thank you. And this tool that you are speaking of, can you give me some more details about what that is? What triggers you to begin to look at it? How long do the backlogs have to be before you begin to put your eyes on the problem and try to rectify it?

Dr. LYNCH. I think, first of all, the answer is that it is individualized, but let me explain the tool to you. As we began to look back at our consults after the incidents in Columbia and Augusta, we observed that there were flaws in our consult process that allowed consults to remain open or unresolved.

That put noise in our system and it prevented us from trying to identify those facilities where there was need for an alternative, such as fee-basis care.

Over the past year, after the incidents in Columbia and Dorm, we went back. We examined over 250 million consults since 1999

in VA. We identified where there were delays. We had to resolve those consults and make sure that they were closed appropriately and that services were provided. And in the process of doing that, we implemented new business rules that helped us separate our clinical consults from what had become some administrative uses of that consult system.

We are in the process of completing that review. It should be completed in the next month or two. With that and with new business rules, we will have the ability to look at a facility, to look at individual specialties within a facility, to take a look at trends in delays and to ask critical questions; whether the facility has the resources to address those delays, whether the facility thinks those delays are temporary, transient, or whether the trend is an indication of increasing delays, and to then work with the facility to decide do we need to add more staff or do we need to use fee-basis services.

Ms. BROWNLEY. Thank you. Are you collecting any data as we speak, looking ahead—we talked a lot about looking to the past and what needs to be done for the future—but looking ahead, are you collecting data and benchmarks vis-a-vis consult backlogs throughout the VA. Obviously, we have determined there was some VISNs, there have been some real problems, but are we going to collect that data to understand the data that data gets shared with the committee and where are the trigger points that we can make an immediate fix to what potentially could be a very, very serious problem.

Dr. LYNCH. I think the answer to that is yes, Congresswoman. In fact, about six months ago, using some initial data that we were beginning to collect, we sent over a $100 million out to the field for facilities to use to contract for fee-basis services. We reduced the wait time, the backlog at that point, by almost 50 percent or 50,000 patients.

So we have begun to use that tool. I think we can also begin to use that tool to look at what I think is the critical issue when we look at access, and that is delayed care. We focus on fourteen day access, but really, importantly, we need to look at where care is delayed. And we can set the filters on this system to look at delays at variable lengths of time, and as we get control of the system, slowly reduce backlog from ninety days to sixty days to thirty days based on the information that we will get.

Ms. BROWNLEY. Thank you. I yield back.

The CHAIRMAN. Mr. Huelskamp, you are recognized for five minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman. Just a couple of follow questions if I might. First, in reference to our previous speaker, Mr. Coates, are you familiar with the specifics of his situation?

Dr. LYNCH. I have not reviewed the specifics of his situation. I assure you, I will.

Dr. HUELSKAMP. And Dr. Clancy, have you any familiarity with this situation?

Ms. CLANCY. Not before what I heard this morning. Not before what I heard this morning.

Dr. HUELSKAMP. Okay. I would ask if you could also follow up on the situation in prior discussions with Mr. Coates that currently

VA is requiring him to drive almost four hours for some follow-up treatments instead of being able to receive it right close to home. Would you please follow up on that and see if that is indeed that case?

Ms. CLANCY. Absolutely.

Dr. HUELSKAMP. Okay. Additionally, I would like to ask a couple of questions of Dr. Lynch. What specific person at the VA Medical Center level is responsible for ensuring timely care is delivered to veterans?

Dr. LYNCH. Ultimately, it is the Medical Center director, sir, working with his quadrad, the director, the chief of staff, the chief of nursing and the associate director who often deals with engineering and environment of care.

Dr. HUELSKAMP. And what specific person or position at the VISN is responsible for ensuring timely care?

Dr. LYNCH. Ultimately, it is the network director, sir. He or she works with the chief medical officer and with the quality medical officer.

Dr. HUELSKAMP. And then at the VA Central Office level, who is responsible for timely care?

Dr. LYNCH. Ultimately, that would go to the office of the deputy under-secretary for operations and management and to Dr. Petzel.

Dr. HUELSKAMP. And out of the people in positions you have just named and anywhere from twenty to forty deaths by delay of veterans, do you know if anybody at all has received any disciplinary action whatsoever?

Dr. LYNCH. I believe that Dr. Petzel discussed disciplinary action the last time he was here. I believe we have identified two physicians in Memphis, which is another issue, where there was discipline. There was discipline in Augusta, as well as Columbia, and there was discipline in Atlanta.

Dr. HUELSKAMP. And did anybody lose their job?

Dr. LYNCH. I can't answer that specifically, sir.

Dr. HUELSKAMP. You don't have the information or is it a refusal to——

Dr. LYNCH. No, I don't have the information, sir. If I did, I would share it with you. I guess I would say, maybe in response—I understand your concern. I understand the chairman's concern regarding accountability and I think that is important and I think VA has some very prescribed purposes for that.

I am troubled a little bit by whether or not firing somebody is necessarily the answer. I think, as I mentioned earlier, almost a third of our employees are veterans.

Dr. HUELSKAMP. Would you be opposed to taking away their bonus?

Dr. LYNCH. Pardon?

Dr. HUELSKAMP. Would you be opposed to taking away their bonus?

Dr. LYNCH. Could I just continue for just a second?

Dr. HUELSKAMP. I don't have time for that answer.

Dr. LYNCH. I think we need to be careful about punishing everybody for what may have occurred at one or two medical centers. I think by and large, sir, we have good people who care for veterans, who deliver quality care. And I think in those circumstances they

should be rewarded. I don't think we should punish the system for what may be incidents that occurred in individual medical centers.

Dr. HUELSKAMP. Lastly, Dr. Lynch, I am looking at your handbook that provides the procedures for disclosure of adverse events to patients.

Dr. LYNCH. Yes, sir.

Dr. HUELSKAMP. And it is pretty clear of the ethical requirements: "Unwavering ethical obligation to disclose to patients harmful adverse events that have been sustained in the course of their VA care." Has this been disclosed to Mr. Coates?

Dr. LYNCH. It would appear from his testimony that it hasn't, sir. I think VA has taken a lead in this area. I don't think we are perfect, but I think we have a good system and it can be better.

Dr. HUELSKAMP. And if one failed to disclose this as apparently it is the case to Mr. Coates, what is the punishment? Who is punished for failure to meet an unwavering ethical obligation?

Dr. LYNCH. Sir, at this point I don't know. I need to understand the circumstances that occurred and I will be looking into that.

Dr. HUELSKAMP. Yeah, I would appreciate the specifics on Mr. Coates, but the general question is who is responsible for meeting this unwavering, ethical obligation?

Dr. LYNCH. The handbook would tell you that it is the executive team of the hospital. It is the director. It is the chief of staff. It is the chief of nursing.

Dr. HUELSKAMP. Thank you, Mr. Chairman. Yield back.

The CHAIRMAN. Mr. O'Rourke, five minutes.

Mr. O'ROURKE. Thank you, Mr. Chair.

Dr. LYNCH. Mr. Coates made a very powerful case that the delay of service to a veteran can effectively mean denial of life-saving care to a veteran, and I think you have made the commitment to look at his case specifically; find out what you can learn from that; apply those lessons to improving the VA, and specifically what happened with those specific doctors and he relayed an anecdote or anecdotes of poor performance on behalf of the doctor, but he also showed us that there are some truly terrific public servants working for the VA. He mentioned the doctor who retired from private practice and is spending time within the VA because he cares about veterans and he wants to make sure that they get the best care.

I have found that to be the case in El Paso, that we have really wonderful doctors, terrific care for veterans who can get in my community, and far too often in other parts of the country is that it is very hard to get into the VA and get an appointment and see a doctor. Anecdotally, I have heard from veterans who served as back as World War II, who need simple procedures like cortisone treatment who have to, as Mr. Huelskamp just described, travel four or five hours to the nearest VA hospital in Albuquerque to get that care. They decide not to get the care and they end up either suffering, choosing an alternative or just going without.

I have spoken to countless veterans who just delay or just do not receive appropriate treatment, procedures, or surgeries for the same reasons. That anecdotal information has been borne out by the recent SAIL report that the VA OIG recently produced that showed that El Paso is arranged 123 out of 128 VHA facilities for

access to care, and when we drilled down into the numbers a little bit further, we found that as recently as six months ago, only 18 percent of veterans seeking to make an appointment were actually able to get an appointment within a reasonable period of time, a standard that you all set for yourselves. So for those 82 other out of every 100 veterans trying to make an appointment, they can't get in and find care.

So, you know, Mr. Huelskamp approached this, I think rightfully so from a perspective of accountability, and what do we do when people don't perform, when veterans don't get access and we have these poor outcomes?

To look at the other side of the question: What are you missing in resources to be able to provide the access that we need to hire the very best doctors, or in El Paso's case, enough doctors so that veterans can get in and get an appointment? What are we not providing to you and to the VA that you need to be able to turn this situation around?

Dr. LYNCH. Dr. Clancy.

Ms. CLANCY. So first, I want to say to you and your colleagues here that we very much appreciate the privilege and opportunity and honor of serving the men and women who have effectively written a blank check to this country; there is no higher calling, really, in medical care delivery.

The issue of timely access is one that we take seriously, so to the extent that you have additional information that we haven't seen, we would love to see and work on that with you.

Mr. O'ROURKE. Here's the thing—and I appreciate what you just said, but I have spoken to Dr. Petzel about this. You all had measured it and seen the outcomes and the lack of service. I am with Ms. Brownley and others who question whether the number of preventable deaths is really accurate. Who knows how many of those in El Paso who are not able to get an appointment or who were told they had to make a ten-hour roundtrip and those not to have the procedure, who knows who their outcomes were. I don't know if we are effectively measuring that.

What I want to know—and I have tried to do this in the most cooperative, polite, diplomatic fashion I can think of—what I want to know is what you are going to do to turn that situation around, and if you need something additional from me, as a Member of Congress, from us as a committee, from the House, the Senate, in terms of appropriating resources, what are you missing that is preventing you from delivering the standard of care that our veterans should be able to expect?

Ms. CLANCY. What we are working on right now are new programs to improve our ability to schedule appointments in a timely fashion. In addition to that, particularly for folks who live in rural areas where traveling great distances often is a big challenge, we are looking into other options when it is feasible. Obviously, if you need an injection or a procedure, you can't do that remotely, but we are looking at a variety of telehealth options sometimes for video consultation. It seems to be a very, very effective way to improve access for people who have mental health appointments, and other venues so that we can be able to get people in faster, and I will personally follow up with Dr. Petzel about your request.

I wanted to make one other comment, just about rankings. If you have 152 hospitals or centers in a system, there will be a number one and a number 152. I think the real question is: Is 123, how does that stack up against the private sector and what is the gap between best possible care and——

Mr. O'ROURKE. And use the other metric that I gave you, which is 82 out of every 100 veterans trying to make an appointment in El Paso cannot get in, in a reasonable amount of time, a standard in which you set. And I have asked Mr. Petzel publicly. We have talked to the office privately.

When can we get something in writing that will tell us when you will be able to meet the standard of care that you, yourselves, have set for the veterans in El Paso, and the veterans all around this country, and I am still waiting for the reply. So I am going to ask you, again, publicly, to please work with Dr. Petzel and our office to get us that reply.

Mr. Chair, thank you.

Ms. CLANCY. I will do that.

The CHAIRMAN. The gentleman's time has expired.

Dr. Benishek——

Dr. BENISHEK. Thank you.

The CHAIRMAN [continuing]. Chairman of the health subcommittee, you are recognized for five minutes.

Dr. BENISHEK. Thank you very much, Mr. Chairman.

I thank both of you for being here this morning. Frankly, this makes me really angry, all right. I mean Mr. Coates is here testifying about this care at the VA where he has going to die and as far—I am a general surgeon. I do colonoscopies. I do colonoscopies at the VA.

This man did not receive the standard of care and it is very frustrating for me to be here and have people calmly explain to me how they are working really hard to make things happen when there is not an emergency. This is an emergency. This gentleman did not receive the standard of care, all right. He did not receive an apology.

It is hard for me to understand, you know, when I ask Dr. Petzel for what are you doing for this kind of stuff?

And it was six people have been disciplined and then I can't even get an answer from him as to which people and why. So how can I believe that the VA is serious about putting a stop to this stuff when I ask a simple question and I can't even get an answer to it. It is very frustrating to me that we have to come up with some sort of legislative fix for how you people manage your department.

I mean it should be a management decision that, you know, a physician who is not giving a colonoscopy when people have rectal bleeding or blood in the stool. This has been the standard of care for 30 years. And, you know, for not even getting a consultation for a colonoscopy for a year and then to get six months before he is—from what I can understand from the timing—six months.

This is an emergency. If I see somebody in my office with rectal bleeding, they get a colonoscopy like the next day or within the week. And I don't know—you know, I just get so frustrated by people like you that come here and calmly say we are going to fix it and it never gets fixed.

Dr. LYNCH. Congressman, I am a surgeon by training. I have spent the last 30 years working in the VA system working with veterans, training residents, working with medical school students. I am angry, as well, sir. I share your anger.

I have been working for the last year since I have been here in central office to put together the tools that give us what we need to manage our system in a fashion so we can identify where there are delays and——

Dr. BENISHEK. No, I understand.

See, you calmly answer me——

Dr. LYNCH. I am not calmly answering you, Congressman. I am angry like you are angry.

Dr. BENISHEK. But I don't see any progress, Dr. Lynch. I don't see any progress.

I mean all I asked of Dr. Petzel was for some things here. We don't see where you are actually fixing it. All we get is calm responses from people that are assuring us that we are actually doing it, but we don't see any progress and, you know, when I see a case like that case that was presented here earlier by Mr. Coates, I just can't stand—what are you doing? I mean what mechanism do you have to find out about stuff like this?

What happened to that doctor? Why wasn't she working on—at the standard of care? I mean these are the kind of questions that we need answers to and we don't ever get them, and so I am very disappointed with the quality and the management of the VA. I mean I worked at the VA for 20 years myself. I think that the VA has made tremendous improvements over the last 20 years, there is no doubt about it, and I applaud you for doing your career there, but, you know, coming from that system, where I worked as a physician, and I come here, and knowing, you know, how the bureaucrats work there, the physicians, to me, didn't have enough input as to how things were done; it was the bureaucrats that decided about a lot of this stuff.

So I would be happy to work with you to give you my insight as to how to do this better. You know——

Dr. LYNCH. Congressman——

Dr. BENISHEK [continuing]. Like I said, it is great——

Dr. LYNCH [continuing]. I would be happy to meet with you.

Dr. BENISHEK. What is the second half of that?

Dr. LYNCH. Dr. Clancy and I would both be happy to meet with you, sir.

Dr. BENISHEK. I will yield back my time and hope——

Ms. CLANCY. And I do want to be clear that we both share your anger and are very, very upset and we know that we can't take that back; it can't be undone. So, a young man who will die prematurely, we get that. But what it inspires us to do is to work harder to make sure that we don't do it again and we have a system in place to make it foolproof so that we don't——

Dr. BENISHEK. Well, my frustration is how can I tell what is happening when I can't even get a simple answer to a simple question from Dr. Petzel? Thank you.

The CHAIRMAN. Ms. Titus, you are recognized for five minutes.

Ms. TITUS. Thank you, Mr. Chairman.

I want to ask Dr. Lynch, I am sure you are aware that the IG is currently investigating the death of Sandi Niccum at the VA hospital out from Las Vegas. That investigation came at the request of the chairman and myself. It is taken awhile, and we hope to get the results soon, but just wonder when the results come to this investigation or any, what you do to follow up; how you assure us that you have made the changes; implemented the recommendations.

Could you comment, maybe, specifically about the Las Vegas case or—and also generally?

Dr. LYNCH. I can't comment specifically about the Las Vegas case. I have not seen the OIG's report yet. I can tell you that when those reports come in, I do read them. I do look at the recommendations and we do have a process for tracking to make sure that those recommendations are acted upon and closed.

Ms. TITUS. Can you elaborate on that process for tracking them so that we can be sure that there is transparency and accountability and I can go back to my constituents and say this was the problem and this has happened to correct it.

Dr. LYNCH. There is an office in VHA whose specific responsibility is to work with the OIG. They obtain those reports and they work with the OIG until such time as he accepts the actions that have been taken and closes the recommendation.

Ms. TITUS. And that is public?

Ms. CLANCY. Yes, that is public information in terms of what was the response of the VA Health System and the follow-up and so forth. So I think we can both commit to you that we will follow-up with you when that report is done.

I want to stress, though, that we don't wait for the Inspector General. The Inspector General is a very valuable resource and a source of information for us, but we have many internal processes. So our National Center for Patient Safety, for example, routinely is collecting information about adverse events and near misses; in other words, circumstances that set people up for errors.

I have heard a lot of concern from all of you this morning, and we share that, about harms to patients and patient safety. And I would love to tell you that we can build an error-free system and that is not possible.

What we can do, and are strongly committed to doing, is identifying things at the earliest possible phase so they can be fixed and the much longer-term consequences and more serious consequences can be prevented. So, we pay a lot of attention to the IG reports to reports by the GAO, but we also have our own internal processes where we are relying on every single employee who works at VA to let us know; it is called Stop the Lying. If you see something, say something. If you see something that could be unsafe, we need to hear about it and you need to let people know so that we can act on it, and together, across the system can learn about it.

Ms. TITUS. Can you tell us then—and I appreciate that, I think that is a good thing that you have—but if something is being done to follow up on the Sandi Niccum case independent of the report that we are waiting on?

Ms. CLANCY. I can get back to you with that. I am not familiar with the specifics of that, but we will definitely get back to you.

Ms. TITUS. Thank you very much.

And I yield back, Mr. Chairman.

The CHAIRMAN. Could you tell me why the video, the surveillance video that day in the hospital that showed Ms. Niccum, who was an elderly lady, was in severe pain and ended up dying, was erased, deleted, how did that occur?

Dr. LYNCH. The only explanation I have heard is that after 30 days, the videotapes are overwritten and we don't have that information; and I understand that I don't know the relationship between your request and when that tape was erased.

I think from our standpoint, it is unfortunate; we would like to have seen what happened as well.

The CHAIRMAN. Wouldn't you think, though, as a matter of principle and good business practice, that if a death occurred in your facility and you had a video of that death—30 days—man, I can understand if it was 24 hours, maybe it got deleted—but 30 days before it got taped over?

Dr. LYNCH. If I recall the case, which is now coming back, I don't believe that Ms. Niccum died that day. I believe she died subsequently, following hospitalization. So I think the concern was that her care was delayed in the emergency department and there was a delay in her receiving radiology service. She went home and was subsequently admitted to another facility and died at that time.

So it wasn't that we had a death in the facility at that time, which I absolutely agree with you, Congressman, would have required that we review those videotapes and look at them.

The CHAIRMAN. The GAO, in their written testimony for this morning's hearing, alleges that oversight of the implementation of VHA's business rules has been limited and has not included independent verification of VAMC actions. So my question to you is: Would the Department be willing to increase oversight of the new business rules and pursue independent verification of VA Medical Center implementation?

Dr. LYNCH. I did read the GAO's testimony, sir. I am not sure that we agree that there is value to auditing of the facilities. We think that we have provided adequate training. We think that we have provided the education that the facilities need to implement those. We know that the facilities have begun to implement and use consult management teams. We feel very strongly that the consult tool that is resulting from this review will give us that individual oversight by facility and by specialty.

The CHAIRMAN. And they also allege in their statement that the Department did not require medical centers to document how they address unresolved consults that were opened greater than 90 days; is that true?

Dr. LYNCH. That is true, sir.

But we felt we had a process defined that identified which consults could be closed. When there were individual patient consults which remained unresolved that resulted—that related to clinical care, that we had a process and an expectation of our medical centers, that those would be reviewed individually.

The CHAIRMAN. In their written statement this morning, GAO references one VA Medical Center where specialty care providers have allegedly been instructed to discontinue consults for appoint-

ments that are not needed within 90 days and to track these consults outside the consult system and to resubmit them closer to the date that they are needed.

Is this an acceptable practice?

Dr. LYNCH. We have a process, as we implement new business rules that will identify consults for what we term "future care." Future care would be somebody who perhaps had an endoscopy——

The CHAIRMAN. So the answer to that question is: Yes, it is an acceptable practice?

Dr. LYNCH. The answer to that is: Yes, we have a process in place to be able to identify those and be sure that we have eyes on those future care consults, sir.

The CHAIRMAN. So we have a dual track list?

Dr. LYNCH. No, sir. We have an electronic process that follows those and kicks them out at the appropriate time back into our system so that we are aware that an endoscopy or a consult needs to be scheduled at the appropriate time.

The CHAIRMAN. Can you respond to the comment made in the IG's written statement that there seems to be a lack of focus on healthcare delivery as priority one at VA medical facilities, as evidenced by the length of time that it takes to fill a vacant position. I think that any one of us that goes to a VA Medical Center for a visit are often not surprised anymore by the number of people that have the word "acting" before their name or that there are positions that are important that are vacant.

Can you respond to those comments?

Dr. LYNCH. Yes, sir.

First of all, I think if we look back through VHA, the system that we currently have was initially developed around 1940 by Omar Bradley, and by Dr. Paul Holly. It focused on clinical care. It focused on academic affiliation and the education of medical school students and residents, and it focused on the value of research.

I realize that healthcare has changed. I respect the IG's recommendations and thoughts. I think we do need to re-examine our system, but I would disagree that I think we are ignoring clinical care in favor of research or education. I think they are both critical components of what we do in VHA. The research that we have done has helped to improve patient care and the care that we deliver. I can give you two recent examples.

There was VHA research on the treatment of PTSD that has resulted in new treatments for patients with PTSD, as well as tools for identifying TBI. There was a study on the use of the drug Prazosin and its value in patients with PTSD that has been implemented, not only in VA, but also in the private sector. I think that research plays a critical role in helping us assure that we have quality care for our veterans.

The CHAIRMAN. Final question from me: Does the VA have every legal authority it needs to pay for a veteran's care whose care is delayed, to receive care outside of the VA system?

Dr. LYNCH. To my knowledge, sir, yes.

The CHAIRMAN. So, would it be correct to say that failure to deliver care in a timely fashion is simply a question of poor leadership at VA?

Dr. LYNCH. I think that would be a stretch, sir. I think that our system strives to treat patients within VHA because we think we do provide good care. We think we provide quality care. I hope that we can identify those circumstances where it may be necessary to send somebody into the private sector. I think we have to use all the resources that we have, sir.

The CHAIRMAN. Ms. Brownley. any further questions?

Ms. BROWNLEY. I don't have any further questions, but I do have a comment that I would like to make, and to say, I, too, share the frustration of the committee that we are not able to get the answers that we want.

And I think, you know, we are looking for specifics, data, metrics, et cetera, and, feel—I always feel as though we never get them. We get answers like "We have a system that provides eyes on the process"; "We have tools." But we are really looking for the specifics.

Our staffs assure us that you know the questions that we are going to ask and what we are interested in knowing through these hearings and it is just my feeling and my only conclusion that I can come to, if you are not willing to reveal the facts, that there is something that you don't want the public to hear, and I just want to make that statement. I don't know what else to conclude when we don't get the facts and the information that we are specifically asking for.

Dr. LYNCH. Congresswoman, I would point out that, in fact, one of your staff members of the HVAC did meet with Dr. Mike Davies of our staff and did go over the consult tool that we are developing and was shown how it works.

The CHAIRMAN. Mr. O'Rourke or Ms. Titus, any further questions?

Thank you very much for being here with us, and the second panel is dismissed.

Members, joining us on the third and final panel—and thank you very much for your indulgence in allowing VA to give their testimony before you—is Deborah Draper, Director of Healthcare for the Government Accountability Office, and, Dr. John Daigh, Assistant Inspector General for Healthcare Inspections for the VA Office of the Inspector General. The committee appreciates both of you for being here today and thank you for your hard work and advocacy on behalf of America's veterans.

Ms. Draper, we will begin with you, you are recognized for five minutes for your opening testimony.

STATEMENT OF DEBRA A. DRAPER

Ms. DRAPER. Chairman Miller and Members of the Committee, I am pleased to be here today to discuss access problems in VA that may delay needed medical care for veterans. GAO and others, including VA's Inspector General, have continued to report that VA medical centers do not always provide timely care, and in some cases, these delays have resulted in harm to veterans.

My statement today covers two access-to-care concerns. First, I will highlight preliminary observations from our on-going work related to VHA's management of outpatient specialty care consults. Second, I will discuss concerns regarding VHA's medical appointment wait times, and scheduling, including progress VHA has re-

ported making in implementing our December 2012 recommendations.

VHA providers request and manage consults for specialty care using VHA's clinical consult process, which is supported by an electronic system. Clinical consults include both clinical consultations, such as an evaluation of a patient's clinical concern, as well as specialty procedures, such as a colonoscopy. The specialty care provider who receives the consult request is to review it within 7 days of it being sent to determine whether it is needed and appropriate. VHA's guideline is for consults to be completed within 90 days.

In 2012, VHA created a database to capture all consults systemwide; however, the data were deemed inadequate for monitoring purposes. One issue was the lack of standard processes and uses of the electronic consult system. For example, in addition to requesting consults for clinical concerns, the system was also being used to request a variety of administrative tasks, such as requesting veterans' travel to appointments. Additionally, VHA could not accurately determine whether veterans actually received the care requested or received it in a timely manner. At the time the database was created, there were approximately two million consults open for more than 90 days.

In May 2013, VHA began an initiative to standardize aspects of the consults process with the goal of developing consistent and reliable systemwide consult information. Among other tasks, VA medical centers were to complete a clinical review as warranted, and as appropriate, close all consults open for more than 90 days.

Through our on-going work on outpatient specialty care consults, we found examples of delays in care at each of the VA medical centers included in our review. For example: For three of ten gastroenterology consults reviewed in one facility, up to 210 days elapsed from the dates the consults were requested to when they were completed.

In another facility, for three of ten physical therapy consults reviewed, more than 100 days elapsed with no apparent actions taken to schedule appointment. These consults were eventually sent back to the requesting providers without the veterans involved receiving the requested care. According to the patients' files, no non-service connected evaluations were being accepted due to resource constraints.

We also found variation in how VHA's consult initiative is playing out at the local level. For example: VA medical centers have developed different strategies for clinical consults that are needed beyond the 90-day completion guideline. Some facilities are managing these future-care consults outside of the electronic system, and consequently, these consults do not appear in VHA's systemwide data.

VA medical centers are also not required to document how they address consults open for more than 90 days. None of the facilities in our review were able to provide us specific documentation in this regard. VHA officials estimated that as of April 2014, of the two million open consults that existed when the systemwide database was created in 2012, 450,000 remained unresolved.

Additionally, oversight of VHA's consult initiative has been limited, and has not included independent verification of VHA medical centers' actions. Without this verification, VHA cannot be assured

that the actions have been implemented correctly. Furthermore, VHA's consult data may not accurately reflect whether veterans received the care needed, or if they received it in a timely manner.

The second access-to-care concern that I wanted to highlight today relates to our December 2012 report and subsequent Congressional testimony. We reported that VHA's outpatient medical appointment wait times were unreliable, and that there were problems in the implementation of VHA's scheduling policy. We recommended VA take actions to: Improve the reliability of medical appointment wait time measures, Ensure the consistent implementation of a scheduling policy, Allocate scheduling resources based on needs and Improve telephone access for medical appointments.

VA concurred with our recommendations and has reported continued actions to address them. For example, VHA officials told us they have implemented new wait time measures, which they say are more reliable. We believe that work needs to continue to fully implement our recommendations. It is essential that VHA also assess the actions taken to ensure that they are achieving the intended improvements.

Mr. Chairman, this concludes my opening remarks, I am happy to answer any questions.

[THE PREPARED STATEMENT OF DEBRA DRAPER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Dr. Daigh, you are recognized for five minutes.

STATEMENT OF JOHN D. DAIGH, JR., M.D.

Dr. DAIGH. Chairman Miller, Members of the Committee, it is an honor to be able to testify before you here today. I would like to recognize the courage of Mr. Coates for his testimony this morning. It was extremely important to hear and I think very sad.

My staff works tirelessly to try to ensure that these events don't occur and this is a failure for us to see a story like this. I believe the VA has lost its focus on the importance of providing quality medical care as its primary mission. In the day-to-day decisions that managers at all levels make, that they take for granted often times, and assume that quality medical care will be provided.

When addressing the competing demands to provide medical education, research, support to our nation in time of national disaster, comp and pen exams, the fight against homelessness, managers have lost focus on the importance of making quality medical care delivery their number one priority.

In my written statement, I addressed three events that we have recently published that have occurred at more than two institutions. One is the colon cancer issue that we discussed here previously, the second would be veterans at Miami and Atlanta who died in VA hospitals from overdoses of street drugs, and in both cases, basic policies were not followed.

In Buffalo and Salisbury, North Carolina, insulin pens designed to be used for one patient to take multiple doses were, instead, used on the ward for multiple patients, putting hundreds of veterans at risk for the risk of blood-borne viral infections. There is no good explanation for these events. They are not consistent with

good medical practice. They are not consistent with common sense, and they are not consistent with VA policies that exist.

The most important factor in preventing these events, in my view, is excellent leadership that instills a culture of safety and accountability. In addition, I believe that a review of VHA's organization and business rules is appropriate to determine if there are changes that would support the singular importance of quality of care and improve the ability of leadership to deliver that high quality medical care across the system.

For example, one might identify positions within the medical center that are deemed essential for the delivery of medical care, and should one of those positions become vacant, for instance, the nurse in the colonoscopy suite or the GI nurse, that job would automatically be refilled. It wouldn't have to compete for being refilled within the administration for medical education or a technician who might want to be hired for research. So, again, a way to try to focus the budget and resources on healthcare.

In addition, VISN and hospital instructions are not standardized. It is not possible to look at—the position descriptions are not the same. The areas of responsibility are not the same. So if you ask the simple question: Who owns the operating room? You are not really sure if it is the chief of surgery; is it the chief of anesthesia; is it the chief of surgical care line; is it the head nurse?

So I believe that these rules that currently exist which—and I will be the first to admit that the VISN system and the mantra that all healthcare is local has served the VA very well. I believe that these systems ought to be looked at to see if it is time to change some of these rules.

With that, I will end this portion of my testimony and be pleased to take questions.

[THE PREPARED STATEMENT OF JOHN DAIGH, JR. APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, both.

I was looking at the written statement for the GAO and you talked about, and the IG talks about it, too, that VA experienced difficulty in hiring and retaining specialists for gastroenterology and physical therapy. And the question is: Did you find any reason for that?

Dr. DAIGH. I guess——

The CHAIRMAN. Either can answer on it.

Ms. DRAPER. Yeah, I think what we heard in some locations was that for some high volume specialities, there is a national shortage of some specialists, so it is difficult to hire. I think we heard, generally, that there was an increased volume of requests for certain specialty services which is complicating providing care. So, you know, if you have a shortage of providers, you can't backfill and, you know, increase the capacity that you have within the specialty clinics, so we did hear some of that.

The CHAIRMAN. I would suspect that if you had a shortage of providers or you had vacancies that you couldn't fill, then the obvious thing would be a fee-for-service if possible, and then the question begs to be answered: Do you think VA makes adequate or even

maximum use of fee-bases resources when those specialists are not available?

Ms. DRAPER. We have not looked at this in any great detail. I mean it varies considerably from facility to facility. And at one facility, for example, they fee-based two to three hundred GI consults a month. In other facilities, they do very little. It is hard to understand what the variation is, but it does vary considerably from one facility to another.

Dr. DAIGH. I would say, sir, that this is not a new problem. We published, you know, a similar report in 2006 that outlined the difficulty that VA had in following up on patients who were being screened for colonoscopy and needed tests to look for the presence of colon cancer on a regular basis. And so I think, A, you have to have a system in place, but, B, you are just talking about a procedure and the procedure can be done by a variety of people trained to do that procedure.

So the question is: If you need a colonoscopy done, well, maybe a PA could do that or maybe a nurse could do that—to have the training and to assist the physicians and other staff to make sure that this simple procedure got done adequately, and where a physician needed to impart additional insight into what one should do, you could schedule visits for that. So I think this is just not a new problem.

The other point I would make is that many VAs, probably 100 of them, are affiliated with medical schools, so you have right there a whole set of physicians that are in the community that are available, so that if you could work with that group of patients, a group of facilities, one could probably construct solutions that would be worthwhile.

So, I think fee-basis consults, creative uses and training of your resources and your people to plan for what you know are going to be on-going problems; they are all parts of the solution here.

The CHAIRMAN. Ms. Draper, have you ever seen an instance or instances where a VISN director or a medical center director restricted the use of fee-basis care funds or diverted those funds to be used in other programs?

Ms. DRAPER. I have not, but for this work we have not looked at that in any great detail.

But I do want to say one thing about fee-basis, as well, is that these are not tracked the same way, so you don't know what the wait times are. So when you fee-base something out there, you lose that tracking ability to see, so you may not really be accomplishing something—you may not be getting the care in a timely way, it is just that VA doesn't—they don't really track that.

The CHAIRMAN. And, again, they should.

Ms. DRAPER. They should, and we pointed that out in our previous report.

The CHAIRMAN. We found this issue in Atlanta, in particular, where mental health care was an issue where basically once VA fees something out, it appeared that they just dropped off the radar screen and they weren't watching it or tracking it again.

Just because they are not getting care in a VA facility doesn't mean that they are not VA's patient or America's patient and VA had darn sure better——

Ms. DRAPER. Right. And VA is paying the bill, so—I mean that was one of the issues that we pointed out in our 2012 report is that is was not tracked.

The CHAIRMAN. Actually, a grateful American taxpayer is paying the bill and I think VA forgets that sometimes; it is the taxpayers' funds, not theirs.

Ms. Brown.

Ms. Titus.

Ms. TITUS. We have been here a long time. Thank you, Mr. Chairman.

I just keep hearing a theme over and over that these things seem to vary have facility to facility, and I understand perhaps the need for some flexibility because some hospitals may be associated with the medical school, different demographics, different geography, and all of that. But it seems to me there is some need for some kind of standardized policy to some extent.

I know at the Las Vegas hospital, they are flying in emergency room doctors from all over the country on contract for a few day schedules. That doesn't seem very practical to me. I mean there must be all of the Las Vegas Valley, some emergency room doctors who could do that. It seems like you would save money and get more of a buy in from the medical community than these kind of flying in doctors.

I would like that addressed, but I also would like to go back to the Sandi Niccum case. Dr. Lynch kind of got his memory back in the course of answering that question, but I would like to ask ya'll if you can give us some kind of progress report so we can find out if that is moving and when we are able to get some results.

Dr. DAIGH. Yes, the research on that has been done. The report has been written. It is in draft phase, and it will be out within a couple—three or four weeks. So we are—we will be ready.

In the normal process, I would like to clarify a little bit what was said previous. We would write a report and lay out the facts as we see them. We would then send a report to VHA at multiple levels, including the hospital in Las Vegas, ask them to read the report and verify they think the facts are correct. We would then make recommendations in the report and ask them to respond to the recommendations and they would, in writing, respond to those recommendations.

At that point, we would offer the Committee and you a briefing on the findings and we would publish the report to the web where it would be public, that would be our report, plus their response.

The response sometimes takes awhile for VA to follow back up on, so we then have a part of our office that does follow-up. Usually, it is that we ask for records to prove that X and Y were done, and if they provide records that X and Y were done, then we usually close it.

Occasionally, we say this is so important an issue that we personally will go back and re-visit the facility and try to do a follow-up. The follow-up documents, though, are not made public unless they are requested, so they are internal to us. I see them, you ask for them, you can get them. We do provide a list to Congress multiple times a year of those recommendations that have not been filled within a year.

So where we have not been unable to close a recommendation on one of our reports within a year, we make that available to you as an item and we are happy to talk about those.

Ms. TITUS. Okay. So when you say the report will be finished within three weeks or so, is that the stage in which you send it to the hospital or——

Dr. DAIGH. No, I think this should be publishable within three weeks or so, three to four weeks.

Ms. TITUS. Well, I will look forward to getting that.

And it seems to me that sometimes these reports that focus on a specific problem in a specific hospital are used to address just that and not taken in the broader, I don't know, perspective, so that they can be used to solve problems at other facilities.

Dr. DAIGH. Well, I think in terms of just producing a report and making sure it is accurate, I have to narrow the scope often times to what I can be accurate about.

Ms. TITUS. Uh-huh.

Dr. DAIGH. But if one looks at the reports that we put out or you ask us to talk about it—I am familiar with the reports that we put out—we are happy to try and talk about patterns that we see.

Certainly, VHA gets the reports and they can look for patterns and we are aware of patterns, so I think you are right; there is a difficulty in that they don't all talk to the universe, but I can't do that and get it out timely.

Ms. TITUS. I understand that.

Mr. Chairman, thank you. I yield back.

The CHAIRMAN. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chair.

Dr. Daigh, a couple things that you said really struck home in terms of trying to figure out what is going wrong and how we fix it. You said it was a question of leadership and you also said it is a question of having a culture that prioritizes safety and accountability. And those issues are so big and so tough to address in a five-minute question and response.

But I will just tell you that I have had the chance to meet Secretary Shinseki. I have heard him testify here. I have no question whatsoever that he has the highest and deepest commitment to improving the service of the VA—and if he were here, I am sure that he would agree and share everyone's frustration—and say that the results that we described today are unacceptable, and I also have no doubt about Dr. Lynch and Dr. Clancy and their commitment.

The people that I meet within the VA are good people who are trying, and yet, the awful numbers that I gave for El Paso earlier are not new. In 2008 we had the worst access not country to be able to get in to see a doctor and it has improved only marginally since then. So, despite good people doing good work and assuring us of their efforts, it is not getting better—certainly not quickly enough for the veterans who need to see care.

Let me ask you this: In assessing the job that I am doing and the job that Congress and this Committee is doing, you know, the primary responsibility for these veterans is within the VA. The ultimate responsibility is within Congress. We have the power and responsibility of authorizing, appropriating, and oversight, and so I will ask you the question that I asked Dr. Lynch: What could we

be doing that we are not doing now to change the outcome and to get veterans the care that is being delayed and ultimately denied, as we heard with Mr. Coates and as I see every single day in El Paso?

Dr. DAIGH. I have watched this system for awhile; I would agree that the people who work in it are excellent. They are committed. Many of them are veterans and they are of the highest quality when you sit and talk with them. That is why I expressed the frustration over the events that I talked about when you say "Well, what really happened?"

And often, I think—so let me go to your point. I think that serious thought needs to go into the business model that VA uses now to deliver care. So if you are in the middle of Manhattan and you have multiple medical schools and many hospitals, you have a different group of folks to deal with in terms of trying to resource and provide care. You would make different decisions about how you provided care. You may decide that cardiac surgery is so great at this hospital that why shouldn't I get into that business, why wouldn't it use it all the time.

And if you are a different facility someplace, you have entirely different business needs, and I think that the VA structure has not morphed over the last number of years, as I think it should. In the past, I think most veterans lived in the shadow of the hospital. If they drove and could get there, they were enrolled in that facility.

If the goal is deliver one standard of care to all veterans who are eligible for that particular piece of care, the ones that live on the other side of the mountain and across the river, I think you have to rethink a little bit how you are doing that. And so I would take a serious look at, given that the information flow has changed; data requirements have changed; data is available—the capabilities of computing are different. I think it is time to take a look and fix what needs to be fixed bureaucratically to drive efficiency and drive standardization, but try very hard to preserve the mantra that all healthcare is local, so that local folks can make important local decisions.

Mr. O'ROURKE. And I appreciate the fact that representatives from the VA are here listening to this, and I am sure at headquarters, they are listening as well, and to a certain degree, they can choose to adopt these recommendations administratively, but just to put a finer point on the question that I am asking: Are you suggesting that, again, despite the best efforts within the VA and current leadership, we are not seeing the kind of change that we need? That the recommendation that you are making needs to come in the form of a legislative proposal, a bill that would force the VA to change how it delivers cares?

Dr. DAIGH. So how change occurs, I am not quite the expert on, whether it needed to be law or discussion. But, certainly, if you were to change business structure, I am assuming that you would need to change some law.

But what I am pointing to is in a GI clinic where you are scheduling colonoscopies and you have people who need colonoscopies, you know what the demand is. If you lose a critical player in that clinic, then you know that you can't do the work that you did be-

fore. So the people in that clinic, the doctors, the nurses, everybody, needs to have an easy conduit to drive change and make it happen.

If the complaint is that at the local level within a hospital, they can't get the positions filled, they need filled to ensure that what gets done gets done, and those people who are not bureaucratically responsible for the delivery of care are somehow able to drive resources outside of the delivery of primary care, I think that needs to be fixed.

I think there ought to be a study. I think there ought to be a good look at how VA is currently set up and see if there are not better ways to manage this system in 2014 and forward.

Mr. O'ROURKE. Thank you, Dr. Daigh, and, Ms. Draper, I thank you for your answers.

Mr. Chair, I yield back.

The CHAIRMAN. The gentleman yields back.

Ms. Titus, do you have a request?

Ms. TITUS. I do, Mr. Chairman, thank you.

I would like to submit Mr. Michaud's written statement for the record because he couldn't be here.

The CHAIRMAN. Without objection.

The CHAIRMAN. Being no further questions from the Committee, we will be submitting some questions for the record. We would appreciate a timely response from all the witnesses today.

I do ask unanimous consent that all members would have five legislative days with which to revise and extend or add extraneous material to their remarks.

Without objection, so ordered.

And, once again, thank you to all of the witnesses for being here today.

This hearing is adjourned.

[Whereupon, at 12:41 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CHAIRMAN JEFF MILLER

Good morning.

The committee will come to order.

Before we begin I'd like to ask unanimous consent for our colleague from Tennessee, Congressman Steve Cohen to sit at the dais and participate in today's proceedings.

Hearing no objection, so ordered.

Welcome to today's full committee oversight hearing, "a continued assessment of delays in VA medical care and preventable veteran deaths."

Today's hearing is the fulfillment of a promise I made in early January to follow-up on delays in care at department of veterans affairs (VA) medical centers in Columbia, South Carolina, and Augusta, Georgia, that, together, resulted in nine preventable veteran deaths.

I had hoped that during this hearing, we would be discussing the concrete changes VA had made—changes that would show beyond a doubt that VA had placed the care our veterans receive first and that VA's commitment to holding any employee who did not completely embody a commitment to excellence through actions appropriate to the employee's failure accountable.

Instead, today we are faced with even with more questions and ever mounting evidence that despite the myriad of patient safety incidents that have occurred at VA medical facilities in recent memory, the status quo is still firmly entrenched at VA.

On Monday—shortly before this public hearing—VA provided evidence that a total of twenty-three veterans have died due to delays in care at VA medical facilities. Even with this latest disclosure as to where the deaths occurred, we still don't know when they may have happened beyond VA's stated "most likely between 2010 and 2012." These particular deaths resulted primarily from delays in gastrointestinal care. Information on other preventable deaths due to consult delays is still unavailable.

Outside of the VA's consult review, this committee has reviewed at least eighteen preventable deaths that occurred because of mismanagement, improper infection control practices, and a host of other maladies plaguing the VA health care system nationwide. Yet, the department's stonewall has only grown higher and non-responsive.

There is no excuse for these incidents to have occurred.

Congress has met every resource request that VA has made and I guarantee that if the department would have approached this committee at any time to tell us that help was needed to ensure that veterans received the care they required, every possible action would have been taken to ensure that VA could adequately care for those veterans. This is the third full committee patient safety hearing we have held since I have been chairman and I am going to save our VA witnesses some time by telling them what I don't want to hear from the department this morning.

I don't want to hear the rote repetition of—and I quote from several prior VA statements, including the written testimony that was provided for this hearing—"the department is committed to providing the highest quality care, which our veterans have earned and deserve. When incidents occur, we identify, mitigate, and prevent additional risks. Prompt reviews prevent similar events in the future and hold those responsible accountable."

Another thing I don't want to hear is—and, again, I quote from numerous VA statements, including a recent press statement—"while any adverse incident for a veteran within our care is one too many," preventable deaths represent a small fraction of the veterans who seek care from VA every year.

What our veterans have truly "earned and deserve" is not more platitudes and, yes, one adverse incident is indeed one too many. We all recognize that no medical system is infallible, no matter how high the quality standards might be. But I think we all also recognize that the VA health care system is unique because it has a special obligation not only to its patients—the men and women who honorably serve our nation in uniform—but also to its financers—the hard-working American taxpayers.

When errors do occur—and they seem to be occurring with alarming frequency—what VA owes our veterans and our taxpayers, in that order, is a timely, transparent, accurate, and honest account about what mistakes happened, how they are being fixed, and what concrete actions are being taken to ensure accountability.

It concerns me that my staff has been asking for further details on the deaths that occurred as a result of delays in care at VA medical facilities for months and only two days before this hearing did VA provide the information we have been ask-

ing for. Even then that information is far from a complete description of the problem and VA's efforts to prevent future deaths.

It concerns me even more that VA's briefing Monday and testimony today include very few details about what, if any, specific actions have been taken to ensure accountability for the twenty-three veterans who lost their lives and the many more who were harmed because they didn't get the care they needed in a timely manner.

On our first panel today, we are going to hear from a veteran who sought care through the William Jennings Bryan Dorn VA medical center in Columbia, South Carolina. That veteran—Mr. Barry Coates—is going to tell us that, and I quote, " . . . the gross negligence . . . and crippling backlog epidemic of the VA [health care] system has not only handed me a death sentence but ruined my quality of life . . . "

Mr. Coates waited for almost a year and would have waited even longer had he not actively, persistently insisted on receiving the colonoscopy that he and his doctors knew he needed. That same colonoscopy revealed that Mr. Coates had stage four colon cancer that had metastasized to his lungs and his liver. Maybe that is why VA does not want to define accountability in terms of employees who have been fired.

The department is going to testify this morning that, instead, we should focus our accountability efforts on correcting systems deficiencies in order to prevent adverse events from occurring again.

There is nothing wrong with fixing systems. But Mr. Coates deserves better than that. His adverse event already happened and, for him, there is no going back. With that, I now yield to acting ranking member Brown for any opening statement she may have.

PREPARED STATEMENT OF MICHAEL MICHAUD, RANKING MEMBER

Thank you, Mr. Chairman, for holding this hearing today. We all agree that patient safety and quality of care issues remain top priorities for this Committee.

I read with concern the testimony provided by our first two panels. All too often, members of this Committee hear the same issues raised again and again in reports by agencies such as the Government Accountability Office and the VA's Office of Inspector General.

Findings such as inadequate training, improper oversight, lack of guidance, no accountability, and failing to follow proper procedures already in place, are too common.

Mr. Chairman, I understand that the Department is a very large agency and not without its challenges. I also understand that mistakes are going to be made. I also believe no matter how transparent the Department is, something clearly has to change.

My frustration lies in the fact that findings are made and plans are implemented, but the situation does not seem to get better. Veterans, like Mr. Coates from our first panel, have suffered terribly from these ongoing mistakes. As Mr. Coates states in his testimony:

"I am not here today for me. I am here to speak for those to come, so that they might be spared the pain I have already endured and know that I have yet to face."

Mr. Chairman, we owe it to the veterans of this nation to do everything we possibly can to improve the processes that will help prevent such incidents' happening in the future, and ensure proper accountability for those who are responsible.

Veterans are not statistics, a number or a column on a spreadsheet. They are people who have fought for the freedoms we so enjoy today. We need to remember that and the Department needs to make much stronger efforts to turn this issue around.

In today's day of advanced systems and rapid technology development, there is no excuse for "losing track" of vital consults and appointments. Ensuring proper tracking and timely appointments is critical.

Mr. Chairman, I do not want to revisit this issue in six months. It is time to stem the tide of rationalizations and excuses. Let's get this done.

I look forward to hearing from our panelists today and want to thank everyone for being here.

Mr. Chairman I yield back the balance of my time.

PREPARED STATEMENT OF HON. CORRINE BROWN

Thank you, Mr. Chairman, for calling this hearing today. We can all agree that veteran safety and quality of care issues at the VA health facilities are of utmost concern for this Committee.

However, It is unfortunate that we must continually call these hearings to make sure that our nation's veterans are receiving the care for which they have already paid dearly for on the battlefields and in service to protect the freedoms we all hold most dear.

I find it disturbing that just two days before this hearing, the VA has releases findings that its healthcare personnel are not fully trained in the importance of timely consults when treating a veteran.

The dictionary defines a consult as the act of seeking information or advice from someone with expertise in a particular area.

The system the VA set up to make these consults easier obviously broke down and it is possible that at least ficve veterans died in Florida because the right information was not shared with the right health professionals.

I am concerned that in the five years after the colonoscopy debacle at the Miami VA, nothing has changed.

To refresh your memory, in 2009, staff members at a number of VA facilities noticed improper reprocessing of endoscopes contrary to the manufacturer's instructions. The VA properly ordered all facilities to Step-Up and get retrained on the procedures. We want employees to feel free to report questionable issue and procedures without fear of retribution for trying to save lives.

It seems that from this new consult problem that the retraining stopped at that one procedure.

The fact sheet your office put out regarding the consults talks a lot about procedure and adverse events. However, I have heard that before and again our veterans are suffering.

I look forward to hearing the testimony today and explanations for this lack of proper care and accountability for these mistakes.

VA we have appropriated much money over the years to overhaul your computer system, and yet, you could not separate that heart consults are of a higher priority than a ride across town?

What kind of training did employees get before and how is the training different now?

PREPARED STATEMENT OF HON. STEVE COHEN (TN 9)

Thank you, Chairman Miller, for allowing me to submit a statement into the record for today's hearing on preventable veteran deaths. While I do not sit on the VA Committee, today's hearing touches on an issue that unfortunately has affected veterans and their families in my home of Memphis, Tennessee. I appreciate the Committee for accepting my statement.

In October 2013, the VA Office of Inspector General released a concerning report regarding three deaths at the Memphis VA Medical Center Emergency Department. The report, which was based on a May 29–31, 2013 site visit, found that certain actions and inactions taken by physicians at the VA may have contributed to the death of the veterans mentioned in the report. I do not dispute the report's findings but instead am interested in learning what Congress and our VA medical centers can do to help prevent incidents like these from reoccurring in my home and at VA medical centers across America.

As soon as this report was released, I sent a letter to VA Secretary Eric Shinseki raising my concerns about its findings as well as those of my constituents. In the same spirit of learning what can be done to prevent avoidable deaths at VA medical centers, in my letter I also invited the Secretary to visit the Memphis facility to meet with Memphis veterans and hospital staff. I asked that he offer any suggestions that would improve care at the Memphis VA center—whether it be increased funding, personnel, technology or equipment.

While I am waiting to hear back from the Secretary's office regarding my invitation, I hope that the witnesses present at this hearing will offer corrective actions that can be taken to improve care at VA medical centers. I am also interested in their suggestions for incorporating standards of care at these facilities so that preventable deaths do not occur in the future.

I have been in close contact with Director C. Diane Knight at the Memphis VA Medical Center, who was appointed in July 2013. While the deaths and the IG site

visit occurred prior to her leadership, I am confident that the reforms she has put into place since becoming director and in light of the report will greatly improve patient care at the facility. I hope that the witnesses' testimonies will reflect this and again, offer constructive suggestions for how we all can work to improve conditions at the VA medical center in Memphis and across America. Our veterans bravely risked their lives for us and we owe them the very best care we can offer.

Mr. Chairman, again, thank you for accepting my statement and I look forward to reviewing the testimonies.

PREPARED STATEMENT OF BARRY L. COATES

My name is Barry Lynn Coates and due to the inadequate and lack of follow up care I received through the VA system, I stand before you terminally ill today. I joined the Army in February of 1991 anxious to serve my country. Near the end of basic training an injury to my back derailed those plans and I was discharged around the first of May that same year.

After a five year fight to obtain service connection status for my injury and the treatment and pain management required as a result of it, I finally became eligible for medical treatment through the VA system. That was the start of the long, painful, emotional, and unnecessary journey that brings me to you.

On November 22, 2010 severe abdominal pain sent me to Carolina Pines Regional Medical Center in Hartsville SC, where a spinal CT showed that my lungs were clear and my liver were normal however, there was blood seen in the stool so a follow-up was recommended and consideration of a colonoscopy was suggested. That follow-up recommendation was completed at the Rock Hill Clinic with Dr. Anuradha Verma on January 20, 2011. No rectal exam was done, I was basically told to continue taking my medications previously prescribed and to come back if things did not improve or things got worse.

Due to increased pain and constipation, on February 25, 2011 I requested to be seen by a doctor or to be referred to a GI Specialist. I saw Dr. Verma again on March 3, 2011 because of increased pain and rectal bleeding. I reminded her of the suggestion made by the ER doctor that a colonoscopy might be needed. I was sent home with hemorrhoidal suppositories and the promise that a colonoscopy might be done at some point. I was not seen until May of 2011 and the results were the same.

I had relocated in October 2010 but had to continued to be seen at the Rock Hill, SC Clinic due to the back log at the Florence, SC Clinic. I was first seen by Dr. Eric Naumann at the Florence Clinic in June 2011. He started by putting me on 100 mg of the stool softener "Docusate" in order to counteract the constipation caused by narcotics necessary to treat the ongoing back pain to my previous injury. He also expressed dismay that this had not be done previously. Most importantly, he agreed that a colonoscopy needed to be done.

However my first GI consult did not occur until August 2011 with Dr. Sylvia Kim. I informed Dr. Kim of the ongoing pain, constipation, and bloody stools that I had been dealing with for over a year only to repeatedly have it dismissed as hemorrhoids. I was simply told to return in two months, still no referral for colonoscopy despite my request. In a conversation with Andy Pigge, Rn at the Florence Clinic, I made it known that my requests were being ignored and I felt it was jeopardizing my health.

On September 1, 2011 after ample time on the Docusate I sent Dr. Naumann a message via my *healthyvet.com* informing him that I was still bleeding every bowel movement and still experiencing pain. As of September 15, 2011 I began having trouble urinating in addition to the other problems and only found some relief sitting in warm water. Dr. Naumann was informed of these new symptoms at this time. He stated that I may need to see a surgeon and may need to be considered for a colonoscopy. Dr. Naumann requested for the second time a colonoscopy October 4, 2011.

I saw Dr. Kim October 12, 2011 and told her that the pain was now constant as well as the rectal bleeding and that my stools have become smaller and bright red in color. I was finally scheduled to have a colonoscopy consultation in April of 2012, which would be approximately a year and a half after the beginning of this journey.

Tired of living in constant pain and knowing that my problems were bigger than hemorrhoids, I persistently called on the chance that there might be an earlier opening or cancellation. I was able to secure an opening for consultation appointment for November 30, 2011 and finally had the colonoscopy done December 9, 2011. The procedure was done at the Fort Jackson Hospital by Dr. Steedman Sarbah which found that I had a 5.5 mm nodule located six to eight centimeters from the anal

verge with almost total luminal obstruction. I was diagnosed with stage four colon rectal cancer. Further tests revealed metastatic nodules on the right lung in the upper lobe along with liver lesions. It was stated that because of the post proximity of the nodules to anal verge a proper rectal exam would have easily found it and prompted treatment sooner.

I saw Dr. Kim days later on the 14 of December 2012 and expressed to her sentiments of the doctor that performed the colonoscopy along with my own that a doctor should take time to listen to her patients as they know their bodies and can often sense when something is wrong. After "supposedly" not being able to feel the tumor during prior exam after seeing the images she was suddenly able to locate it easily.

I had surgery on December 16, 2012 for a post diverting loop colostomy and started chemotherapy in January of 2012 followed by 26 radiation treatments. The tumor was removed July 22, 2012 with a total anal recession. I have since had to endure a permanent colostomy which requires multiple bag changes per day along with catherization several times daily because of the bladder nerves being severed in order to remove the tumor. I am totally and permanently impotent as well as incontinent. The extensive chemotherapy has resulted in permanent neuropathy in both my hands and feet causing constant discomfort and pain.

A follow up exam on April 2, 2014 has shown even further spreading of cancer with new lesions on my liver, multiple new lesions on both lungs, plus growth of the existing lesions and a referral for a MRI as the doctor fears it may have spread to my brain. Another round of Chemotherapy would have been started immediately but was postponed so I would be able to come and speak to all of you.

It is likely too late for me, the gross negligence of my ongoing problems and crippling backlog epidemic of the VA medical system has not only handed me a death sentence but ruined the quality of my life I have for the meantime. I am not here today for me, I am here to speak for those to come so that they might be spared the pain I have already endured and know that I have yet to face.

My situation is made even more unnecessary knowing that a 1.2 million dollar grant was given to the Dorn VA Center to reduce backlog and improve care and treatment of veterans only to learn that the money was misallocated by diverting it to other uses instead of using it for the intended purpose. Only 1/3 of those funds were used properly.

Men and women across this country volunteer every day to serve in the armed forces. The fact that our military stays well-manned and strong solely on the willingness of those volunteers to risk their lives for the protection of the nation as a whole is truly awe-inspiring. Other nations have to force service in order to maintain a strong military. The very least this country should do is to ensure that those volunteers are taken care of after they have made sacrifices to take care of our country. I am not a unique case in the VA health care system as 19 others have already died and 60 more are in the same terminal status. I am here because proper care was not given exams were not performed properly, and diagnostic tests were either postponed or not done at all.

In the civilian world, these doctors would face malpractice suits and medical review boards. As the saying goes "heads would roll." In the VA system oversight is not as clear cut and complaints are often either lost or covered up by bureaucracy. So I ask you today, how many more vets will be allowed to suffer and die before someone is held accountable?

Thank you for your time,

Barry Coates

STATEMENT OF
DANIEL M. DELLINGER, NATIONAL COMMANDER
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"A CONTINUED ASSESSMENT OF DELAYS IN VA MEDICAL CARE AND PREVENTABLE VETERAN DEATHS"

APRIL 9, 2014

In November of 2013, on the heels of delays and patient deaths at the G.V. (Sonny) Montgomery VA Medical Center referred to as "kerfuffles" by senior VA officials[1], the Oversight and Investigation (O&I) subcommittee of this committee held a hearing entitled "Correcting 'Kerfuffles' – Analyzing Prohibited Practices and Preventable Patient Deaths at Jackson VAMC" During that hearing, Chairman Coffman requested a report from the Department of Veterans Affairs (VA) witness on how the facility is specifically addressing the concerns raised by whistleblowers about understaffing, overbooked patients, lack of oversight and lack of access, and requested that report be delivered within 30 days.

The very next day, November 14, 2013, The American Legion contacted the Veterans Health Administration (VHA) and requested a copy of the same report. As of today, nearly five months later, VHA has yet to provide that report.

During an American Legion System Worth Saving Task Force site visit to Jackson, Mississippi from January 20-22, 2014 facility director Joe Battle was unable to provide the action plan the facility was using to address problems with patient deaths. Director Battle stated he could not release the report because it had not been cleared by VA Central Office (VACO). Repeated follow up requests for information to VHA by American Legion staff have been met with the response that VHA cannot release this information to The American Legion. The reason provided has been that could VA's Office of Congressional Legislative Affairs (OCLA) has not cleared or sent this response to Congress. The American Legion is not acting as an arm of congressional oversight and should have access to, and should expect timely delivery of information about patient safety.

This lack of communications with key stakeholders hurts the entire healthcare system because it undermines veteran trust in what is otherwise an excellent healthcare system designed and operated for veterans. The American Legion has historically enjoyed excellent communications with VHA and with Congress. We are not sure what has caused the recent breakdown, but as a congressionally chartered veteran service organization, The American Legion has a responsibility to its members, congress, and a nation of veterans to gather and inform this necessary information. Clear, complete and open communication is of paramount importance in

[1] http://www.cnbc.com/id/101187855 "There have been some public kerfuffles in the paper that don't in my mind reflect the Jackson VA facility,"

matters of patient security and safety. These lines of communication must be opened and must remain open.

Chairman Miller, Ranking Member Michaud and distinguished Members of the committee, on behalf of the 2.4 million members of The American Legion, I thank you and your colleagues for the attention you are devoting to the serious concerns that have surfaced in some locations within the Department of Veterans Affairs (VA) Healthcare system. The VHA oversees the nation's largest integrated healthcare system, operating 152 medical centers, nearly 1,400 Community Based Outreach Clinics (CBOCs), community living centers, Vet Centers, and Domiciliaries. Over 8.3 million veterans rely on VHA for their healthcare needs. Most of the time, those veterans receive excellent care and have justified trust in the system. When that trust is broken, restoration of trust is critical.

The American Legion's primary healthcare evaluation tool is the "System Worth Saving" program. The program was designed and implemented in 2003[2] by American Legion Past National Commander Ron Conley. The mission of the System Worth Saving program is to assess the quality and timeliness of veterans' healthcare and to gather feedback from veterans on their level of care. The System Worth Saving Task Force conducts site visits to 15-20 Department of Veterans Affairs (VA) Medical Facilities every year and each year focuses on one or more quality of care and/or health care issues affecting veterans. The reports from these site visits are compiled into an annual publication which is distributed to the President, Members of Congress, Senior VA Officials and American Legion members. This is our 10th year conducting the program and as such we want to focus on VA's accomplishments and progress over the past ten years, current issues and concerns as well as VA's five-year strategic plan for several program areas.

Many of the visits over the past year have also made a specific effort to focus on the sites where areas of VA mismanagement have recently been highlighted by news events or whistleblowers. Because The American Legion believes in the importance of eyes-on fact finding, having boots on the ground is critical to our responsibility in the role of third party oversight. The American Legion has 2.4 million members, many of whom utilize VHA facilities on a regular basis. It is vital to them and to all veterans we serve that they have trust in their healthcare system through transparency and honest reporting.

The following summarizes some of the key findings at critical locations from the last year's System Worth Saving visits:

Pittsburgh, Pennsylvania (NOV 4-7, 2013)

Issue: By now, the struggles of the VA Pittsburgh Healthcare System (VAPHS) have been well documented. During the fall of 2012, VAPHS noticed an unusual pattern of *Legionella* pneumonia cases. This observation led the facility to investigate a possible environmental link between its patient cases and their internal water system. In April 2013, the VA Office of the Inspector General (OIG) performed an evaluation to determine whether VAPHS was adequately

[2] http://archive.legion.org/bitstream/handle/123456789/401/2004n206.pdf?sequence=2 Resolution 206 - Annual State of VA Medical Facilities Report - AUG 2004

maintaining its system for preventing Legionnaire's Disease. Ultimately, that review found systemic failures within VAPHS that led to the Legionella outbreak. Three days after the OIG review, VA Regional Director, Michael Moreland received the government's highest career award for civil servants that included a $62,895 bonus.

Veteran Feedback: During the Veterans Town Hall Meeting conducted by The American Legion's System Worth Saving Task Force, veterans expressed disappointment with the medical center's lack of ability to properly communicate how it was handling the Legionella outbreak. The veterans were not initially aware of the outbreak, nor were they informed of the steps VA was taking to ensure their safety. Veterans at the Town Hall also voiced their concerns with access to mental health care. Several veterans stated reaching an actual operator through the phone system and getting access to the pain-management program was difficult. One veteran had to wait three months before getting into VA's pain-management program. Another veteran had waited more than eight months to have his eye condition taken care of.

Legion Response: The System Worth Saving Task Force conducted a site visit of the Department of Veterans Affairs Pittsburgh Healthcare System's Oakland Campus. For this visit specifically, the Task Force also addressed the medical center's issue of *Legionella*. During the visit, the Task Force was able to meet with the medical center's Water Safety Committee, which provides oversight on all issues related to the ongoing mitigation of *Legionella* in the water distribution system. After the medical center conducted a Root Cause Analysis (RCA) on *Legionella,* the report found that not everyone understood their roles and responsibilities with *Legionella,* which led to the establishment of a Water Safety Committee in January 2013. The Committee meets twice a month and reviews ongoing remediation efforts, assures policy adherence, testing schedule adherence, and records maintenance with the goal of assuring that VAPHS water supply is safe for the consumer. While VAPHS now claims it is the "safest medical center in the country" when it comes to testing for *Legionella*, The System Worth Saving Task Force discussed the medical center's challenges with transparency and public relations, and recommended that the medical center make better use of getting the word out to Veterans Service Organizations and communicate their aggressive approach taken to test the water.

The American Legion recommended that significant improvement is needed in the ability of the local VA medical center to respond to crises. According to VAPHS, and in discussions with VACO staff afterwards, VAPHS facility staff had a press release and response to the crisis prepared, but VACO's review process takes several weeks to a month to provide approval, and ultimately the release was never approved by VACO leadership. The American Legion believes VACO must examine the communication structure and policies to look at opportunities to reduce time in responding to crises, along with delegation of authority, responsibility and accountability to local VA facility leadership to more effectively and efficiently respond during a crisis.

Jackson, Mississippi (JAN 20-22, 2014)

Issue: The G. V. Sonny Montgomery VA Medical Center in Jackson, Mississippi (JVAMC) has also undergone intense scrutiny over the last year. Multiple whistleblower complaints have been raised by employees who were losing confidence in the medical center's ability to treat veterans.

The complaints ranged from improper sterilization of instruments to missed diagnoses of fatal illnesses, as well as hospital management policies.

On November 13, 2013 the JVAMC participated in a House Veterans Affairs Committee (HVAC) subcommittee hearing entitled, "Correcting Kerfuffles." The purpose of the hearing was to discuss the policies and response of the Department of Veterans Affairs (VA) in the wake of allegations concerning the JVAMC. The hearing originated from a letter that was sent from the Office of Special Counsel (OSC)[3] about several complaints at the JVAMC. The letter was sent to the President and congressional leadership stating it had found a pattern of problems at the JVAMC. The letter cited five separate complaints over the last six years to include poor sterilization procedures, chronic understaffing of Primary Care, and missed diagnoses and poor management by the radiology department.

The heartbreaking focus of that hearing was a veteran who had been hooked up to a hospital machine without proper supervision, ultimately resulting in all of the blood being drained from the veteran's body. The American Legion was concerned that VACO leadership had referred to the problems cited by whistleblowers as "kerfuffles" when veteran lives had been lost.

Veteran Feedback: Over 70 local veterans as well as the JVAMC Director and several members of his staff attended the Town Hall Meeting hosted by The American Legion Task Force. The medical center said that it was important for them to be present to answer any questions that the veterans would have. As The American Legion has noted elsewhere in this testimony, direct communication between local VA facilities and the communities they serve is critical to maintaining a trusting relationship.

Throughout the meeting, veterans were given an opportunity to express their concerns about the Jackson VAMC. A mother of an OIF and OEF veteran stated that her son suffered severely from PSTD upon his return from the conflicts and that the veteran was placed on several medications that were changed constantly, without an explanation. The mother went on to say that after several visits to the mental health clinic, her son's primary care physician told him to "Man Up". The head patient advocate spoke directly to the mother and assured her that he would get to bottom of it.

The veterans at the Town Hall meeting felt reasonably confident that the local JVAMC staff was addressing the past issues addressed in the Congressional hearing.

Legion Response: During the November hearing mentioned above, Chairman Coffman requested that JVAMC provide a full accountability report within 30 days to the Oversight and Investigation (O&I) subcommittee. So far VA has not released this report. On November 14, 2013, The American Legion requested a copy of the report and as of this hearing; The American Legion has not received a copy either.

During our System Worth Saving Task Force site visit, facility director Joe Battle was unable to give The American Legion a copy of the action plan the facility has taken to address the

[3]Re: OSC File Nos. DI-11-1625 and DI-11-2518, March 18, 2013

preventable deaths. Director Battle stated that he could release the report because it was not cleared by VA Central Office.

Upon further requests for this information after our site visit, Veterans Health Administration staff told us that they could not release the report because Office of Congressional Legislative Affairs (OCLA) had not cleared or sent this response to Congress. Not only is Congress waiting for this information but the delays in OCLA responding to Congress have now spilled over and are affecting the abilities of The American Legion to effectively conduct our site visits and inform veterans in the communities of the risks, or mitigations of those risks within these hospitals. In conversations with VACO staff, they reported that OCLA was first sent the action plan from VHA on December 6 has not approved or sent the response to Congress. Furthermore, OCLA came back to VHA on March 26 to have VHA update the document due to the time lag and the information is now outdated.

Congress, Veteran Service Organizations, and veterans that are being treated at medical centers are frustrated, confused and feel inherently out of the loop. Nobody knows what steps VA has taken to resolve problems and that has led to a diminished confidence and renewed interest to press for more accountability on management of these facilities. Veterans in these communities continuously read newspaper articles which may or may not accurately portray the action plan and steps VA is taking to correct issues. Because of the lack of communication and timeliness of VA offices in Washington DC to work together across VA Central Office and in responding to congressional inquiries, the problem is only exacerbated.

According to a source from the Jackson facility that preferred to speak anonymously, three of the five complaints have been closed. The last review of Supply Processing Service (SPS) conducted by the network occurred in December 2012; this resulted in no corrective action needed. SPS is monitored on a daily basis and complies with VACO inspection and monitoring requirements, according to the medical center. Of the two current complaints, one alleges Quality of Care issues from a staff Radiologist identified in a 2010 non medical (pay issue) lawsuit. These issues were extensively reviewed at the time and closed in 2008. The Radiologist in question left VA employment in 2007.

Again, The American Legion cannot stress more clearly the importance of free and open communication between VHA facilities and the veterans in the communities they serve. Veterans died at this facility due to preventable errors, but the facility is not empowered to directly engage the community and allay any fears they may have about seeking care there.

Atlanta, Georgia (JAN 28, 2014)

Issue: The VA Office of the Inspector General identified serious instances of mismanagement at the Atlanta VA Medical Center in two reports dated April 17, 2013[4][5]. The incidents chronicled in the reports led to the drug-overdose deaths of two patients and the suicide of another. The VA Inspector General linked three patient deaths in 2011 and 2012 to mismanagement and lengthy waiting times for mental health care.

[4] http://www.va.gov/oig/pubs/VAOIG-12-03869-179.pdf
[5] http://www.va.gov/oig/pubs/VAOIG-12-02955-178.pdf

Veteran Feedback: During the Veterans Town Hall Meeting conducted by The American Legion's System Worth Saving Task Force, veterans primarily expressed their concerns with Atlanta VAMC's phone system, and poor customer service.

Legion Response: Unfortunately, The System Worth Saving Task Force visited Atlanta's VAMC was condensed to one day due to severe weather conditions. Because of the compressed schedule, each department of the medical center provided abbreviated interviews. Nevertheless, in the short time the Task Force was there, the Atlanta VA Medical Center claimed that VA OIG has closed out all of their recommendations.

The recommendations addressed included:

- Employing safeguards for documentation that accurately reflect staff observation of patients
- Strengthening program oversight including follow-up actions taken by leadership in response to patient incidents
- Equipping functional and well-maintained life support equipment

The medical center also claimed there was no direct linkage between the three patient deaths and mismanagement in mental health care.

The American Legion followed up with a conference call with Atlanta VAMC in an effort to further understand what happened and what steps are in place to reassure veterans' confidence in Atlanta's mental health care. The American Legion found that between 2009 and April 2013, the Medical Center had referred out a total of 4,912 Veterans to the community for contract mental health care. During that time, the Medical Center lacked a reliable process for following up on outsourced services and was unable to determine the treatment status of its referred veterans.

Atlanta VAMC's ultimate goal is to provide most, if not all, veterans' mental health care in house, and the Community Service Board (CSB) contracts were the medical center's way of ensuring that veterans were receiving mental health care in a timely manner. The Atlanta VA strengthened its monitoring and management of its contract mental health program and the facility has reduced the number of contracts it has with mental health organizations (from 26 to 6) while it has strengthened and added quality assurance monitors to the contracts. The Atlanta VAMC currently has 11 licensed clinical social workers/case workers embedded in CSB sites to coordinate care for veterans; they now have improved mechanisms to track clinical and financial data for every referral. The average number of individuals assigned to each VA case worker is 180 and an experienced supervisory social worker manages the embedded case worker program.

In order to reduce the number of veterans on CSB contract, the medical center needs additional space and staff in order to treat more, if not all, veterans in house. In 2015, the medical center plans to activate a new 86,000 square foot outpatient annex and a 15,000 square foot clinical addition that will provide much needed space for additional mental health services. The VAMC is awaiting final congressional approval for its replacement clinic in Cobb County that will increase the clinic's size from 8,000 square feet to 60,000 square feet. With the inability of

Congress to resolve the Congressional Budget Office (CBO) scoring issue, more veterans are being treated outside the VA system.

The medical center has requested The American Legion's assistance in restoring veterans' confidence in the medical center, and the medical center plans to restore this confidence with increased communication, increased transparency, and training for staff to directly communicate with veterans and stakeholders.

The American Legion believes resolution of the CBO scoring issue for CBOCs will help alleviate some of the scheduling concerns, and reiterates the need for better contact with the community. Chairman Miller and Ranking Member Michaud's bipartisan "Department of Veterans Affairs Major Medical Facility Lease Authorization Act of 2013[6]" would provide immediate solutions for many CBOCs, and The American Legion supports this legislation[7] and is is glad the House of Representatives saw fit to pass this bill in December of 2013. It is critical the Senate take action and help resolve this problem for the CBOCs.

Augusta, Georgia (MAR 11-12, 2014)

Issue: At the Charlie Norwood VA Medical Center (CNVAMC), medical center leadership first learned of delays in providing gastrointestinal (GI) services to veterans on August 30, 2012 according to interviews conducted during The American Legion System Worth Saving Task Force site visit. Of the 4,580 delayed GI consults, a quality management review team determined 81 cases required physician case review. Seven of the 81 cases may have been adversely affected by delays in care. Six of seven institutional disclosures were completed and three cancer-related deaths may have been affected by delays in diagnosis. Factors contributing to the 4,580 patient backlog included an explosion of baby boomers turning 50 who now require screening, the medical center's non-anticipation of a spike in GI consult demand, lack of an integrated data base for tracking GI procedures, and GI physician recruitment challenges.

Veteran Feedback: During the Veterans Town Hall Meeting conducted by The American Legion's System Worth Saving Task Force, veterans voiced concerns with the medical center's ability to provide other timely specialty care, specifically pain management and eye care rather than focusing solely on the backlog of GI patients. One veteran waited 8 months for a pain-management appointment and wait times for eye care appointments averaged 6 months. Veterans and family members mentioned problems with receiving service dogs, information sharing, problems with prescription inaccuracies, and a lack of care giver resources.

Legion Response: The American Legion Task Force focused on the VAMC's steps taken to address 4,500+ delayed GI consults, as well as the quality of care offered at the Charlie Norwood VAMC.

During the visit, the Task Force found that the medical center needs to increase transparency, provide crisis information immediately, and provide general health care information, on a regular

[6] H.R. 3521

[7] Resolution 24: "Congressional Budget Office Scoring on Department of Veterans Affairs Leasing" MAY 2013

basis. CNVAMC needs improved communication with the local community, including media representatives, potential hires, current employees, veteran's service organizations (VSO), family members, and patients.

The American Legion recommended strategic communication improvements, including empowering the CNVAMC public affairs office and other VAMCs to share information immediately, especially when responding to local media requests. Since patient safety is first and foremost, the Department of Veterans Affairs Central Office (VACO) should delegate information release at the lowest level that is still properly trained to respond, especially in response to crises, such as a possible link between GI backlog and 3 cancer-related veteran patient deaths.

According to discussions with CNVAMC staff, the medical center had a communications plan to address GI backlog developments, but the release of information from VACO leadership was not approved in a timely manner. VACO should examine its communication structure and policies and harness opportunities to reduce time in responding to crises, along with delegation of authority, responsibility and accountability to local VA facility leadership to effectively and efficiently respond during a crisis.

The Charlie Norwood Medical Center is faced with negative news stories based on 18-month-old information because the communications team is not empowered to proactively communicate with their community. With two sides to every story, Charlie Norwood and the VA are missing opportunities to restore veterans' confidence in their health care, entice new veteran enrollees, and entice future VA staff, in an economy where potential employees can work at other local better publicized medical facilities with higher wages.

Columbia, South Carolina (APR 15-16, 2014)

Issue: In September 2013, six deaths were linked to delayed screenings for colorectal cancer at the veterans' medical center in Columbia, S.C. The VA's inspector general determined that the William Jennings Bryan Dorn VA Medical Center fell behind with its screenings because critical nursing positions went unfilled for months. It also found that only about $275,000 of $1 million provided to the hospital to alleviate the backlog of screening cases had been used over the course of a year. The hospital had also made an effort to reduce the care provided to veterans by doctors outside the VA system, and such care had in the past been used to address backlogs.

Legion Response: Following the OIG's report[8], The American Legion reached out to the OIG in early December 2013 to discuss their findings. During the discussion, OIG discussed the process involved that led to the backlog. According to the OIG, the patient's Primary Care Provider (PCP) sends a GI Consult electronically in the medical center's GI administration system. The OIG found a lack of proper oversight of this process led to no one monitoring the consults coming in, which ultimately led to the backlog buildup. According to OIG, another

[8] VA OIG Report No. 12-04631-313 Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina

factor that may have led to the buildup was the high turnover and numerous positions filled in an "acting role" that had been occurring in all of the medical centers within the Veterans Integrated Service Network (VISN) 7. This turnover may have hampered continuity and moral issues.

From April 15-16, 2014, The American Legion's System Worth Saving Task Force will conduct a site visit of the William Bryan Jennings Dorn VA Medical Center in Columbia, SC. During the visit, the Task Force will focus on the VAMC's steps taken to address the delayed GI consults, as well as the past, present, and future of healthcare offered at the medical center.

Overall Conclusions:

Veterans need to know that the VA healthcare system is a safe place, where they can receive treatment and feel assured that patient safety is a top priority. However, because errors and lapses can occur in any system, The American Legion expects when such errors and lapses are discovered, that they are dealt with swiftly and that the responsible parties are held accountable. This is why The American Legion supports H.R. 4031: the Department of Veterans Affairs Management Accountability Act of 2014.

When veterans see mismanagement practices in their healthcare system that put the patient's health at risk, veterans want to see a leadership commitment from the top down that says their health and safety are the top priority of VA. H.R. 4031 gives the Secretary of Veterans Affairs the tools he needs to help convey that message back to veterans and help ensure veterans have faith and trust in the systems designed to provide health care to them and to care for their wounds of war. This legislation would also provide tools to the Secretary to better manage Senior Executive Service employees, and hold them accountable when they fail to perform their duties in a manner that better serves the veterans entrusted to their care.

In addition to accountability, better transparency and communication is needed. Veterans are left with questions and concerns that local facilities cannot respond to due to restrictions placed on their ability to communicate with the community by Central Office in Washington, DC. The American Legion believes that VA's 152 medical centers should be trained and empowered to respond and provide proper disclosure during events (good or bad) and that VA consolidate and streamline their crisis response time standards regarding reporting and on communication.

Time and time again, throughout the System Worth Saving Task Force visits, The American Legion found situations where improved communication on a local level with the veterans' community would have helped reduce fear and alleviated concerns about safety. The relationship between the veterans and the Department of Veterans Affairs that serves them must be based on trust and mutual support. None of this can exist without free, open and honest communication.

The American Legion thanks this committee again for their diligence in pursuit of the troubling concerns of patient safety. The commitment of all parties to ensuring veterans receive quality healthcare in a safe environment is a sacred duty.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or ideplanque@legion.org

DANIEL M. DELLINGER
NATIONAL COMMANDER
THE AMERICAN LEGION

Daniel Dellinger of Vienna, VA., was elected National Commander of the 2.4 million-member of The American Legion on August 29, 2013 in Houston, Texas during the 95th national convention of the nation's largest veterans organization.

He became an Army Infantry officer after graduating with a degree in criminology from Indiana University of Pennsylvania. He served at Fort Benning, GA., during the Vietnam War and entered the U.S. Army Reserve in 1972, separating from the service in 1984 at the rank of captain.

A member of the Dyer-Gunnell American Legion Post 180 in Vienna since 1982, he was made a life member in 1990. He has served as post, district and department commander and chaired numerous committees. At the national level, he chaired the Legislative, National Security, and Economic commissions as well as the Aerospace Committee. He served as chairman of the Legislative Council and Membership and Post Activities Committee. He has been a member of the Foreign Relations Council, Policy Coordination, Veterans Planning and Coordinating committees as well as the Legislative Council.

Dellinger is a member of the Sons of the American Legion, Past Commanders and Adjutants Club, Past Department Commander's Club, ANAVICUS and the Citizens Flag Alliance. He has served as a presidential appointee on the Federal Taskforce on SBA Hiring and as vice mayor of the Town of Vienna, Virginia as well as serving three terms as town councilman. He is a member of the Loyal Order of the Moose and the Loyal Order of the Kentucky Colonels.

He owned and operated a construction management and general contracting firm for twenty years specializing in commercial, institutional and industrial construction.

Dellinger and his wife, Margaret, reside in Vienna. Margaret served as American Legion Auxiliary Unit 180 President for four years; daughter, Anne, is a 23-year member of Unit 180; and son, Scott, is a 28-year member of Sons of The American Legion Squadron 180.

Commander. Dellinger's theme is **"Building for Tomorrow – Today."**

WRITTEN STATEMENT OF
THOMAS LYNCH, M.D.
ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH
FOR CLINICAL OPERATIONS
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

APRIL 9, 2014

Good morning, Chairman Miller, Ranking Member Michaud, and members of the Committee. Thank you for the opportunity to discuss health care at the Department of Veterans Affairs' (VA) medical facilities across the country. I am accompanied today by Dr. Carolyn Clancy, Assistant Deputy Under Secretary for Health for Quality, Safety and Value.

VA is committed to consistently delivering exceptional health care, which our Veterans have earned and deserve. Each year, the Veterans Health Administration's (VHA) workforce of over 200,000 health care professionals and support staff seek to provide competent and compassionate care to approximately 6.3 million patients. VHA's facilities are consistently recognized by The Joint Commission and other internal and external reviews of quality and safety. The Joint Commission recognized 19 VA medical facilities as top performers in 2011/2012 and 20 VA medical facilities in 2010. Nine VA facilities have been rated as top performers for 2 consecutive years – a noteworthy distinction. We operate with an unwavering commitment to fostering a culture that evaluates errors in order to avoid repeating them in the future.

VHA is the largest integrated health care system in the country, providing 85 million total health care appointments last year and 25 million consultations at more than 1,700 VA health care sites throughout urban and rural America. Regrettably, as in any large health care system, errors do occur. VA is deeply concerned about the impact of every mistake. VA constantly strives to eliminate administrative and systemic errors, including those attributed to leadership and training shortfalls.

When incidents occur, we identify, mitigate, and prevent additional risks. Prompt reviews prevent similar events in the future and hold those responsible accountable.

Allegations of misconduct by employees also are taken seriously. When we learn of credible allegations of misconduct, VA addresses them immediately. In each of the past two fiscal years, approximately 3,000 employees were removed from service at VA – nearly 1 percent of the workforce – due to poor performance or misconduct. In addition, six Senior Executives were removed from Senior Executive Service over the last two years.

In addition, there are multiple layers of oversight within VA and VHA. VA's Office of the Inspector General (OIG) conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter criminal activity, waste, abuse, and mismanagement. VHA's Office of the Medical Inspector (OMI) is responsible for investigating the quality of medical care provided by VHA. OIG or OMI have conducted inspections at several of the facilities mentioned in the hearing invitation letter. They have provided recommendations to guide our actions related to their findings, and we are following through with our action plans.

In delivering the best possible care to our patients, one of VA's most important priorities is to keep our patients free from further illness or injury during their time at our facilities. In some cases, we have not done so, and I am saddened by any adverse consequence that a Veteran might experience while in or as a result of care at one of our medical centers. We send our sincerest condolences to those Veterans and their families.

In 1999, the Department established a National Center for Patient Safety (NCPS) to lead our efforts in patient safety and to develop and nurture a culture of safety throughout VHA. Since its inception, NCPS has implemented a variety of programs associated with improvements in safety such as adverse event reporting, Clinical team training, checklist utilization in operating rooms, and others. Every VA medical center now has at least one patient safety manager. These managers work to reduce or eliminate preventable harm to patients. They do this, in part, by investigating system-level vulnerabilities. There is strong evidence that errors occur because of system or process failures.

No hospital system can eliminate all errors, but our Department is designing systems that reduce the likelihood of preventable errors and lessen the potential harm to patients from errors that do occur. VA relies on a tool called Root Cause Analysis (RCA) to determine the basic and contributing system causes of errors. RCAs study adverse events and close calls with the goal of finding out what happened; how it happened; why the systems allowed it to happen; and how to prevent what happened from happening again.[1] Use of this model has informed the design of inpatient psychiatric wards contributing to a sharp decline in inpatient suicides.

Conclusion

As stated earlier, the Department of Veterans Affairs is committed to providing the highest quality care, which our Veterans have earned and deserve. We will continue to identify, mitigate, and prevent vulnerabilities within our health care system, wherever we find them, and we will continue to ensure accountability and maintain a culture in which accountability principles are clearly stated. And when adverse events do occur, we will identify them, learn from them, improve our systems, and do all we can to prevent these incidents from happening again.

Mr. Chairman, this concludes my testimony. I appreciate the Committee's continued interest in the health and welfare of America's Veterans. At this time, my colleagues and I are prepared to answer your questions.

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[1] http://www.patientsafety.va.gov/CTT/index.html.

United States Government Accountability Office

Testimony
Before the Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m. EDT
Wednesday, April 9, 2014

VA HEALTH CARE

Ongoing and Past Work Identified Access Problems That May Delay Needed Medical Care for Veterans

Statement of Debra A. Draper
Director, Health Care

GAO-14-509T

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

I am pleased to be here today as you examine issues related to delays in medical care provided by the Department of Veterans Affairs' (VA), Veterans Health Administration (VHA). In fiscal year 2012, VHA provided nearly 84 million outpatient medical appointments to veterans through its primary and specialty care clinics, which are managed by VA medical centers (VAMC).[1] Although access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, problems with VHA's scheduling and management of outpatient medical appointments may contribute to delays in care, or care not being provided at all. Over the past few years there have been numerous reports of VAMCs failing to provide timely care to patients, including specialty care, and in some cases, the delays have resulted in harm to patients.[2] Nonetheless, VHA has reported continued improvements in achieving timely patient access to medical appointments. For example, in fiscal year 2011, VA reported that VHA completed 89 percent of medical appointments for new patients within its goal; in fiscal year 2012, VA reported that VHA completed 90 percent of primary and specialty care new patient appointments within the goal.[3] However, in December 2012, we reported that VHA's medical appointment wait times were unreliable and VHA's inadequate oversight of the outpatient medical appointment

[1]Outpatient clinics offer services to patients that do not require a hospital stay. Primary care addresses patients' routine health needs, and specialty care is focused on a specific specialty service such as cardiology or gastroenterology.

[2]See, for example, Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina*, Report No. 12-04631-313. (Washington D.C.: September 6, 2013), and Department of Veterans Affairs, Office of Inspector General, *Healthcare Inspection Consultation Mismanagement and Care Delays Spokane VA Medical Center Spokane, Washington*, Report No. 12-01731-284. (Washington D.C.: September 25, 2012).

[3]In fiscal year 2012, VHA's appointment wait time goal for primary and specialty care appointments was 14 days from the patient's or provider's desired appointment date. According to VHA's scheduling policy, the desired appointment date, referred to as the "desired date," is the date on which the patient or provider wants the patient to be seen.

scheduling processes contributed to VHA's problems with scheduling timely medical appointments.[4]

When a physician or other provider determines that a veteran needs outpatient specialty care, the provider refers the veteran to a specialist for a clinical consult—a request for evaluation or management of a patient for a specific clinical concern, or for a specialty procedure such as a colonoscopy. VAMCs request and manage outpatient consults through an electronic system that retains information about each consult request and is part of VHA's Veterans Health Information Systems and Technology Architecture (VistA).[5] Ideally, the consult system would contain timely and reliable information on the status and outcomes of consults, and would provide VHA information it needs to help effectively manage the process. In 2012, however, VHA found that systemwide consult data could not be adequately used to determine the extent to which veterans experienced delays in receiving outpatient specialty care. As a result, in May 2013, VHA launched an initiative to standardize aspects of the consult process, with the goal of developing consistent and reliable information on consults across all VAMCs.

Appointments resulting from outpatient consults, like other outpatient medical appointments, are subject to VHA's scheduling policy.[6] This policy is designed to help VAMCs meet their commitment to scheduling medical appointments with no undue waits or delays for patients. It establishes processes and procedures for scheduling medical appointments and ensuring the competency of staff directly or indirectly involved in the scheduling process. Additionally, it includes several requirements that affect timely appointment scheduling, as well as accurate wait time measurement. For example, the policy requires schedulers to record appointments in VHA's VistA medical appointment scheduling system.

[4]GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012).

[5]VistA is the single integrated health information system used throughout VHA in all of its health care settings. It contains patients' electronic health records.

[6]VHA medical appointment scheduling policy is documented in VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010). We refer to the directive as "VHA's scheduling policy" from this point forward.

My statement today will draw from ongoing work examining the management of outpatient specialty care consult processes at five selected VAMCs, and our December 2012 report examining the reliability of VHA's reported outpatient medical appointment wait times data and scheduling oversight.[7] In particular, this statement highlights (1) preliminary observations from our ongoing work, and (2) key findings and recommendations from our December 2012 report, as well as the progress VHA has made in implementing those recommendations.

For our ongoing outpatient specialty care consults work,[8] we reviewed documents and interviewed VHA central office officials about VHA's policies and guidance for VAMCs to send, receive, and complete consults, and VHA's procedures for VAMCs to schedule outpatient medical appointments, which include those for specialty care. We also reviewed documents and interviewed VHA central office officials about their efforts to oversee VAMCs' implementation of VHA's consult policies, including VHA's Consult Management Business Rules Initiative, launched in May 2013. Additionally, we interviewed officials from five VAMCs selected for variation in volume of outpatient consults, complexity,[9] and location. These five VAMCs were located in Augusta, Maine; Denver, Colorado; Gainesville, Florida; Oklahoma City, Oklahoma; and Palo Alto, California. For each VAMC included in our review, we interviewed leadership about how VHA's consult policies and any local policies or procedures for managing consults are implemented at their facility. We also interviewed specialty care service chiefs, administrative staff, and providers of three high-volume specialty services—cardiology, gastroenterology, and physical therapy. Additionally, for each of the five medical centers, we reviewed the history of actions taken on a random sample of 30 outpatient consults (10 from each of the three specialties included in our review) that were requested during the period April 1, 2013, through September 30, 2013, that either took more than 90 days to complete or had been in process for more than 90 days. The results of our review of outpatient consults are not generalizable across all VAMCs.

[7]GAO-13-130.

[8]The scope of our work is limited to outpatient consults; however, providers may also request consults for inpatient care and administrative needs, among other things.

[9]VHA categorizes VAMCs according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity.

For our December 2012 report, we reviewed VHA's scheduling policy and methods for measuring medical appointment wait times, and interviewed VHA central office officials responsible for developing them. We also visited 23 high-volume outpatient clinics at four VAMCs selected for variation in size, complexity, and location. These four VAMCs were located in Dayton, Ohio; Fort Harrison, Montana; Los Angeles, California; and Washington, D.C. At each VAMC we interviewed leadership and other officials about how they managed and improved medical appointment timeliness, their oversight to ensure accuracy of scheduling data and compliance with VHA's scheduling policy, and problems staff experienced in scheduling timely appointments. Additionally, in April 2014, in preparation for this statement, we reviewed documentation and interviewed officials from VHA's central office about the extent to which they have addressed the recommendations we made in the 2012 report.

We are conducting our ongoing work on specialty care outpatient consults, which began in July 2013, in accordance with generally accepted government auditing standards. Because this work is ongoing, we are not making recommendations on VHA's consult process at this time. We conducted our prior work on VHA's outpatient appointment scheduling and oversight from February 2012 through December 2012, as well as an update on that work in April 2014, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We shared information we used to prepare this statement with VA. After reviewing this information, VA provided us with technical comments, which we incorporated as appropriate.

Background

When providers at VAMCs determine that a veteran needs outpatient specialty care, they request and manage consults using VHA's clinical consult process. Clinical consults include requests by physicians or other providers for both clinical consultations and procedures. A clinical consultation is a request seeking an opinion, advice, or expertise regarding evaluation or management of a patient's specific clinical concern, whereas a procedure is a request for a specialty procedure such as a colonoscopy. Clinical consults are typically requested by a veteran's primary care provider using VHA's electronic consult system. Once a

provider sends a request, VHA requires specialty care providers to review it within 7 days and determine whether to accept the consult. If the specialty care provider accepts the consult—determines the consult is needed and is appropriate—an appointment is made for the patient to receive the consultation or procedure.[10] In some cases, a provider may discontinue a consult for several reasons, including that the care is not needed, the patient refuses care, or the patient is deceased.[11] In other cases the specialty care provider may determine that additional information is needed, and will send the consult back to the requesting provider, who can resubmit the consult with the needed information. Once the appointment is held, VHA's policy requires the specialty care provider to appropriately document the results of the consult, which would then close out the consult as completed in the electronic system.[12] VHA's current guideline is that consults should be completed within 90 days of the request.[13] If an appointment is not held, staff are to document why they were unable to complete the consult.

In 2012, VHA created a database to capture all consults systemwide and, after reviewing these data, determined that the data were inadequate for monitoring consults. One issue identified was the lack of standard processes and uses of the electronic consult system across VHA. For example, in addition to requesting consults for clinical concerns, the system was also being used to request and manage a variety of administrative tasks, such as requesting patient travel to appointments. Additionally, VHA could not accurately determine whether patients actually received the care they needed or if they received the care in a timely fashion. According to VHA officials, approximately 2 million consults (both clinical and administrative consults) were unresolved for more than 90 days. Subsequently, VA's Under Secretary for Health convened a task force to address these and other issues regarding VHA's

[10]Some consults, referred to as "e-consults," do not require an in-person appointment with the patient and may be addressed electronically through the consult system.

[11]When a provider discontinues a consult, action on the consult is stopped, and a new consult request must be initiated by the requesting provider for the veteran to obtain the specialty care—whether that care is for a clinical consultation or procedure.

[12]The results of consults are documented in the consult system and are contained in the patient's electronic health record.

[13]VHA officials noted that although VHA's guideline is for consults to be completed within 90 days, consults for urgent needs are completed sooner.

consult system, among other things. In response to task force recommendations, in May 2013, VHA launched the Consult Management Business Rules Initiative to standardize aspects of the consult process, with the goal of developing consistent and reliable information on consults across all VAMCs. This initiative requires VAMCs to complete four specific tasks between July 1, 2013, and May 1, 2014:

- Review and properly assign codes to consistently record consult requests in the consult system;[14]
- Assign distinct identifiers in the electronic consult system to differentiate between clinical and administrative consults;
- Develop and implement strategies for requesting and managing requests for consults that are not needed within 90 days—known as "future care" consults;[15] and
- Conduct a clinical review as warranted, and as appropriate, close all unresolved consults—those open more than 90 days.

At the time of our December 2012 review, VHA measured outpatient medical appointment wait times as the number of days elapsed from the patient's or provider's desired date, as recorded in the VistA scheduling system by VAMCs' schedulers. In fiscal year 2012, VHA had a goal of completing new and established patient specialty care appointments within 14 days of the desired date. VHA established this goal based on its performance reported in previous years.[16] To facilitate accountability for achieving its wait time goals, VHA includes wait time measures—referred to as performance measures—in its Veterans Integrated Service Network

[14]These codes identify the type of care requested in the consult (e.g., dermatology or cardiology) and are used by VHA to run reports that assist with managing its services.

[15]According to VHA guidance, the consult system should only be used for services needed within 90 days. VAMCs were given the option to track future care consults either by developing markers so they could be identified in the consult system, or using existing mechanisms outside of the consult system such as electronic wait lists. The electronic wait list is a type of computer software application designed for recording, tracking, and reporting veterans waiting for medical appointments.

[16]In 1995, VHA established a goal of scheduling primary and specialty care medical appointments within 30 days to ensure veterans' timely access to care. VA's reported wait times for fiscal year 2010 showed that nearly all primary and specialty care medical appointments were scheduled within 30 days of desired date. In fiscal year 2011, VHA shortened the wait time goal to 14 days for both primary and specialty care medical appointments.

(VISN)[17] directors' and VAMC directors' performance contracts, and VA includes measures in its budget submissions and performance reports to Congress and stakeholders.[18] The performance measures, like wait time goals, have changed over time.

Officials at VHA's central office, VISNs, and VAMCs all have oversight responsibilities for the implementation of VHA's scheduling policy. For example, each VAMC director, or designee, is responsible for ensuring that clinics' scheduling of medical appointments complies with VHA's scheduling policy and for ensuring that any staff who can schedule medical appointments in the VistA scheduling system have completed the required VHA scheduler training.[19] In addition to the scheduling policy, VHA has a separate directive that establishes policy on the provision of telephone service related to clinical care, including facilitating telephone access for medical appointment management.

[17]VHA's health care system is divided into 21 areas called VISNs. Each of VA's 21 VISNs is responsible for managing and overseeing medical facilities within a defined geographic area.

[18]VA prepares a congressional budget justification that provides details supporting the policy and funding decisions in the President's budget request submitted to Congress prior to the beginning of each fiscal year. The budget justification articulates what VA plans to achieve with the resources requested; it includes performance measures by program area. VA also publishes an annual performance report—the performance and accountability report—which contains performance targets and results achieved compared with those targets in the previous year.

[19]Specifically, VAMCs are required to maintain a list of all staff who can schedule medical appointments in the VistA scheduling system and VAMC directors are required to ensure successful completion of required training by all staff on the list. Schedulers are not to be allowed to schedule medical appointments in the VistA scheduling system without proof of their successful completion of this training.

GAO's Ongoing Work Identified Examples of Delays in Specialty Care, and Limitations in VHA's Implementation of Its Business Rules Impede Its Ability to Assess Delays

Our ongoing work identified examples of delays in veterans receiving requested outpatient specialty care at the five VAMCs we reviewed. VAMC officials cited increased demand for services, and patient no-shows and cancelled appointments, among the factors that hinder their ability to meet VHA's guideline for completing consults within 90 days. Specifically, several VAMC officials discussed a growing demand for both gastroenterology procedures, such as colonoscopies, as well as consultations for physical therapy evaluations. Additionally, officials noted that due to difficulty in hiring and retaining specialists for these two clinical areas, they have developed periodic backlogs in providing services. Officials at these facilities indicated that they try to mitigate backlogs by referring veterans for care with non-VA providers. However, this strategy does not always prevent delays in veterans receiving timely care. For example, officials from two VAMCs told us that non-VA providers are not always available. Examples of consults that were not completed in 90 days include:

- For 3 of 10 gastroenterology consults we reviewed for one VAMC, we found that between 140 and 210 days elapsed from the dates the consults were requested to when the patient received care. For the consult that took 210 days, an appointment was not available and the patient was placed on a waiting list before having a screening colonoscopy.
- For 4 of the 10 physical therapy consults we reviewed for one VAMC, we found that between 108 and 152 days elapsed, with no apparent actions taken to schedule an appointment for the veteran. The patients' files indicated that due to resource constraints, the clinic was not accepting consults for non-service-connected physical therapy evaluations.[20] In 1 of these cases, several months passed before the veteran was referred to non-VA care, and he was seen 252 days after the initial consult request. In the other 3 cases, the physical therapy clinic sent the consults back to the requesting provider, and the veterans did not receive care for that consult.
- For all 10 of the cardiology consults we reviewed for one VAMC, we found that staff initially scheduled patients for appointments between 33 and 90 days after the request, but medical files indicated that patients either cancelled or did not show for their initial appointments.

[20]A non-service-connected disability is an injury or illness that was not incurred or aggravated during active military service.

In several instances patients cancelled multiple times. In 4 of the cases VAMC staff closed the consults without the patients being seen; in the other 6 cases VAMC staff rescheduled the appointments for times that exceeded the 90-day timeframe.[21]

Our ongoing work also identified variation in how the five VAMCs we reviewed have implemented key aspects of VHA's business rules, which limits the usefulness of the data in monitoring and overseeing consults systemwide. As previously noted, VHA's business rules were designed to standardize aspects of the consult process, thus creating consistency in VAMCs' management of consults. However, VAMCs have reported variation in how they are implementing certain tasks required by the business rules. For example, VAMCs have developed different strategies for managing future care consults—requests for specialty care appointments that are not clinically needed for more than 90 days.

- At one VAMC, officials reported that specialty care providers have been instructed to discontinue consults for appointments that are not needed within 90 days and requesting providers are to track these consults outside of the electronic consult system and resubmit them closer to the date the appointment is needed. These consults would not appear in VHA's systemwide data once they have been discontinued.
- At another VAMC, officials stated that appointments for specialty care consults are scheduled regardless of whether the appointments are needed beyond 90 days. These future care consults would appear in VHA consult data and would eventually appear on a timeliness report as consults open greater than 90 days. Officials from this VAMC stated that they continually have to explain to VISN officials who monitor the VAMC's consult timeliness that these open consults do not necessarily mean that care has been delayed.
- Officials from another VAMC reported piloting a strategy in its gastroenterology clinic where future care consults are entered in an electronic system separate from the consult and appointment scheduling systems. Approximately 30 to 60 days before the care is needed the requesting provider is notified to enter the consult request

[21]According to VHA consult policy, when a patient fails to keep a scheduled appointment, the specialty care provider must reassess the need for service and either reschedule the appointment or cancel the consult request, as appropriate. VHA Directive 2008-056, *VHA Consult Policy* (Sept. 16, 2008).

in the electronic consult system for the specialty care provider to complete.

In addition, oversight of the implementation of VHA's business rules has been limited and has not included independent verification of VAMC actions. VAMCs were required to self-certify completion of each of the four tasks outlined in the business rules. VISNs were not required to independently verify that VAMCs appropriately completed the tasks. Without independent verification, VHA cannot be assured that VAMCs implemented the tasks correctly.

Furthermore, VHA did not require that VAMCs document how they addressed unresolved consults that were open greater than 90 days, and none of the five VAMCs in our review were able to provide us with specific documentation in this regard. VHA officials estimated that as of April 2014, about 450,000 of the approximately 2 million consults (both clinical and administrative consults) remained unresolved systemwide. VAMC officials noted several reasons that consults were either completed or discontinued in this process of addressing unresolved consults, including improper recording of consult notes, patient cancellations, and patient deaths. At one of the VAMCs we reviewed, a specialty care clinic discontinued 18 consults the same day that a task for addressing unresolved consults was due. Three of these 18 consults were part of our random sample, and our review found no indication that a clinical review was conducted prior to the consults being discontinued. Ultimately, the lack of independent verification and documentation of how VAMCs addressed these unresolved consults may have resulted in VHA consult data that inaccurately reflected whether patients received the care needed or received it in a timely manner.

Although VHA's business rules were intended to create consistency in VAMCs' consult data, our preliminary observations identified variation in managing key aspects of consult management that are not addressed by the business rules. For example, there are no detailed systemwide VHA policies on how to handle patient no-shows and cancelled appointments, particularly when patients repeatedly miss appointments, which may make VAMCs' consult data difficult to assess.[22] For example, if a patient

[22]As we previously reported, scheduling practices at some VAMCs could result in miscommunication with patients and cause them not to make medical appointments. In addition, outdated or incorrect patient contact information may also affect patient no-shows and cancelled appointments. See GAO-13-130.

cancels multiple specialty care appointments, the associated consult would remain open and could inappropriately suggest delays in care. To manage this type of situation, one VAMC developed a local consult policy referred to as the "1-1-30" rule. The rule states that a patient must receive at least 1 letter and 1 phone call, and be granted 30 days to contact the VAMC to schedule a specialty care appointment.[23] If the patient fails to do so within this time frame, the specialty care provider may discontinue the consult. According to VAMC officials, several of the consults we reviewed would have been discontinued before reaching the 90-day threshold if the 1-1-30 rule had been in place at the time.[24] Three VAMCs included in our review also noted some type of policy addressing patient no-shows and cancelled appointments, each of which varied in its requirements.[25] Without a standard policy across VHA addressing patient no-shows and cancelled appointments, VHA consult data may reflect numerous variations of how VAMCs handle patient no-shows and cancelled appointments.

[23]According to VAMC officials, the 1-1-30 rule provides a minimum standard for specialty care providers to follow in scheduling patient appointments.

[24]The VAMC issued its updated consult policy, which included the 1-1-30 rule, in December 2013 after our request for consults data.

[25]One of the VAMCs allowed for a maximum number of two no-shows for all specialty appointments, with consideration given to the patient's medical needs. The other two VAMCs policies stated that specialty providers should reassess the patient's needs after one no-show and may or may not reschedule the appointment.

Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, and VA Has Initiated Actions to Address Related GAO Recommendations

In December 2012, we reported that VHA's reported outpatient medical appointment wait times were unreliable and that inconsistent implementation of VHA's scheduling policy may have resulted in increased wait times or delays in scheduling timely outpatient medical appointments. Specifically, we found that VHA's reported wait times were unreliable because of problems with recording the appointment desired date in the scheduling system. Since, at the time of our review, VHA measured medical appointment wait times as the number of days elapsed from the desired date, the reliability of reported wait time performance was dependent on the consistency with which VAMC schedulers recorded the desired date in the VistA scheduling system. However, VHA's scheduling policy and training documents were unclear and did not ensure consistent use of the desired date. Some schedulers at VAMCs that we visited did not record the desired date correctly. For example, the desired date was recorded based on appointment availability, which would have resulted in a reported wait time that was shorter than the patient actually experienced.

At each of the four VAMCs we visited, we also found inconsistent implementation of VHA's scheduling policy, which impeded scheduling of timely medical appointments. For example, we found the electronic wait list was not always used to track new patients that needed medical appointments as required by VHA scheduling policy, putting these patients at risk for delays in care. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy, such as ensuring the completion of required scheduler training, was inconsistent across facilities. VAMCs also described other problems with scheduling timely medical appointments, including VHA's outdated and inefficient scheduling system, gaps in scheduler and provider staffing, and issues with telephone access. For example, officials at all VAMCs we visited reported that high call volumes and a lack of staff dedicated to answering the telephones affected their ability to schedule timely medical appointments.

VA concurred with the four recommendations included in our December 2012 report and reported continuing actions to address them.

- First, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to improve the reliability of its outpatient medical appointment wait time measures. In response, VHA officials stated that they implemented more reliable measures of patient wait times for primary and specialty care. In fiscal years 2013 and 2014, primary and specialty care appointments for new patients

have been measured using time stamps from the VistA scheduling system to report the time elapsed between the date the appointment was created—instead of the desired date—and the date the appointment was completed. VHA officials stated that they made the change from using desired date to creation date based on a study that showed a significant association between new patient wait times using the date the appointment was created and self-reported patient satisfaction with the timeliness of VHA appointments.[26] VA, in its *FY 2013 Performance and Accountability Report*, reported that VHA completed 40 percent of new patient specialty care appointments within 14 days of the date the appointment was created in fiscal year 2013; in contrast, VHA completed 90 percent of new patient specialty care appointments within 14 days of the desired date in fiscal year 2012. VHA also modified its measurement of wait times for established patients, keeping the appointment desired date as the starting point, and using the date of the pending scheduled appointment, instead of the date of the completed appointment, as the end date for both primary and specialty care. VHA officials stated that they decided to use the pending appointment date instead of the completed appointment date because the pending appointment date does not include the time accrued by patient no-shows and cancelled appointments.

- Second, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure VAMCs consistently implement VHA's scheduling policy and ensure that all staff complete required training. In response, VHA officials stated that the department is in the process of revising the VHA scheduling policy to include changes, such as the new methodology for measuring wait times, and improvements and standardization of the use of the electronic wait list. In the interim, VHA distributed guidance, via memo, to VAMCs in March 2013 describing this information and also offered webinars to VHA staff on eight dates in April and May of 2013. To assist VISNs and VAMCs in the task of verifying that all staff have completed required scheduler training, VHA has developed a database that will allow a VAMC to identify all staff that have scheduled appointments and the volume of appointments scheduled

[26]Prentice, Julia C., Michael L. Davies, and Steven D. Pizer, "Which Outpatient Wait-Time Measures Are Related to Patient Satisfaction?" *American Journal of Medical Quality*, (Aug. 12, 2013), accessed April 4, 2014, http://ajm.sagepub.com/content/early/2013/07/31/1062860613494750.abstract.

by each; VAMC staff can then compare this information to the list of staff that have completed the required training. However, VHA officials have not established a target date for when this database would be made available for use by VAMCs.

- Third, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to require VAMCs to routinely assess scheduling needs for purposes of allocation of staffing resources. VHA officials stated that they are continuing to work on identifying the best methodology to carry out this recommendation, but stated that the database that tracks the volume of appointments scheduled by individual staff also may prove to be a viable tool to assess staffing needs and the allocation of resources. VHA officials stated that they needed to discuss further how VAMCs could use this tool, and that they had not established a targeted completion date for actions to address this recommendation.
- Finally, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to ensure that VAMCs provide oversight of telephone access, and implement best practices to improve telephone access for clinical care. In response, VHA required each VISN director to require VAMCs to assess their current telephone service against the VHA telephone improvement guide and to electronically post an improvement plan with quarterly updates. VAMCs are required to routinely update progress on the improvement plan. VHA officials cited improvement in telephone response and call abandonment rates since VAMCs were required to implement improvement plans. Additionally, VHA officials said that the department has also contracted with an outside vendor to assess VHA's telephone infrastructure and business process. VHA expects to receive the first report in approximately 2 months.

Although VA has initiated actions to address our recommendations, we believe that continued work is needed to ensure these actions are fully implemented in a timely fashion. Furthermore, it is important that VA assess the extent to which these actions are achieving improvements in medical appointment wait times and scheduling oversight as intended. Ultimately, VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

Chairman Miller, Ranking Member Michaud, and Members of the Committee, this concludes my statement. I would be pleased to respond to any questions you may have.

GAO Contact and Staff Acknowledgments

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STATEMENT OF
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OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
HEARING ON
"A CONTINUED ASSESSMENT OF DELAYS IN VA MEDICAL CARE AND PREVENTABLE VETERAN DEATHS"
APRIL 9, 2014

Chairman Miller and Members of the Committee, thank you for the opportunity to testify today to discuss preventable medical errors at Department of Veterans Affairs (VA) medical facilities. The VA Office of Inspector General (OIG) has issued many reports that have addressed circumstances that led to patient harm, including death at VA medical centers (VAMC). I am deeply concerned that these reports portray events which, had the VA medical center staff followed VA policy, may have never occurred. For the purposes of this statement, I will focus on seven recent reports that I believe are indicative of issues facing VA in providing quality health care.[1]

BACKGROUND

The VA provides medical care to 6.5 million veterans through a system of medical facilities including 151 Medical Centers, 300 Vet Centers, and 820 Community Based Outpatient Clinics (CBOC). The Veterans Health Administration (VHA) Central Office provides leadership and policy guidance to the nationwide system of care. Hospitals, clinics, and related medical facilities are grouped into 21 Veterans Integrated Service Networks (VISN). VISNs and their related hospitals' organization and business practices have evolved at different paces and have been significantly influenced by local preferences since their creation, resulting in 21 different VISN organizations, each charged with the same mission.

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[1] *Healthcare Inspection – Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina* (9/6/2013); *Healthcare Inspection – Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013); *Healthcare Inspection – Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida* (3/27/2014); *Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013); *Healthcare Inspection – Emergency Department Patient Deaths Memphis VAMC, Memphis, Tennessee* (10/23/2013); *Healthcare Inspection – Inappropriate Use of Insulin Pens, VA Western New York Healthcare System, Buffalo, New York* (5/9/2013); *Healthcare Inspection - Review of VHA Follow-Up on Inappropriate Use of Insulin Pens at Medical Facilities* (8/1/2013).

COLON CANCER SCREENING

Colon cancer has long been recognized as a silent killer in that the cancer is often able to grow within the intestine to significant size before being discovered. Patients may be screened for this cancer by a variety of tests, some of which focus upon the presence of blood within stool or the physical presence of a mass within the intestine. Examinations that test stool for the presence of blood or other chemicals or visualize the intestine are common diagnostic tests used to discover the presence of this silent killer.

In 2006, the OIG published a review, *Colorectal Cancer Detection and Management in Veterans Health Administration Facilities* (February 2, 2006), of aspects of VHA's performance in the delivery of colon cancer screening and management of positive screening tests. This review found that the time between having a positive screening test for colon cancer and the provision of the next test to diagnose a tumor took several months. VA agreed that this delay in action was not acceptable. When colon cancer was diagnosed, surgeons and oncologists responded quickly with treatment, yet the lag between the identification of a specific risk and the determination that there was or was not colon cancer was not timely.

In that report, the Under Secretary for Health concurred with the findings and recommendations we made to more efficiently and more timely address the lag between the positive screening test and the diagnostic test for colon cancer. The Under Secretary for Health indicated in the response to this report that timelines would be established to monitor the timeliness of colon rectal cancer diagnosis after a positive screening test and that a directive would be issued to establish national standards for the management of this process. This was accomplished with the issuance of VHA Directive 2007-004, "Colorectal Cancer Screening," in January 2007.

In September 2013, the OIG reported a disturbing set of events at the William Jennings Bryan Dorn VAMC in Columbia, South Carolina, that led to thousands of delayed gastroenterology (GI) consults for colon cancer screening and the determination that over 50 veterans had a delayed diagnosis of colon cancer, some of whom died from colon cancer.[2] After patients are screened positive for possible colon cancer or require a GI procedure, a consult to GI is usually sent by the primary care provider. Network and facility leaders became aware of the GI consult backlog at Columbia in July 2011 involving 2,500 delayed consults, 700 of them deemed "critical" by VA physicians. Additional funds were requested by the facility upon determining the need for a large number of GI procedures, and the VISN awarded the facility $1.02M for Fee-Basis colonoscopies in September 2011.[3] However, facility leaders did not ensure that a structure for tracking and accounting was in place and by December 2011, the backlog stood at 3,800 delayed GI consults. The facility developed an action plan in January 2012 but had difficulty making progress in reducing the backlog. The delayed diagnosis

[2] *Healthcare Inspection – Gastroenterology Consult Delays, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina* (9/6/2013).

[3] Fee basis care is non-VA/private sector care paid for by VA when the service is not available in a timely manner within VHA due to capability, capacity, or accessibility.

of a patient with colon cancer in May 2012 prompted facility leaders to re-evaluate the GI situation, and facility, network, and VHA leaders aggressively pursued elimination of the backlog. This was essentially accomplished by late October 2012. However, during the review "look-back" period, 280 patients were diagnosed with GI malignancies, 52 of whom were associated with a delay in diagnosis and treatment. The facility completed at least 19 institutional disclosures providing patients and their family members with specific details of the adverse event or delay of care and their right to file a claim.

A confluence of factors contributed to the GI delays and hampered efforts to improve the condition. Specifically, the facility's Planning Council did not have a supportive structure; Nursing Service did not hire GI nurses timely; the availability of Fee Basis care had been reduced; low-risk patients were being referred for screening colonoscopies, thus increasing demand; staff members did not consistently and correctly use the consult management reporting and tracking systems; critical network and facility leadership positions were filled by a series of managers who often had collateral duties and differing priorities; and Quality Management staff was not included in discussions about the GI backlogs.

In its response to the report, VHA indicated that national VHA leadership considered delays in consult responsiveness to be of significant concern. VHA Central Office leadership took specific steps to address these issues in Columbia as well as system-wide. In January 2013, VHA undertook a national review of open consults to gain a better perspective on nationwide demand for consultative services. In May 2013, VHA launched an initiative to standardize use of the clinical consultation software package in the electronic health record.

The appropriate management of patients who are at risk for colon cancer is standard medical practice. This issue has been discussed by VHA for years, and yet veterans were not timely diagnosed with colon cancer at this academic VA medical center.

MENTAL HEALTH POLICIES AND PROCEDURES

The OIG has issued two reports recently on veterans who died of narcotic drug overdoses while in VA facilities for mental health care.[4] In both cases, the hospital staff failed to ensure that veterans, who by their prior behavior were known to be at risk of abusing narcotic medication, were placed in environments that were secure from those drugs.

At the Miami VA Healthcare System, in Miami, Florida, we found that a patient died in his room in the substance abuse residential rehabilitation treatment program (SARRTP), and autopsy results indicated the patient died from cocaine and heroin toxicity. This veteran had a history of multiple positive urine drug screens while in the SARRTP. We found that the SARRTP security surveillance camera was not working at the time of the

[4] *Healthcare Inspection – Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013); *Healthcare Inspection – Unexpected Patient Death in a Substance Abuse Residential Rehabilitation Treatment Program, Miami VA Healthcare System, Miami, Florida* (3/27/2014).

patient's death, was still not working at the time of our site visit, and no alternative arrangements were made to monitor patients in the absence of an operational camera. Moreover, we found that evening, night, and weekend SARRTP staff often sat in a backroom where they had an extremely limited view of the unit and no view of the unit's entrance and exits. We also found that staff were not consistent in their methods of contraband searches and did not monitor patient whereabouts or unit visitors as required.

In our report on the Atlanta VA Medical Center in Decatur, Georgia, we received allegations that the VA did not protect a veteran from illicit drugs while an inpatient on the locked mental health unit and that he died of an overdose. We substantiated that the facility did not have adequate policies or practices for patient monitoring, contraband, visitation, and urine drug screening. We found inadequate program oversight including a lack of timely follow up actions by leadership in response to patient incidents.

At both Miami and Atlanta, as the reports indicate, standard steps to ensure veterans were kept safe while under VA control were not taken and two veterans died. In each instance, VA managers did not ensure that hospital staff performed their jobs.

The OIG reported on poor management of contracted mental health care at the Atlanta VAMC, where between 4,000 – 5,000 veterans who were referred for non-VA mental health care at a public non-profit Community Service Board (CSB), were not followed or managed.[5] In a sample of 85 cases, 21 percent of the referred veterans did not receive mental health care and, outside of the sample, several veterans were found to have died with a history of inadequate mental health care support from VA or non-VA sources. Mental Health Service Line managers did not adequately oversee or monitor contracted patient care services to ensure safe and effective treatment. This lack of effective patient care management and program oversight by the facility contributed to problems with access to mental health care and as a VA employee told the OIG "may have contributed to patients falling through the cracks." The facility's contract program lacked an integrated and effective Quality Assurance (QA) program and did not have a CSB QA process. For example, VA facility program managers did not track and trend patient complaints or conduct oversight visits to the CSB sites, as required by VA directives and the contract.

Our review also confirmed that facility managers did not provide adequate staff, training, resources, support, or guidance for effective oversight of the contracted mental health program. Managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety. Furthermore, other administrative issues contributed to the delay because the facility managers did not pay invoices promptly. These delays affected the CSBs' ability to accept new patients and plan their patient census.

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[5] *Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia* (4/17/2013).

The Atlanta VAMC was overwhelmed by the demand for mental health services over a multiyear period. VA leadership's response to this crisis was fragmented, ineffective, and resulted in poor care, and may have contributed to the death of some of the veterans among the 4,000 to 5,000 patients referred for non-VA care.

EMERGENCY DEPARTMENT ISSUES

In October 2013, we issued a report detailing three deaths in the Emergency Department (ED) at the Memphis VAMC in Memphis, Tennessee.[6] We received allegations that three patients died subsequent to care they received in the Memphis VAMC ED. We found the following:

- A patient was administered a medication in spite of a documented drug allergy and had a fatal reaction. Handwritten orders for this patient did not comply with the facility's requirement that all provider orders and patient care be documented in the electronic medical record. Since the orders were not entered into the electronic medical record, systems in place to notify the provider of a drug allergy conflict with ordered medications were bypassed. The patient died of a reaction to a medication allergy that was identified in the electronic medical record.
- Another patient was found unresponsive after being administered multiple sedating medications without being properly observed.
- A third patient had a critically high blood pressure that was not aggressively monitored and experienced bleeding in the brain.

The facility did complete protected peer reviews of the care for all three patients. Two of the deaths were also evaluated through root cause analyses (RCA), which are quality reviews designed to identify and correct systemic factors and conditions that may pose a threat to patient safety. However, we found that the implementation of the RCA action plan was delayed and incomplete. Additionally, the RCA documentation we reviewed contained several errors of fact, such as how long Patient 1 was monitored in the emergency room before discharge and the number of intravenous medications given to Patient 2.

Decisions were made which permitted the electronic medical record and its safeguards to be bypassed and to have patients on multiple sedating medications to be located in places difficult to monitor. Furthermore, when issues were identified through the RCA process, actions to prevent a recurrence were not taken seriously.

INTRODUCTION OF NEW TECHNOLOGY

Several VAMCs including the medical centers in Buffalo, New York, and Salisbury, North Carolina, failed to introduce new technology properly into the hospital

[6] *Healthcare Inspection – Emergency Department Patient Deaths Memphis VAMC, Memphis, Tennessee* (10/23/2013).

environment.[7] This resulted in 700 patients at Buffalo and 260 patients at Salisbury being exposed to the risk of blood borne viral infections when insulin pens, designed to be used with one pen per patient, were instead used improperly such that one pen was used on multiple patients.

In late October 2012, the Buffalo Chief of Pharmacy discovered three insulin pens, which were designed for single-patient use only, with no patient labels in a supply drawer of a medication cart. Facility officials subsequently found three more pens without patient labels in medication carts on three other inpatient units, and, when queried, several nurses reportedly acknowledged using the pens on multiple patients. Inappropriately using single-patient use insulin pens on multiple patients may potentially expose patients to blood borne pathogens.

We identified six factors that contributed to the misuse of insulin pens at Buffalo. We also found that misuse of the insulin pens went undetected for 2 years because even though facility staff often observed pens with no patient labels on the medication carts, they did not report it because they either did not fully comprehend the clinical risks of sharing pens, or they accepted the unlabeled pens as standard practice believing they were both multi-dose and multi-patient devices. We found that VHA did not notify Members of Congress or at-risk patients until January 2013 because of the time required for multiple levels of coordination between VA and VHA and inefficiencies in VHA's internal review process for large-scale adverse event disclosures.

In addition to the Buffalo incident, nurses at two other facilities were found to have inappropriately used insulin pens on multiple patients. In January 2013, the Salisbury VAMC reported that two nurses had inappropriately used insulin pens on multiple patients. VHA instituted a large-scale adverse event disclosure to notify 266 at-risk patients. At another facility, a nurse acknowledged using a pen on two patients on one occasion. We identified two contributing factors to explain why some nurses misused the insulin pens:

- Facilities did not fully evaluate the risks of using insulin pens on inpatient units, specifically in regards to the impact on nursing procedures.
- Facilities did not provide comprehensive nurse education on the pens.

We found that VHA has processes in place to identify important patient safety alerts, including product recalls, and disseminate this information to facility managers. VHA's National Center for Patient Safety and Pharmacy Benefits Management Service lead VHA's efforts to collect patient safety information and share this information with facilities. At the facility level, patient safety managers are responsible for disseminating alerts to appropriate administrative and clinical staff and tracking the facility's response through a national database. VHA has followed up and tested for evidence of infection in the patients identified in this report.

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[7] *Healthcare Inspection – Inappropriate Use of Insulin Pens, VA Western New York Healthcare System, Buffalo, New York* (5/9/2013); *Healthcare Inspection - Review of VHA Follow-Up on Inappropriate Use of Insulin Pens at Medical Facilities* (8/1/2013).

The use of these insulin pens in this fashion violates the core principles of infection control. Multiple personnel in several hospitals over an extended period of time failed to comprehend the impact of the decision to introduce pens of this nature onto inpatient wards. The decision to introduce new technology into hospital use is one that occurs routinely and to be done safely requires facility leaders to coordinate their actions and understand the implications of their decisions. Facilities with a singular focus on delivering high quality medical care should have recognized the risk these devices bring to the inpatient environment and taken appropriate actions to mitigate that risk.

OBSERVATIONS

OIG work routinely reports on clinical outcomes or performance that did not meet expectations. We routinely determine that there were opportunities by people and systems to prevent untoward outcomes. In addition to local issues at the facility, there are several organizational issues that impede the efficient and effective operation of VHA and place patients at risk of unexpected outcomes.

Although health care delivery may be the first priority of many within the system, others are focused on research, training the next generation of health care providers, disaster preparedness, homelessness, support for compensation evaluation requirements, and other related missions. This lack of focus on health care delivery as priority one can be seen by the process commonly used at hospitals to fill vacant positions. A resource board reviews open positions and then determines which should be filled. Thus the position recently occupied by a nurse in the GI clinic, who is essential to the delivery of required care, may not be filled while a position that is important to the research or teaching community is filled. The decision by this board, to not fill a clinic position, may have far reaching consequences. The clinic that does not have the nurse may not function properly. The leadership of the clinic is left believing that hospital "leadership" does not understand or does not care about the care provided in that clinic. All a provider can do is ask for clinical positions to be filled, and if they are not filled, either leave VA or agree to work in an environment that provides less than satisfactory care. There is no national process to establish a set of positions that are deemed "essential" to the delivery of health care and thus are priority one for the hospital administration to resource.[8] The establishment of "essential positions" in the context of a standard hospital structure would enhance the delivery of quality patient care.

VA hospitals and clinics do not have a standard organizational chart. Some hospitals have a chief of surgery and a chief of anesthesia; others have a chief of the surgical care line. The lack of a common organizational chart for medical facilities results in confusion in assigning local responsibility for actions required by national directives. Variation in staff organization also creates difficulty in comparing the performance of clinical groups between hospitals and clinics.

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[8] *Healthcare Inspection – Delayed Cancer Diagnosis, VA Greater Los Angeles Healthcare System, Los Angeles, California* (7/24/2007).

Leadership, teamwork, communication, and technical competence are among the most important factors in providing quality health care. However, organization, assignment of clear responsibility, and efficiency of operation all make important contributions to the process of improving the quality of health care delivered.

CONCLUSION

The unexpected deaths that the OIG continues to report on at VA facilities could be avoided if VA would focus first on its core mission to deliver quality health care. Its efforts would also be aided by discussion of the best organizational structure to consistently provide quality care. The network system of organization and the accompanying motto, 'all health care is local,' served the VA well over the last several decades but does not standardize the organization of medical centers. It is difficult to implement national directives when there are no standard position descriptions or areas of responsibility across the system. VA has embraced the "aircraft checklist" approach to improve the chances that preventable medical errors will not occur in the operating room, but has taken the opposite approach to the assignment of duties and responsibilities in medical centers, where no two hospitals are alike. I believe that it is appropriate to review the organizational structure and business rules of VHA to determine if there are changes that would make the delivery of care less prone to error and reinforce the priority that the delivery of health care should receive.

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

From Chairman Miller to VA
Q+A

Questions for the Record
Committee on Veterans' Affairs
U.S. House of Representatives

"A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths"
April 9, 2014
Questions for the Record from the Honorable Jeff Miller, Chairman

1. **Please list and describe the efforts made by local Department of Veterans Affairs (VA) medical facility or Veterans Integrated Service Network (VISN) leaders in the areas where consult backlogs resulted in preventable veteran deaths and/or institutional disclosures, to utilize existing authorities- including but not limited to fee basis care, beneficiary travel benefits, and the Veterans Transportation Service -to ensure that veterans received needed care in a timely manner.**

On Wednesday, May 21, former Secretary Shinseki directed the Veterans Health Administration (VHA) leadership to personally review their appointment scheduling processes to ensure the Department of Veterans Affairs (VA) is doing everything possible to schedule Veterans for their appointments.

VA has redoubled its efforts to provide quality care to Veterans and has taken steps at national and local levels to ensure timely access to care. VHA has developed the Accelerating Care Initiative, a coordinated, system-wide initiative to accelerate care to Veterans, and promptly communicated this to leadership in the field on May 22, and launched implementation the morning of May 23.

The purpose of the initiative is to strengthen access to care in the VA system, while also ensuring flexibility to use private sector care when needed in accordance with VA guidelines. Where VA cannot increase its own capacity, VA is increasing the use of care in the community through non-VA care. Each of VA's facilities is reaching out to Veterans to coordinate the acceleration of their care.

Non-VA Medical Care: VA may authorize the use of Non-VA Medical Care for eligible Veterans when care is not readily available through VA or the VA facility is geographically remote from the Veteran's home, as well as in emergency situations.

Beneficiary Travel (BT): BT promotes Veterans' access to care, but by law (38 U.S.C. §111 and 38 C.F.R. Part 70) is provided only to certain Veterans who have a VA-adjudicated service connected disability and/or low income. VA pays for special mode transportation for Veterans who are eligible for BT when they need to be transported in a vehicle specific to their limitations, if a VA clinician determines the

transportation is medically required, and if VA approves the transportation in advance except in emergencies. BT is available to eligible veterans for travel to VA facilities and VA authorized facilities.

Title 38 United States Code (U.S.C.) § 111, "Payments or allowances for beneficiary travel" as implemented in 38 Code of Federal Regulations CFR) §§ 70.1 – 70.50 authorizes mileage reimbursement (currently $0.415), special mode (ambulance, wheelchair van etc.) transport, and common carrier (plane, bus etc.) transport to certain eligible Veterans and other beneficiaries. VA may also provide or reimburse for the actual cost of bridge tolls, road and tunnel tolls, parking, and authorized luggage fees when supported by a receipt. The actual cost for meals, lodging, or both, not to exceed 50 percent of the local government employee rate, may also be provided in limited circumstances. The Beneficiary Travel Program (BT) is discretionary in nature with funding coming from the yearly VA health care Medical Services appropriation.

Veterans Transportation Service (VTS): Title 38 U.S.C., § 111A(a), "Transportation of individuals to and from Department facilities" authorizes VA to transport any person to or from a VA facility or other place for the purpose of examination, treatment, or care. The Veterans Transportation Service (VTS) provides Veterans with transportation regardless of BT eligibility, and can be used to assist Veterans when they lack the ability to get to their health care appointments. The program is intended to improve access to care by removing, where possible, travel as a barrier to care. VTS provides transport to VA care using VA vehicles and drivers through a combination of direct patient transport from residence, "bus route" pick-up and return, and transport between VA facilities (shuttles). VTS FY 13 expenditures were $19.25 million.

BT vs. VTS: BT authorizes VA to ***pay or reimburse for*** transportation provided to eligible beneficiaries while VTS allows VA to ***provide*** transportation to eligible beneficiaries, using VA vehicle and staff resources, regardless of their BT eligibility.

Volunteer Transportation Network: Additionally, under 38 U.S.C. § 111A(b), the Volunteer Transportation Network (VTN) provides needed transportation for Veterans seeking services from a VA facility or an authorized facility. VTN guidelines permit volunteer participation in providing transportation to Veterans using a volunteer's privately-owned conveyance or a government-owned vehicle, including donated vehicles, county vehicles, and DAV Department (State) or Chapter (local) vehicles.

Please describe the anticipated effects of the National Consult Delay Review on the way consults are monitored locally, regionally, and nationally throughout the VA health care system.

The National Consult Delay Review, which is scheduled to be complete mid-

summer, 2014, will do two things: 1) review and address open consults and 2) implement standard business rules. This will allow VHA's new consult oversight information system (called the consult switchboard) to separate clinical consults from other uses of the electronic consult package (for example, some facilities use the consult package to order tests such as an EKG). VHA officials will be able to use this system to see all VHA consults individually, which enables monitoring of the data locally, regionally and nationally. This system will allow VHA officials to monitor the number of open consults and consult timeliness.

3. **Please list the VA official(s) who will be responsible for monitoring and acting on information provided via the new consult "switchboard" at the local, regional, and national level.**

   VHA created the new consult "switchboard" to assist VA facilities in day-to-day management of the consult process. Veterans Integrated Service Network (VISN) Directors are responsible for monitoring this information for their regions. Several national program offices, e.g., the Mental Health Operations program office, will be reviewing and monitoring the information at the national level. Each program office aggregates the data and uses it for a specific purpose (e.g., Mental Health Operations will monitor the mental health access information). In October 2013, VHA assigned responsibility for the overall aggregation and trending of this information into the Access and Clinic Administration Program (ACAP) organized within VHA operations.

4. **When will the Consult Management Committees be in place in all VA medical facilities? What will the composition of these Committees be and what authority will they have to take needed actions to address consult delays? How will the effectiveness of these Committees be measured?**

   In an Under Secretary for Health memorandum dated May 23, 2013, regarding Consult Business Rule Implementation, it was recommended, but not required, that facilities either stand up a committee or assign an existing committee the task of overseeing and managing the business rules and outcomes. The memorandum did not specify a target date or certification requirement regarding such a committee. Training calls managed by VHA's Office of Access and Clinic Administration included discussion on the functions and benefits of having a committee and the need for facility oversight, group decision making, and review of the implementation process, and consult performance.

   The Medical Center Director oversees the consult processes locally. The consult committees are a mechanism the director uses to assist in monitoring open consults, improving consult processes, and assisting in creating care coordination agreements. These agreements aim to improve the patient care related communication between Primary Care and Specialists. It is anticipated that the effectiveness of local consult management processes will be measured by consult

timeliness, the number of open consults over 90 days, and the number of consults that are written but subsequently sent back to the sender.

5. **According to information the Department provided, VA has issued 76 institutional disclosures to-date as a result of consult delays. Of those, 23 veteran patients are now deceased. Moving forward, how will VA monitor the health of the 53 surviving patients who received institutional disclosures? Please list what, if any, additional health benefits these veterans will be eligible to receive should they require care in connection with conditions they may have developed while waiting for VA care?**

   Patients for whom institutional disclosures are completed continue to be followed by their providers, who coordinate appropriate treatment and follow-up.
   Any Veteran enrolled in VA health care is eligible for care provided under the medical benefits package based on clinical need. VA providers are actively working with those Veterans who received institutional disclosures to ensure that they receive any needed services.

6. **How is the implementation of the Patient Centered Community Care Program (PC3) expected to impact the timely delivery of consults through the VA health care system?**

   Patient-Centered Community Care (PC3) is expected to improve the timely delivery of health care through the VA health care system and improve the patient experience when receiving care in the community. VA currently monitors and tracks expenditures through the PC3 contracts, in order to compare the use of PC3 to other non-VA care contract vehicles.

   Local VA facilities create authorizations (orders) for non-VA medical care when the required medical services are not readily available through VA or the VA facility is geographically remote from the Veteran's home. Authorizations for PC3 follow the Non-VA Care Coordination (NVCC) process which is a system of business processes that standardize and streamline front-end processes, and improve patient care coordination. Included in the NVCC process is the creation, routing, and issuance of authorizations, which are used for all non-VA medical care, including PC3.

   PC3 will help the patient-care coordination process through contractually-mandated timeliness requirements which cover the following areas:

Requirement Description	Standard
Time from receipt of authorization to appointment completion	• 30 days or less
Timeliness from completion of the authorized episode of care to the return of clinical documentation	• Medical documentation authorized outpatient care submitted within 14 calendar days after completion of initial appointment • Medical documentation for authorized episode of inpatient care submitted within 30 business days
Timeliness of critical and urgent findings reporting	• Urgent oral report transmitted to VA within 48 hours of finding • Documentation return critical findings on outpatient imaging or lab testing transmitted to VA by phone within 24 hours of completion of test/evaluation/treatment • Urgent written report transmitted to VA within 48 hours of finding • New diagnosis of cancer reported to VA within 48 hours • Notification within 24 hours if Veteran requires urgent follow-up or additional care during authorized episode of care
Network adequacy to enable access	• Regular care: o Urban within 60 minutes of commute time o Rural within 120 minutes of commute time o Highly rural within 240 minutes commute time • When a higher level of care is needed, which is specialized consultative health care, usually for inpatients and in a facility that has personnel and facilities for advanced medical investigation and treatment, such as tertiary referral hospital, e.g., cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for serve burns, advanced neonatology services, palliative, and other complex medical and surgical interventions: o Urban within 120 minutes of commute time o Rural within 240 minutes of commute time o Highly rural within community standard commute time

7. **Please list and describe the oversight mechanisms the Department has in place to monitor compliance with VA directives and policies at the local, regional, and national level.**

VA has a robust set of oversight mechanisms in place to monitor compliance with VA and VHA directives, handbooks, memorandums, and other policy documents. In light of recent events, we are aware of the need to do more, and so we are developing processes and tools to enhance oversight.

Responsibility for ensuring compliance with policy falls to every staff member in the Department, while oversight falls to the managers and leadership teams at each level of the organization. VA nurtures an environment that encourages staff to speak up when they believe there is a potential issue or violation of policy occurring. Staff are routinely trained on the ways in which they can speak up about issues that may be occurring at their facility. National Program Offices also provide program specific oversight across all VISNs and Facilities. Some specific mechanisms include, but are not limited to:

- One oversight mechanism utilized by the Department includes the analysis and reporting of data, as well as associated site visits. As one example, VHA Occupational Health monitors drug testing lab error reports, workers compensation claims and cost data, sexual assault training completion and facility violence risk assessment data as well as employee health clinic quality metrics. Occupational Health uses laboratory-generated error reports and random site visits to monitor compliance with VA policies and mandatory Department of Health and Human Services (HHS) guidelines on the Drug Free Workplace program. Results of site visits are used to improve performance via feedback to facility and VISN executives, and VHA leadership.

- As a second example of an oversight mechanism, VHA Central Office program offices also collect and utilize data from the field to monitor compliance. VHA Mental Health Services, in coordination with VHA Mental Health Operations, surveys the field quarterly to ascertain compliance with the Uniform Mental Health Services Handbook. This survey evaluates programs at the local, regional and national level. Additionally, Mental Health Services supports Mental Health Operations in conducting site visits which thoroughly evaluate all mental health programs at a local level.

- A third mechanism is the use of metrics to assess performance. The VHA Health Information Management (HIM) office co-produces and publishes

metrics related to facility compliance with clinical coding requirements. In addition, HIM collaborates with the VHA Chief Business Office on coding and billing audits and shares its findings with facility and VISN leadership. When negative trends are discovered, HIM prepares training for HIM professionals nationwide to ensure improved clinical coding practices. HIM also shares best practices that individual facilities have employed to improve their success in these areas. In a similar fashion, VHA Rehabilitation and Prosthetic Services utilizes dashboards for certain performance measures, with regular reporting to VHA Policy and Services and the Office of the Assistant Deputy Under Secretary for Health for Clinical Operations to enforce compliance. The program office uses the Procurement Acquisition Lead Time tool to monitor provision of prosthetic items to Veterans (and any delays). It also monitors corporate data (from the Decision Support Systems, and the VHA Support Service Center and Office of Productivity) and distributes analyses to the field to provide feedback, education and support.

- A fourth mechanism for oversight is ongoing communication and coordination with the field to monitor compliance. Data on Patient Aligned Care Teams (PACT) implementation including access, continuity, and care coordination are available online in the PACT Compass. This data is available at the provider, facility, VISN and national level, and is extracted in a PACT Dashboard that indicates each facility's level of achievement. The VHA Office of Primary Care Operations leads twice monthly calls with Primary Care VISN Leads, where primary care leaders representing each VISN are provided the opportunity to discuss issues and problems they are having implementing PACT functions and processes at the regional level, and Compass and Dashboard data are routinely reviewed. On a quarterly basis, these calls include facility leads as well.

8. **When a patient safety incident and/or preventable veteran death is identified does VA automatically review the incident to assess whether administrative action is warranted against the employees involved? Please explain.**

Any adverse event for a Veteran within our care is one too many. When an incident occurs in our system we aggressively identify, correct and work to prevent additional risks. We conduct a thorough review to understand what happened, prevent similar incidents in the future, and share lessons learned across the system.

VHA along with many other healthcare organizations pursues a "just culture", in which accountability principles are clearly stated but people are not punished for making inadvertent medical errors. Professor Lucian Leape of the Harvard School of Public Health has testified before Congress that the single greatest impediment to error prevention in the medical industry is that we punish people for making

mistakes.[1] Calling for punishment and termination of employees is not supported by the research describing Just Culture as a model for management of mistakes and errors. Ignoring what the science of safety tells us about the causes of human error encourages staff to cover up or not report such errors. Adverse events and close calls are a function of system level vulnerabilities rather than intentionally unsafe acts requiring administrative review or disciplinary action. Event reporting and speaking up by employees is openly encouraged by VHA leadership. The National Center for Patient Safety (NCPS) collects and analyzes adverse events and close call reports in order to share remedies and lessons learned. Reports and analyses collected by NCPS are not used for administrative or disciplinary action.

When a patient safety incident or preventable death occurs and it reasonably appears to be the result of, among other issues, an intentional or negligent unsafe act on the part of a provider, the case is given a preliminary review by clinical leadership at the facility. If facility leadership has concerns related to the adverse event, it may convene an administrative investigation.

In the case of adverse events in which clinical decision-making associated with care delivery is of concern, a peer review of the case can be initiated. A Peer Review program is in place in every VA facility to assist with this process and to improve the quality of care provided to Veterans. Peer review for quality management is an evaluation of the care provided by an individual provider to evaluate the performance of a peer professional. If a clinical event falls into one of the categories listed in the VHA policy on peer review for quality management, e.g., death appears to be related to a hospital-incurred incident or a complication of treatment, the case will be referred for peer review pursuant to policy. Any resulting recommended actions to improve performance are communicated back to the provider who was the subject of the peer review. However, if willful misconduct or gross negligence is identified during the initial case review or conduct of a peer review for quality management, the peer review will not be initiated, or will be discontinued. The case will then be referred back to facility leadership to determine the appropriate administrative course, e.g., an Administrative Investigation Board.

9. **The Department's written statement alleges that the root cause analysis (RCA) is used to, "...determine basic and contributing system causes of errors." Yet, the VA Inspector General (IG) found that implementation of the RCA action plans at the Memphis VA Medical Center were delayed, incomplete, and contained errors in fact. The IG also found that, "when issues were identified through the RCA process, actions to prevent a recurrence were not taken seriously." Please respond to the IG's findings. In addition, please provide the number of RCAs that were conducted at VA**

[1] Testimony, United States Congress, House Committee on Veterans' Affairs, Dr. Lucian L. Leape, MD, October 12, 1997.

medical facilities last year. Of those, how many concerned delays in care and treatment?

The October 23, 2013, OIG Report documents that the Memphis VA Medical Center completed actions related to the OIG recommendation that the facility director ensure root cause analysis action plans are documented, monitored, and completed promptly. The facility established a tracking tool for RCA actions in June 2013.

The National Center for Patient Safety (NCPS) SPOT (electronic Root Cause Analysis database), reflects 1,597 RCAs for the period from Jan 1, 2013 to Dec 31, 2013. Of those, 195 were related to delay in diagnosis, treatment, or combined category.

10. **During the hearing, the American Legion referenced waiting approximately five months for the Department to respond to a request for a report regarding the Jackson VA Medical Center. When will the Department provide that report to the American Legion?**

The report referenced is in final review at the Department. It will be provided to the Committee when review is complete.