Statement to House Committee on Veterans Affairs Regarding Deficiencies at the Manchester VA Medical Center.

Erik J Funk MD FACC
Non-Invasive Cardiology
Manchester VA Medical Center Manchester, NH
September 2017

Mr. Chairman and members of the committee.

I appreciate the opportunity to submit this statement regarding my observations and efforts (as well as others) to maintain and improve Cardiology services at the Manchester VA Medical Center. What needs to be conveyed today is that the VA Manchester is currently an absolutely and unequivocally a broken hospital system. A system that was devoid of adequate funding, is culturally dysfunctional and lacking in qualified administrators. The question is whether our hospital can be salvaged from the dustbin? I am a believer however that the Manchester VA can and must be an accessible and quality provider. To be sure our nascent Task Force committee project demands a comprehensive plan and follow through. This newly developed master plan and eventual end product should be guided by talented directors and chiefs of services who are in turn accountable to employees, providers as well as to the veterans we serve and finally to the Secretary, Dr. David Shulkin who has thankfully endorsed this effort.

I received my medical degree 42 years ago and have practiced Cardiology in the private sector for over 30 years. I joined the VA in December 2013. Prior to my current government service work, I was in private practice involved in outpatient and inpatient invasive and non-invasive Cardiology services. I was very fortunate to have participated in the development of Cardiac services two new hospital systems including HCA in Portsmouth, New Hampshire the Portsmouth Regional Hospital in 1987 and a Catholic hospital, the Good Samaritan Hospital in southern Illinois in 2014. In both projects I worked hand in hand with hospital administrators, department heads and nursing directors. I have also had the nurturing experience to practice at a very busy tertiary care center, The Heart Hospital of New Mexico (2004-2007) in Albuquerque, NM. All these experiences were "can do" experiences. So all in all, one could say that I have been "around the block "a bit. On my arrival at VA Manchester it did not take long to appreciate how separated, disconnected and disempowered providers were here.

Physicians were completely disenfranchised regarding any input in directing the medical center programs at the VA. There were no direct educational seminars or grand rounds in which providers and physicians could commiserate as well as discuss professional issues together. Almost all provider communications are digital and rarely by phone or face to face. This was disheartening and at the same time disappointing for it was not a culture I was accustomed to in contrast to my previous hospital practices where I typically had in person contact with other physicians. It sadly remains an academically and socially sterile place here today which I believe detracts from a challenging and stimulating collegial work environment that it could be and in turn potentially translate into quality Medicare care. If only our ORs were so sterile and antiseptic.

The next jolting revelation was that the medical center was essentially run by the administrative level nursing staff (rather than physicians) who were ill equipped to manage a medical center. I have no axe to grind against nurses in fact far from it having worked in my career quite smoothly and collaboratively with nursing staff. But here I readily became aware that the most if not all hospital services including operating room, pharmacy and urgent care center were overseen by the Head of Nursing, Carol Williams, RN. She fortunately retired in August 2017 after pressure from whistle blowers and the Boston Globe article. Most of the programmatic and fiscal decisions were run through Ms. Williams and officiated by Danielle Ocker the hospital director who was also dismissed in summer 2017. This was an outrageous revelation that there was virtually no input from practicing physicians regarding management at the VA. Between 2014-2016 the nuclear camera in radiology was breaking down several times per month. This is a critical diagnostic tool used for stress testing and needed assess patients for coronary disease. It was in dire need of replacing. Chest pain work ups and pre-op patients were being rescheduled and truly inconvenienced. Administration also would not fund rental of a nuclear camera which could have ameliorated the problem. This was and remains a culture of “no it can’t be done” here. Despite administrative promises, we were informed in January of this year that funding was not available for design and construction for the CT/Nuclear camera as well. The COS, James Schlosser, MD indicated that stress test patients would have to be sent to Boston much less preferable to veterans or that they would have to rely upon a very broken VA Choice program administered by an even less timely Health Net scheduling program for Non VA referral. This was a very faulty program that was subsequently indicted for gross delays in scheduling specialty testing and thankfully scrapped. This type of delay in care is tantamount to the optic of a cardiac patient with chest pain sitting in traffic on route 95 considering popping nitroglycerin and waiting for the traffic to clear en route to their stress tests to a referral center.

My former cardiology colleague, Dr Lombardi announced his plans for enter private practice in December 2016 with his subsequent departure in late January 2017. When discussing the hiring of a full-time Cardiologist to replace him with Danielle Ocker and Carol Williams, Ms. Williams made the disturbing comment that she was distracted by the need to hire 10 housekeepers for the hospital. She had to "balance their fiscal resources". It was frankly outrageous that Ms. Ocker and Williams had hired at least 70 non-clinical staff that the hospital could neither afford nor need. We needed providers not more educators and non-clinical staff. I might add that prior to Dr. Lombardi's departure, SAC Cardiology had 3 providers. Our program was touting a 90% access rating but unfortunately this declined to 37% in the second quarter due to the staffing shortfall in Cardiology. We will be seeing an additional 0.3 FTE Cardiologist added this month.

This compilation of events and others which will be presented today brought myself, Dr. William "Ed"Kois and Dr. Stuart Levenson together and along with eight other whistle blowers to expose the gross mismanagement that has occurred during our tenure here at the Manchester VA and and bring us to propose potential solutions to provide better access to convenient high quality medical care for our veterans.

The Manchester VA and members of the Task Force have their work cut out for them. Many choices, platforms and solutions will be considered. The first choice which may be least desirable to providers and for most veterans which is complete privatization as some legislators have hinted. The second is a hybrid public-private partnership plan culling out some least accessible medical and surgical specialty services and shunting them to the private sector. I do think that services such as Cardiology, Pulmonary, Oncology and mental health services could be bolstered at the Medical Center. For example the development of a hospital based comprehensive heart failure case management program would save millions of federal dollars and reduce CHF readmission rates. The third option and most challenging is resurrecting and rebuilding a "full service" inpatient facility service here. This would be a daunting task indeed. I do believe that whatever direction or directions this ship will sail toward it most certainly requires experienced, talented and energetic administrators who are not just skilled navigators of stormy seas but also change masters who can improve a dysfunctional institutional culture we have here today. Thank you for your attention.

Statement to House Committee on Veterans Affairs Regarding Deficiencies at the Manchester VA Medical Center.

Stewart I Levenson MD FACR
Medical Service Chief (ret)
VISN 1 Medicine Service Line Manager (ret) **September 2017**

Mr. Chairman and Members of the Committee,

Thank you for allowing me to submit this statement regarding my efforts for reform at the Manchester VA Medical Center.

As a physician I have been employed until recently at the Manchester VA Medical Center. I was initially hired to provide both primary care and rheumatology services. Within the last several years in Manchester I became the department chairman and then the New England Network Director of the Medicine Service Line. During my tenure I have been given assignments as the chief of primary care and the chief of urgent care. I have also been assigned to another medical center as the assistant to the director. As you are all aware the Manchester VA has been featured in a Boston Globe article exposing deficiencies in care. Despite efforts on the part of myself and the other so called whistleblowers no corrective action had been taken until this article was published.

These efforts began individually by concerned physicians who worked to improve care on their own through official channels. Only when frustration was voiced to each other in informal associations, was it learned that problems were endemic and were a common experience. At that point the individual physicians came together to try to address problems as a group. Regular meetings were held and discussions were undertaken to try to sway the leadership. Not only was this effort unsuccessful but retaliation was meted out by the leadership. As the core of the group that became known as the whistleblowers grew we would meet with the medical center director and then by early 2016 meet with members of Congress. I myself became frustrated with the pace of action so I contacted the Boston Globe Spotlight Team. The Globe staff felt the issue compelling and conducted in depth interviews. This led to the publication which brought the current scrutiny to the issues of patient's receiving substandard care.

Each member of the whistleblowers is witness to individual issues but also shares the common experiences which make up the shoddy care provided our veterans. As a leader I myself became the recipient of concerns brought to me by my subordinates.

The first major issue that became a concern for our group of physicians was noted in cardiology. This issue had to do with care of a stroke patient that eventually led to the $21M judgment against the medical center. It also led to the unfair smearing of physicians who were directly involved in trying to improve care at the medical center.

In approx. 2003 the medicine division hired a full time cardiologist for the first time. Dr. Dan Lombardi wasted no time in bringing to my attention the shortcomings of the echo tech who performed cardiac echos. It seems that this tech never had any formal industry recognized training. She had only received on the job training through the VA. She had no certifications and had no interest in gaining any expertise. Dr. Lombardi repeatedly brought his concerns to me and I forwarded them to the tech's supervisor, who was the recently removed nurse executive, Carol Williams. Ms. Williams was not only unsympathetic but showed no interest in correcting the problem even when the Boston VA Medical Center commented that the quality of the echos was so bad that no cardiologist should validate the studies. Having our complaints fall upon deaf ears our cardiology division functioned as best it could. This culminated with the echo of a patient with a question of a cardiac derived embolic stroke being referred for a trans esophageal echo. The tech was unable to perform the study, blaming the problem on a faulty probe. It was later learned that the tech did not know how to turn on the probe.

The acceptance of incompetence is a common theme. When Dr. Kois took over as the staff physician in the spinal cord clinic he expressed similar concerns with regard to spinal cord patients. Concerns were brought to upper leadership and completely ignored. If a member of upper leadership tried to intervene they too would face retaliation. Dr. Anderw J. Breuder, the long time chief of staff, tried to assist in dealing with issues, and was removed from his position on a thin pretext. Like myself he tired of fighting and retired from the VA.

The committee will receive many statements dealing with individual issues. I will instead deal with the common threads. One obvious issue is that the VA cannot police itself. Investigations done internally become nothing more than farce, and usually end with retaliation against those who instigated the complaint process. Such was the case with Dr. Brueder. This also occurred with myself. The office of Inspector General conducts incompetent investigations geared at scapegoating and then forwards its results to Administrative Review Boards. These boards then single out a scapegoat and retaliation is undertaken. This happened to myself several years ago. It is currently happening to Gary Von George the business office chief who questioned the director's management of the Choice program. Other examples continue to arise.

Leadership covers for each other and when caught is allowed to transfer to another position in the network. Tammy Krueger (formerly Follensbee), refused to deal with problems that led to the huge malpractice judgment. She also stood by while other patients were endangered in Urgent Care. As acting chief of urgent care I brought problems to her almost daily. As retaliation for doing this I was passed over for the position of chief of staff. Despite my track record of success, I was not even given a second interview. When the issues in urgent care came to light Ms. Krueger was allowed to transfer to a position at the VISN headquarters. In a move that would be comic if not so tragic, she is now being named to the task force to study problems at Manchester.

Other incompetent leaders seem to reappear as well. Even Dr. James Schlosser, the incompetent chief of staff who was recently removed is being considered for the Care in the Community Coordinator. This position is actually constructed to deal with problems that Dr. Schlosser himself created. I personally can think of no greater irony.

Incompetent failed leaders being repeatedly placed in positions of authority occurs repeatedly. Danielle Ocker the removed medical center director also fits this mold. Her own issues led to removal at White River VA and could have predicted her poor performance at the Manchester VA. Reviewing the education alone of these leaders should have been a red flag to begin with. It is my understanding that Ms Kreuger and Ms Ocker have only on line rudimentary degrees. In Ms. Ocker's case it is from a for profit institution.

Much of the blame for the problems in Manchester I place with Dr. Michael Mayo-Smith the VISN 1 Network director. There is simply no way that Dr. Mayo-Smith could have remained unaware of the problems at Manchester or the other medical centers for any length of time. His insular style of leadership can only be compared to Nero fiddling while Rome burned. While much of his discussions about the problems at Manchester occurred behind closed doors, he would comment on the problems at various times such as the monthly video conference referred to as "Super Tuesday." I myself have informed him of problems only to be told that they are to be handled by local leadership. As of late I have been in frequent contact with Dr. Mayo-Smith and have tried to find common ground going forward. I truly believe we both want the same outcomes for our veterans. Yet when confronting him about recent issues he still falls back on the reply that the local leadership should handle this. Is it any wonder why these issues that endanger veterans continue unabated?

One of the greatest areas of incompetence is in the area of wasteful spending. This has had a huge impact upon patient care. Through hiring of non clinical personnel and other excessive spending Danielle Ocker placed the medical center in a deep financial deficit. Without regard for patient safety and with the full knowledge and cooperation of Dr. Mayo-Smith and Dr. Schlosser clinical programs were curtailed. The money for care in the community hospitalizations was most affected. Patients were no longer being admitted to a local community hospital but only to VA facilities. This led to decreased satisfaction and mistrust. It seemed that if a patient had to be admitted to a local hospital it came directly at the expense of an on site clinical program. A single hospitalization could cost the same as an entire clinical employee FTEE. Schlosser Ocker and Mayo-Smith stood by while programs were being decimated.

Even as this committee meets, millions of dollars are being wasted at Manchester. When the water pipe burst it was estimated that it would cost $10M to bring the building back on line. This building is well past its useful life and is now being evaluated for replacement. If it is decided that the building needs to be replaced the money spent repairing it is a total loss.
This speaks to a larger issue. Manchester is not the only VA that is exposed in the news. In fact it is so commonplace to see a story describing a VA as being terrible, that these stories fail to make the national press. In the VA system there is a culture of incompetence. Meeting measurements at the expense of providing good care, following rules while ignoring common sense and experience, are deeply ingrained in the corporate culture. The VA is a failed system that fails to keep its promise to veterans. Leadership is incompetent, money is wasted and good hardworking employees are harassed and retaliated against for trying to provide excellent care. Unless the VA changes on a fundamental level, the only solution will be to shutter it and move to a system of privatization. This in my opinion would be a mistake. The VA is the largest integrated health care system in the United States. It could be a model for providing efficient healthcare to all US citizens, instead it has become a national tragedy.

Statement to House Committee on Veterans Affairs Regarding Deficiencies at the Manchester VA Medical Center.

Ritamarie Moscola, MD, MPH, CMD, CPE
Certificate Added Qualification Geriatric Medicine, Certificate Added Qualification in Hospice Medicine Service Line Manager Geriatrics and Extended Care
Medical Director Community Living Center
Medical Director Hospice and Palliative Care
Medical Director Home Based Primary Care
Medical Director Hospice and Palliative Care
Medical Director Home Based Primary Care

September, 2017

Mr. Chairman and Members of the Committee,

On or around June 30, 2016, we placed veterans requesting home maker home health services and service in adult day health care centers on the Electronic Wait List (EWL). This was at the direction of the Medical Center Director, Danielle Ocker and the Chief of Staff, James Schlosser. Over the course of several months we attended weekly meetings during which the EWL for Geriatric and Extended Care (GEC) services was discussed. Senior Leadership was present. We requested guidance on removing veterans from the EWL. We did not receive approval to move forward.

In February, the Director responded that we needed more investigation into the process. VISN leadership was aware because the veterans triggered on the consults pending for >90 days.

On July 11, James Schlosser commented at monthly meeting with VISN that Manchester was the only facility with EWL for GEC services.

On July 17, I received an email stream stating that Manchester was not the only facility with GEC-EWL.

On July 17, I received an email stream documenting that Manchester was not the only facility with GEC-EWL. I was asked how I was going to address this. I called a meeting of the staff working on providing these services. I told them that we would review veterans with new and old consults for eligibility. We would refer all those meeting eligibility requirements to the appropriate home health agency or adult day health care facility. Later in July, Corey Wilson, the Acting Chief of Business Office, contacted the GEC nurse and gave her assignments regarding the EWL and consults. No one spoke with me about changes in job descriptions and duties even though I am the Service Line Manager.

On 8/28, at meeting with GEC staff, the Acting Chief of Staff of Business Office, I learned that the review of consults for home maker home health services was being removed from GEC and transferred to him. He asked me why I created the EWL for GEC services. I responded that I was told to do this by Senior Leadership due to the budget. He commented that there was always money in the system for GEC services.

Electronic Wait List Numbers:

- Veteran Directed: 62
- Adult Day Health Care: 34 with 5 veterans on the EWL for over one year.
- Home Maker Home Health Aide: 138

Statement to House Committee on Veterans Affairs Regarding Deficiencies at the Manchester VA Medical Center.

Mark Sughrue, ACNP
Cardiology Nurse Practitioner **September 2017**

Thank you for allowing me to address some of my observations. I was unable to make the hearing as I have Veterans scheduled to see me in clinic and I always try to defer to my Veterans and try not to reschedule them unless absolutely necessary.

1. The nuclear camera has been due for replacement for over three years as it has been obsolete and parts have only been available by retrieving from old machines. The camera has failed on occasions causing patients to have to repeat tests getting dosed by radiation more than one time to complete testing. The National Acquisition Center has purchased a new camera to be installed apparently pending the local Medical Center paying for the installation. The Manchester VAMC initially failed to account for the installation costs delaying the install more than 3 years ago then delayed in obtaining the designs for the construction to install the camera. The camera install was delayed again until the next Fiscal year 2017 for install with the excuse of "no money left to cover the install". Then the administration decided to delay installation of the camera as the nuclear technician decided to retire despite the assurance that construction would begin early 2017and be completed by August of 2017. The timeframe for installation of the new camera is still not known but not until at least 2018 roughly 4 years after the process started.

2. The administration at the VAMC failed to plan for the anticipated downtime that was going to be required during the installation of the camera despite multiple requests from Cardiology and Radiology to consider the downtime. The response in early 2016 was "we will utilize Veterans Choice to bridge the construction time". When cardiology and radiology both stated the fact that VA Choice would delay care and potentially cause patients to fail testing the administration continued to plan for VA Choice to bridge the install time. When cardiology and radiology repeatedly pointed out to the administration that the cost of renting a camera to bridge the 6 month construction gap time would only cost $26,000 approx. for 6 months and allow for quicker safer testing at the Manchester VAMC the administration still decided to pursue VA Choice as the preferred option. For example of ineffective VA Choice testing when the cardiology echo technician went out on emergency leave for medical injury VA Choice was utilized instead of hiring a temporary echo tech and keep cardiology echo at the Manchester VAMC. For 3 months cardiac echo tests were referred to VA Choice to be completed. After 3 months almost 300 echo tests were returned to the Manchester VAMC as not completed by VA Choice, both delaying care to Veterans at great risk and increasing cost as now many man hours had to be dedicated to rescheduling and triaging the echoes for priority. The typical cost of a nuclear stress test is approximately $4000. The administration of the Manchester VA decided instead of spending $26,000 for 6 months of nuclear stress test (roughly 150 stress tests) that cost shifting to failed VA Choice program was more beneficial. It is clear that the benefit was not for the Veteran but rather for the bottom line of the administration.

3. The administration decided not to act to maintain the nuclear department despite persistent requests from Cardiology and Radiology. There was a full time and a part time nuclear technician until Fall 2016. The part time nuclear technician wanted to become a full time nuclear technician but the administration had declined to make her full time (despite being aware of the impending retirement of the full time nuclear technician). That nuclear technician was offered a full time position in Massachusetts outside of the VA and despite the pleading of cardiology and radiology the administration continued to decline to hire her full time so she left fall of 2016. The sole Nuclear Technician got her retirement day finalized for the end of January 2017(it had been known she was going to retire for 2 years). From fall of 2016 through January 2017 the administration would not pursue any plan to install the camera or replace the nuclear technician despite now having a firm retirement date. The administration actually allowed the nuclear camera to go unrepaired with a function called attenuation correction because it was “going to be replaced and they didn't want to spend any further money on the camera”. Then 1 week prior to the remaining nuclear technician’s retirement there was an emergency meeting held the week of January 14th 2017. Present was Chief of Staff Dr Schlosser, Chief of Nursing Carol Williams, Associate Chief Nurse Linda Pimenta, Chief of Radiology, Chief of Medical Specialty Dr Levenson, Nursing Supervisor of Specialty and Acute Care Shauna Dalleva, Dr Funk Cardiology, myself Mark Sughrue Nurse Practitioner Cardiology, Lead Technician Radiology Doreen Mitchell, business office representative, a union representative, and a patient safety representative were present. At this meeting a plan for nuclear testing including nuclear stress tests, nuclear imaging for other departments were considered. Cardiology, Chief of Medicine, nursing supervisor of Specialty and Acute Care, radiology, business office and patient safety all expressed the concerns with choosing to send nuclear testing to VA Choice (especially in the setting of known failures with doing exactly that with echoes which was a failure as noted above and no change had occurred to improve VA Choice at that time). Manchester averaged 11 days to completion of stress tests (which included weekends and holidays when testing not completed and patient’s desires to schedule into the future for planning etc). It was known that VA Choice could routinely take up to 7 days to even make first contact with patients followed by 30 days to actually schedule the test and up to 60 days to return the results to the VA. I suggested that the nuclear department not be closed due to above factors and the known delay in care as well as some cases of VA Choice not even completing testing as a patient safety, public health and increased cost to overall VA operations. Dr Funk also stated his opposition to closing the nuclear department and sending patients to VA Choice. Business office expressed similar concerns and felt the volume of test would overwhelm current staffing in business office who were unable to follow VA Choice effectively already. The administration stated that since the nuclear technician was leaving and a cardiologist was also leaving that the “utilization of VA choice was the best course”. When cardiology requested they hire a new technician and cardiologist so that the nuclear department could be kept the leadership including Carol Williams and Dr Schlosser both stated that the Manchester VAMC didn't have the money to hire anyone. Carol Williams stated that Manchester VAMC "can't recruit a new cardiologist as we have to hire housekeepers, we are down 10 housekeepers". Linda Pimenta expressed that hard decisions had to be made but there was no money to make

any other choices other than VA Choice. All of the above safety and delay concerns were felt to not be enough to choose not using VA Choice according to leadership that was present including Chief of Staff, Chief of Nursing, and Associate Chief of nursing. The plan became no technician would be hired until the new camera was installed which was then planned for fiscal year 2018 and that VA Choice would be used to complete nuclear testing for at least the next 10 months.

4. The typical cost of nuclear stress testing is approx $4000. The Manchester VAMC averaged 350 nuclear stress tests per year totaling $1.4 million in cost shifted to VA Choice budget from the Manchester VAMC budget. The cost to complete at Manchester VAMC would include partial salary for Cardiologist and Cardiology Nurse Practitioner(who also completes other patient visits), EKG technician (who also has other duties), Nuclear technician (also completes nuclear testing for other tests), cost of the nuclear material, camera cost and other various facilities cost which definitely costs less than $4000 per test.The utilization of VA Choice enabled the Manchester VA administration to cost shift the testing to the VA Choice budget therefore "saving the Manchester VA money" as they say it. There was no consideration from the administration regarding the proven concerns and prior failures with utilizing VA Choice for time sensitive life altering tests.

5. After the transition to utilization of VA Choice for nuclear stress testing started in January of 2017 and through July 2017 multiple tests had not be scheduled or completed in some cases greater than 3 months delay for symptomatic patients. Multiple patient safety reports were been submitted with no action taken from the administration to change plan or change plan to hire a nuclear technician despite the old camera which at least was still partially functioning was still present, no movement in actually hiring a cardiologist (looking was approved but not hiring). The camera install was apparently submitted improperly therefore it was not clear if it will even be installed at this point and not any sooner than 2018 at the earliest despite more than 3 years of knowing this equipment needed substantial planning and redesign of the radiology department to install. Manchester VAMC continued to refer patients to VA Choice despite continued lack of scheduling and completion of the tests as of mid May 2017.

6. After the Boston Globe article was released many changes in action from the new administration to correct the errors of the prior administration proceeded. The new acting director ordered the nuclear camera restarted (cost to decommission and then the cost to recommission likely more that the yearly salary of the nuclear technician). Unfortunately, since no recruitment for a new nuclear technician was started the nuclear stress department has yet to open but the nuclear camera is being used for less complex non cardiac testing.

7. A part time cardiologist was hired to increase availability of cardiology resources, but this is still less than the number of cardiologist available prior to the old administration effectively dismantled the cardiology service line to save money.

Observations:

The connecting theme of most of the above decision points that the Manchester VAMC administration made was completely driven by increasing bureaucracy, cost shifting and was not driven by improving care for the Veterans. The thought was never how can we make the Manchester VAMC a destination for care. It was only about how do we cover the bottom line because the Manchester VAMC budget and planning were lacking. Decisions were made to hire multiple middle management but not new clinical staff to actually see the Veterans and provide care despite the clinical staff functioning at greater than capacity in nearly all departments. An example is the creation of at least 2 new executive nursing positions in the nursing hierarchy effectively creating more managers to oversee less clinical staff because there "wasn't enough money in the budget to hire clinicians". At no point along the multiple decision points did the administration consider the input from the content experts and front line personnel to make decisions for the Veterans. The decisions were made in the dark and then dropped on the clinical staff with only token "listening sessions" where input was clearly not exploited.

What have I seen since the new acting director and the visit from VA Secretary Shulkin came to the medical center. Some changes have been positive such as more involvement of medical providers in decision making for the medical center. It seems that the cardiology service line is at least partially being rebuilt though still below prior provider levels.

Unfortunately, I have also experienced "more of the same/the VA way" still occurring. Officials removed from one job and placed in other positions of power despite the many decisions made that knowingly negatively affected Veterans. The hierarchy that enabled the poor and unsafe care of our Veterans are still in place and continue to make decisions without involvement of content experts and clinical staff. An example which may seem small but can truly negatively affect patient care. Electrocardiogram (EKG) electrodes were changed after being approved by middle management, but no input was sought from cardiology or clinical engineering (responsible for all medical devices throughout the medical center) regarding the change. The result has been increased artifact on EKGs especially during stress testing as the stickers don't stick well on someone who is moving and sweaty. This could have been avoided with less middle management making decisions without the support and input of the clinical providers or at least content experts.

I truly hope that the positive changes will be sustained but concerns remain given the persistent atmosphere of entitlement from certain staff and decisions made not because it is best for the Veteran but for other reasons.

The VA should solely be motivated to be the destination of care for our Veterans. I have seen some of that culture in the VA but it is not pervasive and was not present in the prior administration and remains in Manchester in some of the previously established hierarchy.

Statement to House Committee on Veterans Affairs Regarding Deficiencies at the Manchester VA Medical Center.

Gary Von George,
Business Service Manager

September 2017

My name is Gary Von George, and I am the Business Office Manager at the Manchester VA Medical Center. I have been an employee with the Department of Veterans Affairs for 33 years. I have held positions of progressive responsibility throughout my career serving Veterans as I have worked at three different VA Medical Centers within VISN 1 and at our VISN 1 network office. Prior to July 26, 2017 I had not received any adverse actions nor had I been counseled for any performance or misconduct issues. On July 27, 2017 I received a letter from my supervisor, Kevin Forrest, Associate Medical Center Director that informed me that I was being detailed to the office of Mental Health as an Administrative Officer, pending an investigation. This letter was signed by Alfred Montoya, Acting Medical Center Director. This letter is the result of recent communications that I have had with senior leadership and possibly other investigative teams that I met with and provided information to.

As the Business Office Manager for the Manchester VAMC, my duties included oversight of the Community Care office. The Community Care office is responsible for processing care that is referred to civilian providers, when it cannot be delivered through VA processes. The Veterans Choice Program, as it relates to New Hampshire Veterans, is encumbered under the Community Care office. The Community Care office at the Manchester VAMC has been understaffed throughout this Fiscal Year. On June 30, 2016 the community care section lost 40% of the community care case management staff as two of the nurse practitioners took other positions within the VAMC. On October 1, 2016, the Chief, Community Care became vacant as this person accepted another position within the VISN. I immediately did the expected resource request, and then the shell game of approving staff at the Quadrad level began. I repeatedly asked for these positions to be filled through both written and verbal communications to my supervisor and through written verbal communications at various meetings.

On June 7, 2017 I sent an email to Kevin Forrest, Associate Director and James Schlosser, Manchester VAMC Chief of Staff regarding processes, budget concerns and possible misuse of the of Dental care as it pertains to the non-VA Care dental process. I had identified several instances of high dollar referrals for care that did not meet the guidelines spelled out in the Community Care Dental Desk Top guide, to include mismanagement of referrals over $1,000 which is a violation of 38 U.S.C. 1712. In addition, at a leadership meeting on June 8, 2017, I further clarified verbally to leadership that I had identified what seemed to be a large amount of dental care that was being referred to one particular dental provider and that this care was not meeting the consult review process of having a second level VA Dental opinion. On July 5, 2017 the Manchester VAMC Privacy Officer sent me a Freedom Of Information Act (FOIA) request that was received from the Boston Globe on June 12, 2017. In this request, the Boston Globe is asking for payments made to civilian dentists for a specific timeframe.

On July 21, 2017, Carol Williams, Nurse Executive sent out a communication to all clinical staff that effective Monday, July 24, 2017 the Community Care section would be stood up as a new unit separate from the Business Office and that it would be led by the Social Work Chief. This was the first communication that I received notifying me that this would be taking place and I immediately sent an email to Kevin Forrest questioning why I was not kept in the loop as the Service Line Manager. On July 22, 2017 at approximately 4:30 PM, Kevin Forrest and I had a telephone conversation regarding this process. During this conversation, I informed Mr. Forrest that I have personally witnessed Carol Williams "bully" her way around to get what she wanted. I told Mr. Forrest that VACO Office of Community Care was recommending a physician be placed in charge of this new office and that "with all that has been occurring here at the facility, Manchester does not have the juice to go against what VACO is recommending." This comment further proved to be true when VA Undersecretary for Health, Dr Poonam Alaigh came to Manchester and announced at a town hall meeting that the Community Care office would be led by a physician.

On July 19th, I was told by leadership that the OMI wanted to interview me. I presented to this interview and was asked about Veterans Choice questions. As I was not sure what they were going to ask me, and as such I was not fully prepared. It is important to note, that when I was interviewed by OMI in January 2017, I was informed by the former Quality Manager what the topic was. On July 26, I again met with OMI and this meeting was set up at my request as I felt that I had not been able to give the team a complete picture of Veterans Choice, lack of support from the VISN 1 BIM and other concerns. During this meeting, I clarified with OMI a request for information that I had received from our leadership. I then disclosed to leadership that I had net with OMI a second time and had clarification that I sought.

My case is a classic example of how this agency treats employees that try to bring issues to light and they suspect of being a whistleblower. Leadership removed me from my position and proceeded to limit my access and knowledge. I have been blocked from program folders, have had system access removed and have been removed from pertinent mail groups that will hinder me from ever returning to my position. The "investigation" against me is now entering its eighth week and I have yet to be contacted by an investigator or be allowed to defend myself against the charges. As I had built a reputation of trust and respect amongst my peers here at the Manchester VAMC, the agency has sent a clear cut message to all other employees at the Manchester VA of what will happen to you if you challenge their norm or talk to institutions outside of their control. I had not spoken to the Boston Globe regarding the dental issue or any of my Veterans Choice concerns, as I instead preferred to work within the VA system, a healthcare system that I know and believe in, as it serves our nation's highest heroes.

Edward Chibaro, MD
John McNemar, DNAP, CRNA
Stephen Dubois, CRNA

The surgical and anesthesia staffs represented are comprised of three providers. One surgeon and two are anesthesia providers. All three providers documented multiple areas of severe deficiency and offered suggestions and recommendations.

There has been lengthy discussion with regard to absent and outdated surgical and anesthesia equipment and instrumentation. Instruments have been repeatedly contaminated and flies were noted in operating room number two. The Chief of Surgery step-down occurred as a result of ineffective leadership, lack of productivity, unsettling day-to-day conflict and relentless opposition to develop a prestigious surgical program with Veterans as the top priority. The current acting one-day-a-week acting Chief of Surgery defers to the OR nurse manager the remainder of the week. In his absence she executes Chief of Surgery duties. Medical staff members have noted the acting chief of staff expresses no interest in Manchester and habitually dismisses concepts and ideas brought forth by permanent Manchester staff. The administrative support staff for surgery is located on different floors and is of very limited assistance to operating room ventures.

A robust culture of disrespect prevails in the OR and most of the medical center. Antagonistic interpersonal work relationships are the daily norm in the operating room. Nurses have refused to execute physician and/or provider orders, only to receive full support from nursing leadership. A concerning number of staff sign-on for employment then quickly resign from the Manchester VA.

The nurse manager bullies nursing staff, housekeepers and others. She has browbeaten and intimidated staff in the presence of nursing leadership, chief of staff and other administrators, and has not been admonished whatsoever. She has reprimanded staff in view of patients. She has lied, exhibited inferior sterile technique, encouraged the use of contaminated instruments and violated multiple Joint Commission guidelines for unprofessional behaviors. Nursing staff have complained about not receiving lunch breaks, often while the nurse manager and assistant nurse manager are sitting at their desks, in their offices. She inaccurately educated staff with respect to the World Health Organizations mandated protocol for the "time-out" procedure and encouraged staff to refrain from calling for emergency assistance in the event of a code blue. She has requested that providers fill in for OR nursing lunch breaks, an extraordinarily unorthodox request. She was noted to have not properly logged critical OR incidents, such as humidity control and contamination problems. She was unable to track cases cancelled due to contaminated equipment. Her direction of an OR remodel yielded absent emergency call intercoms or code blue buttons standardly found in operating rooms. Manchester VA administration, the Office of Medical Investigation and the Office of Whistleblower and Accountability have received numerous letters of complaint written by staff members from many disciplines, including physicians and other providers. Her supervisor is incapable of resolving everyday clinical issues and is completely unknowledgeable with regards to OR routines, primarily because her background is in primary care. Frivolous, expensive and unnecessary office renovations were approved and directed by the nurse manager. These renovations superseded recurrent pleas for essential staff, essential equipment and essential instruments required for patient care and patient safety. More extensive and serious concerns have been documented and shared with VA administration and multiple internal VA investigative agencies.

The culture in the operating room at the Manchester VA parallels the noxious culture throughout the remainder of the facility. There is a forceful refusal to collaborate on vital topics and a customary atmosphere of autocratic execution and rogue decision making. Expensive and critical surgical and anesthesia supplies and equipment were independently ordered by nursing staff, without approval, collaboration or any stakeholder participation. This autocratic culture remains active today and is everyday business in the Manchester OR. Focus groups, task forces and team methodologies are all baseline concepts in any operating room, yet do not exist in the Manchester OR. Vital support staff has been repetitively requested, agreed to and confirmed, only to later be cancelled and denied. Communications are nearly non-existent. Most personnel do not respond via phone, email or otherwise. Providers are essentially on their own, often left to flail and fail. They receive little to no support by means of staff, administration or other.

ENT surgeon Dr. James Snyder, a US Navy Captain and highly renowned surgeon in the community, was personally called and recruited to the Manchester VA last year by then Undersecretary Dr. David Shulken. In his time in Manchester, Dr. Snyder struggled to get instruments and assistance. He received no help from OR staff, leadership or administration. After being pushed to his limits when offered a miniscule workspace after the recent flood, he submitted a resignation. The administration neither appeared concerned, nor tried to troubleshoot the resignation and convince him to stay. Meanwhile, many staff members were and are in spacious offices that could have temporarily served Dr. Snyder to complete his work. Leadership is indifferent to the loss of valued staff and administration appears expressionless, despite a revolving door of employees.

Several years ago anesthesia providers had no method for drug administration. This virtually did not exist. In high-risk fashion, medications were removed outside of the OR and carried in for each patient, every case. Emergency drugs were not present and pharmacy personnel provided enormous levels of opposition and defiance when workable resolutions were suggested. Patients about to receive anesthesia get little time with anesthesia providers as providers are required to restock anesthesia supplies and clean equipment between each and every case. This highly irregular practice is necessitated as anesthesia has no support staff. After submitting countless literature sources in support of hiring this staff member to administration, anesthesia staff was repeatedly promised this position would be hired, only to be repeatedly denied. The OR pharmacist had little to no knowledge regarding anesthesia medications and ASHP (American Society of Health-System Pharmacists) and ISMP (Institute for Safe Medication Practices) protocols and guidelines. Pharmacy personnel attempted to require anesthesia providers to pick up and drop off anesthesia drugs, a practice that would be considered highly irregular. Pharmacy technicians restock medications in all operating rooms, but at the Manchester VA they are not permitted in the OR by order of the nurse manager. Pharmacy involvement is minimal as related to anesthesia, which is also highly irregular. Pharmacy personnel "lost" a large number of Propofol vials, the liquid anesthetic that killed Michael Jackson. Pharmacy personnel then accused anesthesia staff of diverting the drug, an accusation that was later rescinded in a letter of apology written by the Chief of Staff. To date, there has been no follow up with anesthesia as to the status of those missing vials. Pharmacy personnel attempted to have a standardized drug return bin removed from the exterior of the not-yet-purchased anesthesia dispensing cabinets that will be ordered. This is a violation of ISMP protocols (Institute for Safe Medication Administration) and an action that will make duties easier for pharmacy personnel, while increasing risk of incorrect medication administration to patients and increasing liability for providers and the Medical Center. This hazardous notion has more recently been supported by the interim Chief of Surgery from the White River Junction VA Medical Center, who is a surgeon and appears unacquainted with the potential safety implications of this deviation from recommended guidelines

Providers are habitually excluded from involvement with decision making that affects their specific practice, while other uninformed staff members are incapable of completing their own duties because they are diligently working to execute duties that are not their own. This peculiar practice is unconventional, yet customary in Manchester. Providers must be integrated into their own areas of expertise and empowered to regulate their professional practice. They must also be consistently and sincerely acknowledged when conveying undisputable practice concerns. Investments into essential staff and essential equipment must be supported to provide proper care, and the use of standards of practice and recommended guidelines must be compulsory and established with an evidence-based framework. There is an imperative need to educate all Manchester VA personnel with regards to the zero tolerance policy for disruptive behavior as recommended by the Joint Commission. Rudeness, disrespect and intolerance must be replaced with optimism, kindness and basic mutual civility. This policy has to be strictly adhered to locally and all employees held accountable for their approach as the Medical Center endeavors the paradigm shift from a culture of disrespect to a culture of respect.