

**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**

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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.

¹ <http://www.patientsafety.va.gov/CTT/index.html>.