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116TH CONGRESS
1ST SESSION

S. 3147

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 23, 2019

Referred to the Committee on Veterans' Affairs

AN ACT

To require the Secretary of Veterans Affairs to submit to Congress reports on patient safety and quality of care at medical centers of the Department of Veterans Affairs, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the ''Improving Safety and
3 Security for Veterans Act of 2019''.

4 **SEC. 2. DEPARTMENT OF VETERANS AFFAIRS REPORTS ON**
5 **PATIENT SAFETY AND QUALITY OF CARE.**

6 (a) REPORT ON PATIENT SAFETY AND QUALITY OF
7 CARE.—

8 (1) IN GENERAL.—Not later than 30 days after
9 the date of the enactment of this Act, the Secretary
10 of Veterans Affairs shall submit to the Committee
11 on Veterans' Affairs of the Senate and the Com-
12 mittee on Veterans' Affairs of the House of Rep-
13 resentatives a report regarding the policies and pro-
14 cedures of the Department relating to patient safety
15 and quality of care and the steps that the Depart-
16 ment has taken to make improvements in patient
17 safety and quality of care at medical centers of the
18 Department.

19 (2) ELEMENTS.—The report required by para-
20 graph (1) shall include the following:

21 (A) A description of the policies and proce-
22 dures of the Department and improvements
23 made by the Department with respect to the
24 following:

1 (i) How often the Department reviews
2 or inspects patient safety at medical cen-
3 ters of the Department.
4 (ii) What triggers the aggregated re-
5 view process at medical centers of the De-
6 partment.
7 (iii) What controls the Department
8 has in place for controlled and other high-
9 risk substances, including the following:
10 (I) Access to such substances by
11 staff.
12 (II) What medications are dis-
13 pensed via automation.
14 (III) What systems are in place
15 to ensure proper matching of the cor-
16 rect medication to the correct patient.
17 (IV) Controls of items such as
18 medication carts and pill bottles and
19 vials.
20 (V) Monitoring of the dispensing
21 of medication within medical centers
22 of the Department, including moni-
23 toring of unauthorized dispensing.
24 (iv) How the Department monitors
25 contact between patients and employees of

1 the Department, including how employees
2 are monitored and tracked at medical cen-
3 ters of the Department when entering and
4 exiting the room of a patient.
5 (v) How comprehensively the Depart-
6 ment uses video monitoring systems in
7 medical centers of the Department to en-
8 hance patient safety, security, and quality
9 of care.
10 (vi) How the Department tracks and
11 reports deaths at medical centers of the
12 Department at the local level, Veterans In-
13 tegrated Service Network level, and na-
14 tional level.
15 (vii) The procedures of the Depart-
16 ment to alert local, regional, and Depart-
17 ment-wide leadership when there is a sta-
18 tistically abnormal number of deaths at a
19 medical center of the Department, includ-
20 ing—
21 (I) the manner and frequency in
22 which such alerts are made; and
23 (II) what is included in such an
24 alert, such as the nature of death and

1 where within the medical center the
2 death occurred.
3 (viii) The use of root cause analyses
4 with respect to patient deaths in medical
5 centers of the Department, including—
6 (I) what threshold triggers a root
7 cause analysis for a patient death;
8 (II) who conducts the root cause
9 analysis; and
10 (III) how root cause analyses de-
11 termine whether a patient death is
12 suspicious or not.
13 (ix) What triggers a patient safety
14 alert, including how many suspicious
15 deaths cause a patient safety alert to be
16 triggered.
17 (x) The situations in which an au-
18 topsy report is ordered for deaths at hos-
19 pitals of the Department, including an
20 identification of—
21 (I) when the medical examiner is
22 called to review a patient death; and
23 (II) the official or officials that
24 decide such a review is necessary.

1 (xi) The method for family members
2 of a patient who died at a medical center
3 of the Department to request an investiga-
4 tion into that death.
5 (xii) The opportunities that exist for
6 family members of a patient who died at a
7 medical center of the Department to re-
8 quest an autopsy for that death.
9 (xiii) The methods in place for em-
10 ployees of the Department to report sus-
11 picious deaths at medical centers of the
12 Department.
13 (xiv) The steps taken by the Depart-
14 ment if an employee of the Department is
15 suspected to be implicated in a suspicious
16 death at a medical center of the Depart-
17 ment, including—
18 (I) actions to remove or suspend
19 that individual from patient care or
20 temporarily reassign that individual
21 and the speed at which that action oc-
22 curs; and
23 (II) steps taken to ensure that
24 other medical centers of the Depart-
25 ment and other non-Department med-

1 ical centers are aware of the suspected
2 role of the individual in a suspicious
3 death.

4 (xv) In the case of the suspicious
5 death of an individual while under care at
6 a medical center of the Department, the
7 methods used by the Department to inform
8 the family members of that individual.

9 (xvi) The policy of the Department for
10 communicating to the public when a sus-
11 picious death occurs at a medical center of
12 the Department.

13 (B) A description of any additional au-
14 thorities or resources needed from Congress to
15 implement any of the actions, changes to policy,
16 or other matters included in the report required
17 under paragraph (1)

18 (b) REPORT ON DEATHS AT LOUIS A. JOHNSON
19 MEDICAL CENTER.—

20 (1) IN GENERAL.—Not later than 60 days after
21 the date on which the Attorney General indicates
22 that any investigation or trial related to the sus-
23 picious deaths of veterans at the Louis A. Johnson
24 VA Medical Center in Clarksburg, West Virginia, (in
25 this subsection referred to as the ''Facility'') that

1 occurred during 2017 and 2018 has sufficiently con-
2 cluded, the Secretary of Veterans Affairs shall sub-
3 mit to the Committee on Veterans' Affairs of the
4 Senate and the Committee on Veterans' Affairs of
5 the House of Representatives a report describing—
6 (A) the events that occurred during that
7 period related to those suspicious deaths; and
8 (B) actions taken at the Facility and
9 throughout the Department of Veterans Affairs
10 to prevent any similar reoccurrence of the
11 issues that contributed to those suspicious
12 deaths.
13 (2) ELEMENTS.—The report required by para-
14 graph (1) shall include the following:
15 (A) A timeline of events that occurred at
16 the Facility relating to the suspicious deaths
17 described in paragraph (1) beginning the mo-
18 ment those deaths were first determined to be
19 suspicious, including any notifications to—
20 (i) leadership of the Facility;
21 (ii) leadership of the Veterans Inte-
22 grated Service Network in which the Facil-
23 ity is located;
24 (iii) leadership at the central office of
25 the Department; and

1 (iv) the Office of the Inspector Gen-
2 eral of the Department of Veterans Af-
3 fairs.
4 (B) A description of the actions taken by
5 leadership of the Facility, the Veterans Inte-
6 grated Service Network in which the Facility is
7 located, and the central office of the Depart-
8 ment in response to the suspicious deaths, in-
9 cluding responses to notifications under sub-
10 paragraph (A).
11 (C) A description of the actions, including
12 root cause analyses, autopsies, or other activi-
13 ties that were conducted after each of the sus-
14 picious deaths.
15 (D) A description of the changes made by
16 the Department since the suspicious deaths to
17 procedures to control access within medical cen-
18 ters of the Department to controlled and non-
19 controlled substances to prevent harm to pa-
20 tients.
21 (E) A description of the changes made by
22 the Department to its nationwide controlled
23 substance and non-controlled substance policies
24 as a result of the suspicious deaths.

1 (F) A description of the changes planned
2 or made by the Department to its video surveil-
3 lance at medical centers of the Department to
4 improve patient safety and quality of care in re-
5 sponse to the suspicious deaths.
6 (G) An analysis of the review of sentinel
7 events conducted at the Facility in response to
8 the suspicious deaths and whether that review
9 was conducted consistent with policies and pro-
10 cedures of the Department.
11 (H) A description of the steps the Depart-
12 ment has taken or will take to improve the
13 monitoring of the credentials of employees of
14 the Department to ensure the validity of those
15 credentials, including all employees that inter-
16 act with patients in the provision of medical
17 care.
18 (I) A description of the steps the Depart-
19 ment has taken or will take to monitor and
20 mitigate the behavior of employee bad actors,
21 including those who attempt to conceal their
22 mistreatment of veteran patients.
23 (J) A description of the steps the Depart-
24 ment has taken or will take to enhance or cre-
25 ate new monitoring systems that—

1 (i) automatically collect and analyze
2 data from medical centers of the Depart-
3 ment and monitor for warnings signs or
4 unusual health patterns that may indicate
5 a health safety or quality problem at a
6 particular medical center; and
7 (ii) automatically share those warn-
8 ings with other medical centers of the De-
9 partment, relevant Veterans Integrated
10 Service Networks, and officials of the cen-
11 tral office of the Department.
12 (K) A description of the accountability ac-
13 tions that have been taken at the Facility to re-
14 move or discipline employees who significantly
15 participated in the actions that contributed to
16 the suspicious deaths.
17 (L) A description of the system-wide re-
18 porting process that the Department will or has
19 implemented to ensure that relevant employees
20 are properly reported, when applicable, to the
21 National Practitioner Data Bank of the Depart-
22 ment of Health and Human Services, the appli-
23 cable State licensing boards, the Drug Enforce-
24 ment Administration, and other relevant enti-
25 ties.

1 (M) A description of any additional au-
2 thorities or resources needed from Congress to
3 implement any of the recommendations or find-
4 ings included in the report required under para-
5 graph (1).
6 (N) Such other matters as the Secretary
7 considers necessary.

Passed the Senate December 19, 2019.

Attest: JULIE E. ADAMS,
Secretary.