STATEMENT OF
MS. RICA LEWIS-PAYTON
VISN 16 NETWORK DIRECTOR
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

NOVEMBER 13, 2013

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

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

Let me discuss recent events at the Jackson VA Medical Center and what we are doing in response. Be assured that we have thoroughly investigated various allegations. We know that a number of issues have been raised about this Center, and we take those concerns seriously. We work aggressively to identify and correct any

errors, and we are adopting a series of significant reforms to improve the center. When appropriate to do so, we hold people accountable. Because this is an open hearing, with members of the public present, by law I am not at liberty to provide specifics about what has been done in individual cases.

On March 18, 2013, the Office of Special Counsel (OSC) sent a letter stating that OSC had found a pattern of issues at the Jackson VA Medical Center that are indicative of poor management and failed oversight. The letter cited five separate complaints received from facility employees since 2009.

Three of the complaints concerned allegations relating to the Sterile Processing Department. The letter alleged that poor sterilization procedures existed; that VA made public statements mischaracterizing previous investigative findings about the facility's sterilization procedures; and that VA had failed to properly oversee corrective measures within the Sterile Processing Department. The letter also cited complaints alleging chronic understaffing of physicians in primary care clinics; lack of proper certification for nurse practitioners; improper nurse practitioner prescribing practices for narcotics; and missed diagnoses and poor management by the Radiology Department. All of these complaints were referred to VA for investigation pursuant to 5 U.S.C. § 1213.

At the time the March 18th letter was received, VA had appropriately responded and corrected the issues cited in the three whistleblower allegations related to the Sterile Processing Department. These issues are all closed. Jackson VA Medical Center has implemented stringent oversight processes to ensure reusable medical equipment is cleaned and sterilized according to manufacturers' instructions before every use. The facility has also invested more than a million dollars into state-of-the-art

reprocessing equipment to ensure proper cleaning and sterilization and transitioned to the use of more disposable devices when these are available. After receiving the March 18th letter, VA initiated a quality of care review of sterile processing services at the facility. The review found that the VAMC utilizes effective systematic processes to safely perform the re-processing of all critical and semi-critical reusable medical equipment in the facility. The Jackson VA Medical Center continues to monitor and evaluate the Sterile Processing services.

The other two complaints discussed in the March 18th OSC letter had been referred to VA on February 29 and March 5, 2013. The February 29th complaint involved the Primary Care Unit at the Jackson VA Medical Center, and the March 5th complaint contained allegations concerning the accuracy of certain interpretations by a VA radiologist who is no longer a VA employee. In response to these OSC referrals, a review team outside the Veterans Integrated Service Network (VISN), chartered by the Deputy Under Secretary for Health for Operations and Management (DUSHOM), conducted a full investigation of the two new cases.

VA's reports on these two investigations were delivered to OSC on July 16 and July 29, 2013. The OSC sent a follow-up letter, dated September 17, 2013, concerning those reports. Therein, OSC reported the Department had substantiated some of the whistleblowers' allegations and recommended follow-up actions, but OSC indicated the status of the recommended actions was unknown.

Efforts to implement the recommendations in VA's July 2013 reports are well underway by the facility and the VISN, with active monitoring by the Office of the Medical Inspector (OMI). Specifically, in September 2013, the Under Secretary for

Health directed the OMI to oversee implementation of the action plan at the Jackson VA Medical Center. OMI conducted a site visit on October 22-23, 2013, and both reviewed and concurred with the facility's action plan. OMI and the DUSHOM will continue to monitor implementation of the action plan and keep Veterans Health Administration (VHA) leadership apprised of the progress in implementing the reports' respective recommendations and the sustainability of the recommendations. On May 24 and June 12, 2013, OSC referred two additional complaints to VA for investigation. These referrals concerned pharmacy operations and the credentialing and privileging processes at the Jackson VA Medical Center. VA's report on the credentialing and privileging matter was delivered to OSC on August 15, 2013. The facility revised its credentialing and privileging processes to ensure it is consistent with National VHA policy. The Jackson VA Medical Center will ensure all members of its Executive Committee of the Medical Staff have equal access to review all credentialing and privileging folders prior to submitting its recommendations to the Medical Center Director for approval. The report concerning pharmacy operations was delivered to OSC on August 27, 2013.

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

deployed to fill key leadership vacancies. These activities are in addition to the standard annual reviews of quality and safety, financial operations, and environment of care.

On April 3, 2013, VHA hosted a town hall meeting in downtown Jackson. The Under Secretary for Health was among the speakers at the meeting, which was attended by nearly 300 Veterans, facility staff members, and other community partners. During the town hall meeting, the participants discussed many of the issues covered in the OSC letters and other issues of concern to Veterans. Mr. Battle has personally addressed participant comments provided on comment cards at the town hall meeting and met with all interested parties who desired a meeting with him as follow up.

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

Conclusion

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