

**STATEMENT OF MICHAEL J. MISSAL
INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
"THE CURIOUS CASE OF THE VISN TAKEOVER:
ASSESSING VA'S GOVERNANCE STRUCTURE"**

MAY 22, 2018

Mr. Chairman, Ranking Member Walz, and members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG) recent report, *Critical Deficiencies at the Washington, DC VA Medical Center*, and how those findings are indicative of a breakdown of oversight at several levels within the Department of Veteran Affairs (VA).¹ Since becoming Inspector General two years ago, I have made VA leadership and governance issues a priority for our work, recognizing that deficiencies in these areas ultimately affect the care and services provided to veterans and allow significant problems to persist unresolved for years.

BACKGROUND

VA's Veterans Health Administration (VHA) has over 9 million enrolled veterans. It manages the largest integrated healthcare system in the nation, with over 145 VA medical centers (VAMCs) and approximately 1,230 outpatient sites. Oversight for these VAMCs and outpatient sites is the responsibility of 18 regional networks called Veterans Integrated Service Networks (VISNs). VHA established the VISN offices to improve access to medical care and ensure the efficient provision of timely, quality care to our nation's veterans. In 1995, VHA submitted a plan to Congress called *Vision for Change* that restructured VHA field operations into VISNs. VHA specifically decentralized its budgetary, planning, and decision-making functions to the VISN offices in an effort to promote accountability and improve oversight of daily facility operations.

The OIG has had a longstanding focus of governance issues in VHA. For example, in March 2012, the OIG issued two reports dealing with VISN management and structure: the *Audit of VHA's Financial Management and Fiscal Controls for Veterans Integrated Service Network Offices* and the *Audit of VHA's Management Control Structures for Veterans Integrated Service Network Offices*.² Our work determined that VHA did not have adequate data to monitor VISN operations or staffing levels. This weakness led to inadequate oversight of VISN operations, a lack of accountability, and noncompliance with policies. Work we have conducted since that time suggests that there continues to be leadership and governance issues between medical centers and their VISN, as well as between VISNs and the VA central office. Strong leadership and governance are

¹ The report was published on March 7, 2018.

² Both reports were issued on March 27, 2012.

critical to not only consistently achieving goals, but also to creating a culture that fosters personal accountability and positive change, frequent and effective communications, and compliance with policies and high-quality standards. Where there are deficiencies in leadership and governance there likely will be a cascade of persistent and pervasive problems like those we found at the DC VAMC. Although the report on that facility is our focus for this testimony, the lessons learned can be applied to VISNs and medical centers across the nation.

A CASE STUDY: THE WASHINGTON, DC VA MEDICAL CENTER

The OIG received information from a confidential source about the Washington, DC VAMC (DC VAMC) in March 2017 alleging that patients and resources were at risk. Due to the seriousness of the allegations and the initial findings, the OIG issued an interim report on April 12, 2017, that included the following findings:³

- Inaccurate and underutilized supply, instrument, and equipment inventories that made it difficult to meet healthcare provider and patient needs
- Inadequate product safety recall processes
- Dirty conditions in some clean/sterile storerooms
- Millions of dollars in noninventoried supplies and equipment
- Numerous vacancies in key positions that would make remediation of these conditions difficult

The OIG continued the inspection for the next nine months and reported in March 2018 on significant pervasive problems that affected risks to patient care and safety, service deficiencies that impeded healthcare providers' efforts, lack of control over assets, and leadership failures at multiple levels of VA. The report also details that many management offices at VHA Central Office (VHACO), VISN 5 leaders, and leaders at the DC VAMC had been given reports regarding many of these documented problems but they failed to appreciate the impact on patient care or had failed to take the necessary actions to correct the problems in many cases.⁴ Significantly, we did not find any patient deaths or other adverse clinical outcomes relating to these deficiencies, primarily due to the efforts of a number of committed healthcare professionals who improvised as necessary to ensure veterans received the best possible care under the circumstances. The final report contained 40 recommendations addressing deficiencies in multiple core functions of the DC VAMC's operations—all of which were agreed to by VA.

Service Deficiencies Affecting Patient Care

Although the medical center and VISN 5 have taken steps to address the supply chain inventory management issues described in the OIG Interim Report (such as detailing additional personnel to enter data into the authorized inventory system), problems persisted during the time of our inspection in getting supplies, instruments, and

³ *Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC*

⁴ VISN 5, VA Capitol Health Care Network, includes the Washington, DC VAMC.

equipment to patient care areas when they are needed. The OIG identified wide-ranging factors involving multiple deficiencies across several key services in the medical center, including the following:

- Continuing supply chain and inventory management problems
- Unsafe storage of clean/sterile supplies
- Deficiencies in the Sterile Processing Service
- Backlogs of open and pending prosthetic consults
- Staffing shortages and human resources mismanagement
- Lack of control over assets

Supply Chain and Inventory Management Problems

The Generic Inventory Package (GIP) is the authorized software program used by VHA medical facilities to manage the receipt, distribution, and maintenance of supplies. The DC VAMC was required to use the GIP system until early May 2015 when the facility was directed to implement a new inventory system called Catamaran. However, as noted in the final report, medical center staff informed the OIG that the Catamaran system was never relied upon. Although the medical center had nominally transitioned to Catamaran in May 2015, VHA Procurement and Logistics Office (P&LO) staff were aware by January 2016 that the medical center had reverted to its manual inventory management practices and was not using the Catamaran system. These staff told OIG inspectors that they had no authority over the medical center, could not compel it to comply, and did not escalate the matter to VHA P&LO leaders. VHA subsequently terminated the Catamaran contract. Prior to the OIG receiving the allegations discussed in our report, VA's Policy, Assistance, and Quality (PAQ) staff from the VHA P&LO, conducted a review of inventory management at the medical center. PAQ staff determined in its January 2017 report that the medical center did not have a VHA-authorized inventory system in place.

On March 21, 2017, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) instructed the VISN 5 Director and the Medical Center Director via an emailed memo to provide an action plan addressing the PAQ concerns. Staff were detailed to the DC VAMC to take corrective action. Despite those efforts, the concerns were not adequately addressed and the OIG final report provided many examples of how inventory mismanagement contributed to the lack of medical supplies being available where and when they were needed, including oxygen nasal cannula tubing, disposable surgical staplers, and tubing for blood transfusions.

We continued to find ongoing inaccuracies in the data entered in GIP. Even for a small number of items, the medical center could not reconcile its actual inventory with the data in GIP. As a result of the medical center's underutilization of GIP (estimates of 15–25 percentage of items included), it could not rely on the system to identify when

supplies were running low or out of stock.⁵ The product recall process was also vulnerable because an accurate inventory was not kept. The medical center did institute a stop-gap measure to deal with supplies that may have been subject to a recall, but that was inadequate because Logistics Service and clinical staff had no way of verifying that all specified items had been removed from use. Without an accurate inventory, there is a heightened risk to patients that recalled products could be mistakenly used. In addition to patient risks associated with the medical center running out of supplies or using recalled products being elevated, the lack of accurate stock levels contributed to urgent reordering, some overstocking, and waste of government resources.

Unsafe Storage of Clean/Sterile Supplies

To advance both patient safety and sound financial management, inventoried items must be secured and maintained in clean conditions. Proper storage of clean/sterile supplies is essential to preventing contamination and patient infections, as well as product deterioration. According to VHA directive, to maintain supplies properly, clean/sterile storerooms must have stable temperature and humidity, restricted access, weekly shelf-cleaning by Logistics Service staff, and solid bottom shelves at least eight inches from the floor. Logistics Service staff must sign a weekly log stating that the area has been checked for expired supplies, cleanliness, and damage. While Logistics Service staff have responsibility for some specific cleaning tasks in clean/sterile storerooms, the Environmental Management Service (EMS) is responsible for the overall cleanliness of the rooms.

EMS and Logistics Services reported having difficulties hiring and retaining qualified staff. VISN 5 knew of the staffing shortages in EMS in early fiscal year (FY) 2017 and knew of the Logistics Service staffing issues as early as 2014 from an external consultant's report. However, adequate steps to remedy the deficiencies were not taken.

After our interim report, we noted some improvements in the cleanliness of storage rooms. The medical center had entered into a contract with a commercial cleaning service in June to supplement the medical center EMS staff but some areas were still of concern. As of September 2017, the Acting Human Resources Director reported to the OIG that 138 of 147 authorized EMS positions were filled.

Deficiencies in the Sterile Processing Service

The OIG detailed multiple deficiencies in the Washington DC VAMC's Sterile Processing Service (SPS). These ranged from broken and discolored instruments reaching clinical areas; incomplete surgical trays in the operating room; improper tracking and reprocessing procedures for loaner instruments; missing or expired SPS supplies; failure to follow reprocessing instructions; inadequate documentation of staff competencies; and not separating clean and dirty items in satellite reprocessing areas.

⁵ In response to OIG findings, VA has reported that the DC VAMC has transitioned inventory to the GIP system and addressed stock levels, which will be assessed in OIG's follow-up process.

These problems were not new. Prior reviews were shared with the medical center, the VISN, and VHACO that consistently revealed deficiencies in SPS processes and procedures, staffing and leadership within SPS, and environment of care concerns that dated back to at least 2015. The National Program Office for Sterile Processing reported concerns in April 2015, September 2015, and October 2016. The October 2016 report had 140 corrective actions including some repeat findings. In response to why conditions were uncorrected for so long, SPS managers cited chronic understaffing of SPS and difficulties retaining qualified personnel.

In November 2017, the OIG received a complaint about cancellation of nine surgeries at the medical center. The OIG confirmed the cancellations and that the medical center had reported to VHACO that spotting and discoloration were found on some instruments. A contractor was hired and examined 8,931 pieces of equipment and instruments over a two-day period. The contractor reported finding rust on about 30 instruments; those items were polished and returned to service. On further inspection the same contractor recommended replacing 216 instruments. Our report found that historically even when new instruments were purchased, they could not always be reprocessed appropriately nor were they always stored appropriately. In its response to the OIG report, VA stated that it purchased more than \$3 million in surgical instruments and contracted to construct additional space for SPS.

Backlog of Open and Pending Prosthetic Consults

VHA requires that quality patient care be provided by furnishing properly prescribed prosthetic equipment, sensory aids, and devices in an economical and timely manner. To order a prosthetic appliance or implant, a medical center provider must initiate and submit a consult (a request for an item that allows for subsequent tracking) in the electronic health record to the Prosthetics Service.

A prosthetic consult is considered “closed” when a patient receives an in-stock item, a purchasing agent ships an in-stock item to the patient, or a purchasing agent places an order with a vendor for a nonstocked item to be shipped directly to the patient. A prosthetic consult is placed in a “pending” status if other actions must be taken before the consult can be completed and should be documented in the prosthetic consult to allow for tracking through completion. VHA business practice guidelines for prosthetic consult management states that pending prosthetic consults “must be reviewed at least weekly by the Chief, [Prosthetic and Sensory Aids Services] and the Prosthetic employee responsible for completing that consult.” VHA requires the closure of pending prosthetic consults upon the earlier of 45 working days or 60 calendar days.

Medical center and VISN 5 leaders became aware of the increasing number of open and pending prosthetic consults in May 2016 but due to incomplete administrative actions by the medical center leaders to provide access to its systems, VISN 5 could not take the necessary steps to provide assistance in addressing the increasing number of open and pending prosthetic consults.

To resolve the consults backlog identified by the OIG, the Acting Medical Center Assistant Director reported VA had efforts in progress to hire staff, redesign the organizational structure, claim 2,000 square feet of warehouse space for inventory, and develop a walk-in clinic. In addition, he reported that nine purchasing agents had been assigned from across VHA to assist with resolving open and pending prosthetic consults.

On August 29, 2017, OIG staff spoke with the Acting Chief of Prosthetics who confirmed that through the use of additional staffing, the medical center had been able to reduce the number of prosthetic consults to approximately 6,130, of which 3,800 were more than 30 days old. Also in August, the DC VAMC chartered an Administrative Investigative Board to determine accountability for the failures identified within the Prosthetics Service. In its response to our final report, VHA stated that “as of January 2018, the DC VAMC had no pending prosthetics consults over 30 days.” We will verify this information during our follow-up process.

Staffing Shortages and Human Resources Mismanagement

Medical center personnel often attributed deficiencies in Logistics Service and SPS to chronic understaffing. To obtain additional staff, the medical center’s policy specifies that Service Chiefs must determine the minimum number of positions needed to perform the functions of their services and submit requests for new positions or changes in the grade of already approved positions to the Resource Management Committee (RMC). The Associate Director of the medical center chairs the RMC, which makes recommendations to the Director regarding approval or disapproval of these requests, based in part on budgetary considerations. The medical center Human Resources Management (HR) is responsible for executing actual hiring actions.

The OIG determined that Logistics Service and SPS had experienced historically high vacancy rates. A number of factors contributed to these rates, including a failure to maintain accurate data on the numbers of authorized positions throughout the medical center; the RMC not performing its duties in accordance with policy; and HR not completing hiring actions appropriately.

The OIG confirmed that high turnover rates in HR leadership may have contributed to the failure to resolve staffing issues. VHACO and VISN 5 provided teams and personnel to support the medical center’s general HR functions, but the DC VAMC did not implement action plans developed from those consultative site visits.

VA reports progress in hiring but vacancy rates for SPS staff are still high at the medical center, although VA reports some of those positions being filled by contractors in their response to the OIG report.

Lack of Control Over Assets

The medical center continually mismanaged significant government resources and did not adequately secure veterans’ protected information. Its financial and inventory systems produced inadequate data, lacked effective management controls, and yielded

no reasonable assurance that funds were appropriately expended. Accordingly, the OIG could not estimate the loss to VA as a result of the failings identified in the final report. A number of examples are provided in the report, however, that show significant overpayments for particular products; unsecured access to and mismanagement of more than 500,000 items accumulated in an off-site warehouse that included purchases not meeting medical center needs, overstocked items, and some items that appeared damaged; abuse of purchase cards; and other failures to use taxpayer dollars appropriately.

The following are examples of how government resources were at risk for or subject to fraud, waste, and abuse:

- There was excessive use of government purchase cards for medical equipment and supply purchases (89 percent of the medical center's total purchase card use was for medical supplies) instead of approved federal contracts that leverage buying power and helped ensure appropriate pricing and purchasing. Purchase card use was not as closely scrutinized and did not take advantage of the typically lower prices associated with buying under federal contracts. They were misused, in part, because leaders failed to ensure proper controls or fix an inventory system—which sometimes led to urgent purchases needing to be made on purchase cards for quick delivery as a workaround for supply problems.
- The VISN 5 Agency/Organization Program Coordinator (A/OPC) for the purchase card program reported potentially fraudulent purchase orders to medical center leaders and the Chief of Prosthetics in September 2016. After no action was taken by either, the VISN 5 A/OPC took action to reduce a purchasing agent's limit and initiated an audit. Also VA policy limited the number of purchase card accounts for which an approving official is responsible to not more than 25. At the medical center, the Chief Logistics Officer (CLO) was responsible for approving expenditures made by all of the 86 cardholders.
- A general lack of controls was found over acquisition of medical supplies and equipment, including the inability to consistently provide documentation such as purchase orders, invoices, receiving reports, or other item-level records required for proper auditing. For example, the medical center incurred nearly \$875,000 in rental fees for three specialized hospital beds for patients' in-home use that could have been purchased new for a total of about \$21,000.
- The medical center failed to segregate duties so that the same individual was not both purchasing and receiving or inventorying goods to ensure the integrity of procurement processes and prevent theft or abuse.
- The medical center lacked an updated and accurate inventory for nonexpendable equipment. VA requires medical facilities to perform an annual physical inventory of all nonexpendable items and maintain an Equipment Inventory List (EIL). EIL includes all nonexpendable property with assigned numbers that correspond to the responsible department. Although the EIL Custodial Officer is responsible for completing and signing the EIL, the Medical Center Director and CLO (or their designee) must ensure accountability and oversight for all nonexpendable

property and equipment in their facility. The Medical Center CLO failed to submit data for the VHA Quarterly EIL reports for three years. Furthermore, a March 2017 memo from the DUSHOM to the VISN Director and the Medical Center Director stated that Reports of Survey listing lost or stolen property had not been completed for more than five years.

- Because of failures in Records Management, more than 1,300 boxes of unsecured documents, including some patient protected health information and personally identifiable information were found in various locations including the off-site warehouse, on-site storage, the DC VAMC basement, and a dumpster.

Risks to Patient Care

It is clear that functions typically thought of as administrative in nature can have a profound impact on the ability of healthcare providers to do their jobs effectively and on the risk of harm to patients. During extensive interviews conducted by the OIG's Rapid Response Team and other personnel, 13 healthcare providers stated that they had reported their concerns to the Chief of Surgery and 12 healthcare providers stated that they had reported supply, instrument, or equipment concerns to the Medical Center Chief of Staff. As I will discuss further, these and other issues at the DC VAMC were reported to the VISN and by program offices within VA.

For our review, OIG healthcare staff independently reviewed the care provided to 124 DC VAMC patients to determine if they experienced adverse clinical outcomes because their healthcare provider did not have the appropriate supplies, instruments, or equipment. As discussed earlier, while the OIG did not find that patients suffered adverse clinical outcomes for the review period, staff provided several examples that illustrated an impact on patients when supplies, instruments, and equipment were not available when needed. These included unnecessary anesthesia, prolonged procedures or hospitalizations, and alternative surgical techniques due to failure to ensure the availability of instruments or supplies. For example, a "mesher" used to place small holes in the skin to assist with drainage had a missing handle and the surgeon needed to conduct the procedure manually, which can result in uneven drainage. In some cases, procedures needed to be delayed, rescheduled, or required staff to leave the facility to borrow what was needed from a nearby private hospital. For example, an instrument was not sterilized since its last use and was unavailable to the surgeon after the patient received general anesthesia, resulting in the procedure being cancelled and rescheduled two days later, which unnecessarily exposed the patient to the risks associated with the anesthesia. In another case, staff went "across the street" to a medical facility to acquire mesh while the operation was ongoing. We found that staff lacked confidence that managers and leaders overseeing the facility would fix these problems and resorted to creating their own workarounds to ensure patients received proper care.

Patient Safety Reports

Patient safety reports allow for the reporting and tracking of adverse events and "close calls" as well as allowing VA medical facilities to identify and address unsafe conditions. For the interim report review, OIG staff found 193 patient safety reports at the DC

VAMC since January 1, 2014, were entered into VHA's National Center for Patient Safety (NCPS) database. However, we determined that the number of patient safety events was under-reported and at least 376 patient safety events related to supplies, instruments, or equipment were reported within the medical center. Of those, 206 patient safety events were entered into the facility's system, but were not entered into the VHA database as required. Overall, the DC VAMC failed to appropriately score, trend, and record patient safety events and the patient safety manager did not properly identify that further analysis was warranted.

Within an individual medical center, the patient safety manager can identify emerging trends that could potentially compromise patient safety through event reporting and analysis. At the national level, the VHA NCPS analyzes data reported from all medical facilities to identify emerging trends that have the potential to compromise patient safety in multiple facilities. At DC VAMC, although data were available, the patient safety manager did not detect the widespread nature of the supply, instrument, and equipment problems until June 2016, when an individual root cause analysis was conducted on an incident involving the use of expired surgical supplies during a surgical procedure.

Other mechanisms for aggregating information to inform VISN and medical center leaders about emerging issues include the work of quality management and safety committees. The OIG conducted an extensive review of meeting minutes from the Executive Committee of the Governing Body (ECGB), which is responsible for oversight of critical quality and patient safety monitors, and its subordinate committees. The ECGB oversees the Medical Executive Committee and Quality Council as well as other organizational patient safety and performance improvement initiatives.

VHA policy requires the ECGB to keep minutes that describe and track issues to resolution, as well as to make recommendations to leaders. The OIG review of minutes from October 2015 through April 2017 revealed a pattern of reporting and oversight deficits. In addition to the ECGB meeting minutes, the OIG reviewed meeting minutes of other committees that provide oversight for patient safety and performance improvement initiatives. Review of the Director's morning report also revealed a lack of appropriate follow-up actions for surgical instrument issues.

The OIG confirmed through interviews and analyses of documents provided that action plans, if implemented, were not consistently effective at resolving issues as evidenced by ongoing deficiencies in many areas. The VISN Quality Management Officer who has responsibility for overseeing all aspects of quality management and performance improvement at VISN 5 facilities acknowledged these concerns in an interview with OIG staff, and reported that he would be "pushing for a rapid process improvement initiative." VA has also reported that following our findings, the DC VAMC cleared its backlog of patient safety incident reports.

Failures in Leadership

It is clear that information and documentation outlining some, if not most, of the failings in the medical center reached responsible officials in DC VAMC, VISN 5, and VHACO as early as 2013, but actions taken did not effectively remediate the conditions.

From 2013 through 2016, the DC VAMC and VISN 5 received at least seven written reports detailing significant deficiencies in Logistics, Sterile Processing, and other Services, many of which were identified as persistent at the time of the OIG 2017 on-site visits.

- Management Quality Assurance Service (MQAS) Report (2013) – This report evaluated the performance of selected areas of logistics operations and identified areas requiring improvement. This report was provided to the Medical Center Director in January 2013 as well as VHACO Procurement and Logistics Office (P&LO) and VISN 5 leaders. It contained 52 conditions including nine repeat findings and two concerns related to compliance with VA and VHA directives that required management attention.

There was an exchange of information between MQAS and the Medical Center Director in March and May 2013 but in December 2013, MQAS staff emailed medical center staff requesting an update as the completion dates were past due. Again in February 2014, MQAS staff reached out for an update but the Medical Center did not respond. In June 2014, MQAS requested assistance from VHA P&LO. VHACO contacted the VISN CLO for an update and to offer assistance. Moreover, the VISN 5 CLO admitted that the VISN “may have dropped the ball on response.” In October 2014, MQAS advised the VISN 5 CLO that they would elevate these issues if the DC VAMC did not provide information. The medical center responded in piecemeal fashion. In December 2015, MQAS determined based on representations from the Medical Center, that all but one recommendation was satisfied. As late as February 2017, MQAS continued to follow up with DC VAMC Logistics Service for required reports.

- VISN 5 Network External Review (NER) (2013) – Each VISN was required to conduct an annual review of its facilities’ logistics operations. In May 2013, the VISN Director sent the Medical Center Director the NER relating to Logistics Service containing 55 observations including a finding that the medical center was not using GIP to manage its inventory. In June 2013, the Associate Medical Center Director responded and provided estimated implementation dates for each of the 55 areas.
- VISN 5 Consultant Report (2013) – In December 2013, at the direction of VISN 5, a consultant reviewed the medical center’s Facility Management Service and Safety Programs. The report was presented to medical center leadership and detailed numerous concerns, including that “the Sterile Processing Service (SPS), a high visibility program with critical responsibility toward patient safety, is working in an area that was identified to be outside of required environmental

controls (humidity), and environmental monitoring is not being consistently or continuously conducted.” In addition, the consultant noted that documentation of SPS staff competencies was not available. The OIG is unable to determine what remedial efforts were made, if any. Any improvements were not sustained because the SPS deficiencies identified in the 2013 Consultant Report persisted at the time of the 2017 OIG site visits.

- VISN 5 Logistics Study (2014) – VISN 5 engaged an external consultant to study Logistics Service operations within its facilities in 2014. After reviewing the consultant’s observations, the VISN noted the DC VAMC’s Logistics Service staffing was significantly lower than similar facilities and the facility had high staff vacancy rates in both the expendable supply and nonexpendable equipment Logistic Service. The medical center’s CLO attempted to increase staffing but contended efforts were impeded by a lack of support from the medical center’s HR staff. The OIG identified emails alerting the leadership of this issue.
- Nursing Report (2016) – VISN 5 reviewed nurse staffing and related issues in its facilities in 2016. In May 2016, the VISN shared the results with the DC VAMC Director, which included the facility was short approximately 98 nurses and the supply chain was broken. The Medical Center Director acknowledged the vacancies and commented that there were no sentinel events at the facility.
- National Program Office on Sterile Processing (NPOSP) Reports (2015 and 2016) – In April 2016, the medical center reported it had “closed” (satisfied) 25 of 28 recommendations arising out of the September 2015 site visit. The medical center reported that it planned to resolve two recommendations on or before May 20, 2016, and that the final recommendation relating to workflow would be addressed during a renovation of SPS planned for 2017. However, a repeat visit from NPOSP in October 2016 identified recurring issues previously reported as resolved, including environmental issues, lack of SOPs, and inadequate documentation of staff competencies. NPOSP issued additional recommendations, some of which were repeat findings from the 2015 visits.

In response to the October 2016 NPOSP recommendations, the medical center submitted another detailed action plan on December 9, 2016, with periodic progress updates thereafter. Documentation shows that the medical center updates falsely reported that some action items identified in the NPOSP 2016 visit had been completed, resulting in VISN 5 reopening an action item in April 2017 previously reported as corrected.

The chronic medical center deficiencies noted in the 2013–2017 reports speak to leaders’ at various levels inability or unwillingness to implement and sustain lasting change within various services.

Ineffective Follow Up

Turnover and inadequate governance affect remediation. For example, in terms of staffing, the DC VAMC has had five Associate Directors since 2013, most of who assumed the role in an acting capacity. The Associate Director is responsible for the managerial and administrative services and operations that are the subject of the report, including Logistics Service, HR, Fiscal Service, and EMS. Lack of consistent leadership in this key role since December 2015 made it more likely that the medical center managerial and administrative deficiencies would remain unaddressed.

Many recommendations from previous reports concerning the sterile processing of instruments and Logistics Service functions were deemed implemented or “closed” but were not effectively addressed. VISN 5 leaders and some VHACO personnel were aware of many of the problems identified and did not ensure that adequate corrective action had been taken by the medical center to address them. Methods used by the VISN and VHACO to oversee the medical center were either inadequate or did not include accurate or complete data on key aspects of medical center operations. As the Director of VISN 5 acknowledged, the VISN responsibility should be to intervene when it has notice of a problem. Or, as the Director bluntly conceded, “the buck stops with him.”

There has been significant focus recently on the ratings given by the Strategic Analytics for Improvement and Learning (SAIL). The DC VAMC was rated a 2-star (slightly below average) rating from 2011 through the third quarter of FY 2015, and then improved to a 3-Star (average) rating, maintaining that rating through March 31, 2017.⁶ The SAIL rating is based on clinical measures but does not include supply chain inventory and logistic issues even though such functions have clinical impact. The SAIL model incentivizes facilities to take action to improve the quality of care, however its minimal focus on administrative functions that support patient care can leave patients vulnerable.

Our report also found that VHACO receives information daily from medical centers and VISNs to inform policymaking, but that information is not always shared with officials who can take action to remedy the deficiency.

OTHER OIG WORK ASSESSING LEADERSHIP AND GOVERNANCE

We seek to address in all of our work—whether an audit, review, or inspection—the underlying cause (or causes) of the identified condition and who is responsible. This focus has revealed that there is often a lack of oversight for compliance with policies and procedures, reporting mechanisms are not reliable, and operations are not effective or efficient.⁷

⁶ VA no longer publishes star ratings but based on SAIL data, the facility is currently between 1 and 2 stars.

⁷ *Healthcare Inspection – Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System, Oklahoma City, Oklahoma, November 2, 2017; Review of Research Service Equipment and Facility Management, Eastern Colorado Health Care System, March 29, 2018; Audit of Beneficiary Travel Program, Special Mode of Transportation, Eligibility and Payment Controls, May 7, 2018.*

One specific example is the change we made in April 2017 regarding our cyclical review of VAMCs. We now include a review section on the leadership at the facility when conducting our Comprehensive Healthcare Inspection Program (CHIP) reviews. We provide a descriptive evaluation of VHA facility leadership performance and effectiveness as evidenced by the reduction of organizational risks and provision of quality care that result in positive patient outcomes and experiences and optimal levels of employee engagement and satisfaction. Our work will continue to examine leadership and governance issues throughout VA.

CONCLUSION

We found critical deficiencies in our inspection of DC VAMC. Although the findings and recommendations focus on improvements in that facility, the issues raised could be used almost as a checklist for other facilities, VISNs, and VHA leaders.

While the concrete deficiencies present significant challenges, we believe the greatest obstacle to change is the sense of futility or culture of complacency among some staff and leaders. At the core, the DC VAMC report is about the breakdown of systems and leadership at multiple levels, and an acceptance by many personnel that things will never change. This was evidenced by

- staff that got used to “making do,”
- acceptance or normalization of non-compliant practices,
- acceptance of information/data at face-value without asking the next question, and
- willingness to rationalize poor practices with “nobody’s been harmed.”

We fervently believe that VHA has talented and committed people that could lead the turnaround at the DC VAMC and other facilities. We saw healthcare professionals and other staff making significant efforts to ensure patients were safe and receiving quality care by using workarounds or trying to do the right thing. With time and concerted effort, we know that positive change can be realized. VHA needs to recognize the urgency in making strong leadership decisions now to oversee that change.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.