STATEMENT OF
DR. TERESA D. BOYD
ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH
FOR CLINICAL OPERATIONS
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

September 5, 2018

Good morning Chairman Bergman, Ranking Member Kuster, and Members of the Subcommittee. I appreciate the opportunity to discuss the Department of Veterans Affairs (VA) Sterile Processing Services (SPS) programs in respect to reusable medical equipment (RME). I am accompanied today by Dr. Beth Taylor, Deputy Assistant Deputy Under Secretary for Health (USH) for Clinical Operations.

VA's Veterans Health Administration (VHA) operates one of the largest health care delivery systems in the Nation, serving over 9 million Veterans. In providing health care services to Veterans, VA medical centers (VAMC) use RME which must be reprocessed between uses. Reprocessing refers to the cleaning, disinfecting, or sterilization of RME, such as surgical instruments or endoscopes. Due to the increasing complexity of device designs and components, reprocessing has become much more complicated and time consuming. Improper reprocessing creates potential risks, like infection, and can adversely affect timely access to care, such as delayed or canceled surgeries due to the lack of properly reprocessed RME. The SPS programs within each

VAMC provide oversight and manage reprocessing within their respective facility. To help ensure patient safety, VHA policy establishes requirements VAMCs must adhere to when reprocessing RME. Further, VHA policy requires inspections to be completed each year to determine the extent to which VAMCs are following said requirements and that incidents involving improperly reprocessed RME are reported.

On June 8, 2018, the U.S. Government Accountability Office (GAO) provided VA with a draft report entitled *"VA HEALTH CARE: Improved Oversight Needed for Reusable Medical Equipment."* In the report, GAO states that VHA does not have reasonable assurance that VAMCs are following policies related to reprocessing RME. Further, the report contends that VHA has not ensured that all VAMC RME inspections have been conducted because it has incomplete information from the annual inspections from the Veterans Integrated Service Networks (VISN) which oversee VAMCs. GAO also found that VAMCs face challenges operating their SPS programs, notably addressing workforce needs. The report resulted in three recommendations that VHA agreed to implement to further strengthen the SPS programs and solidify patient safety standards.

GAO recommended that the USH ensure all RME inspections are being conducted and reported as required and that the inspection results VHA has are complete. VHA fully concurs with this recommendation. The National Program Office for Sterile Processing (NPOSP) will establish an oversight process for reviewing and monitoring findings from site inspections and reporting to VA Central Office leadership. NPOSP's oversight process will include follow-up and feedback loops with VISNs on their oversight of facility corrective action plans. The Office of the Deputy USH for

Operations and Management will ensure SPS and RME issues are reported to a National RME Committee advisory group for risk assessment and response. The target completion date of July 2019 reflects implementation of the new oversight and governance processes and time for data collection.

GAO recommended that the USH consistently analyze and share top common RME inspection findings and possible solutions with VISNs and VAMCs. VHA fully concurs with this recommendation. NPOSP will analyze data from site inspections; identify trends or risks; develop possible solutions in collaboration with VISNs; and provide a written briefing to the National RME Committee, VISNs, and facilities. NPOSP will publish the briefing and possible solutions on the NPOSP Web site with a target completion date of July 2019. Additionally, NPOSP will communicate the report with the VISN and VAMC leadership through current educational sessions and national calls.

Lastly, GAO recommended that the USH examine SPS workforce needs and take action based on this assessment, as appropriate. VHA fully concurs with this recommendation. The VA Workforce Management and Consulting (WMC) Office is championing an interdisciplinary work group with NPOSP, the VA Office of Nursing Service (ONS), and the VA Quality, Safety, and Value (QSV) High-Reliability Systems and Consultation Service. The work group has identified actions to address the SPS workforce needs including: a revised qualification standard that will encompass a specified assignment for a VISN SPS Program Manager; implementation of an enhanced market-based approach to pay; and establishment of an occupational-specific recruitment and development infrastructure. Additionally, WMC will provide workforce

related data, as available, to assist partners in ONS, NPOSP, and QSV in their development of a staffing model for the occupation. This will allow VAMCs and health care systems to appropriately determine resources needed to more effectively execute mission requirements. This initiative has a target completion date of December 2018.

The VA Office of Inspector General (OIG) released a report in March 2017 entitled *"Critical Deficiencies at the Washington DC VA Medical Center."* The report mentioned a myriad of concerns, including SPS issues. However, despite these issues, the Washington, DC VAMC has lower infection rates than that of the overall industry. In fact, the rolling 12-month surgical site infection (SSI) rate for all surgical procedures assessed under the VA Surgical Quality Improvement Program ending March 31, 2018, is 1.41 percent nationally, whereas the SSI rate for the Washington, DC VAMC for the same time period is 1.09 percent. Notably, these are both lower than the most recent data on infection rates industry-wide, which found an SSI rate of 1.9 percent.

OIG made several recommendations and VHA concurred in full and has since taken action. The Washington, DC VAMC Acting Medical Center Director, in collaboration with NPOSP, and the VISN 5 Patient Safety Officer, developed a Quality Assurance process which was implemented on November 2, 2017, to verify the cleanliness, functionality, and completeness of instrument sets to ensure that the sets are available when needed. Any non-conformities are communicated to SPS in real time as well as data collected and aggregated. The Quality Assurance staff representative for SPS meets with the Chief of SPS twice weekly to review Quality Assurance monitors.

Moreover, a new policy regarding the proper reprocessing of loaner instruments and trays was developed, published, and communicated to staff through training during staff meetings. The policy was also reviewed by the facility RME Committee, who is charged with responsibility for monthly tracking of policy compliance. There is currently a process for reporting all non-conformities in the RME Committee meeting; these data are reviewed monthly. Also, SPS will report to the RME Committee monthly regarding the maintenance of readily-accessible standard operating procedures for all instruments and equipment within SPS and its satellite areas in accordance with VHA policy. Compliance with standard operating procedures completion will be validated through facility and VISN-led inspections as well as through the monthly RME Committee.

Lastly, SPS will report to the RME Committee monthly regarding the status of competencies and proficiencies of the SPS employees. Ongoing compliance with competencies will be validated by competency audits incorporated into facility and VISN-led SPS inspections. Staff from the NPOSP provided on-site training to all SPS staff, including contract technicians, during the week of December 4, 2017. Since that training, there are staff trained with appropriate competencies to work in all areas where RME reprocessing is occurring. Competency validation, however, is an ongoing process. New staff, as part of their orientation, will have appropriate training and competency validation prior to independently performing reprocessing. As new equipment or instrumentation is acquired and as standard operating procedures are updated and/or implemented, staff members who use the equipment or instrumentation will have training with competency validation. The Washington, DC VAMC remains committed to patient safety and the well-being of our Veterans.

VHA is strongly committed to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality, and safety of the VA health care system. VHA will use these findings to continue to make improvements and fulfill our mission of honoring America's Veterans by providing exceptional health care that improves their health and well-being.

NPOSP is dedicated to sustainable corrective actions. This is achieved through communication, education, and training, as well as commitment to collaborative policy changes with key stakeholders which include workforce management and consulting, logistics, contracting, facilities management, risk management, and patient safety.

As evidence of VHA's commitment to sustainable improvements, NPOSP has implemented several actions to enhance the reporting of findings and improve communication with the field, VISN, and national stakeholders to provide support for the success of SPS programs. These actions include: updating NPOSP-led triennial audit/ action plans every 60 days until all non-conformities identified by the audit have been completed; follow up on all issue briefs relating to SPS every 30 days until closed; and maintaining regular calls with SPS-challenged facilities; and organizing a variety of communication methods and forums to share trends. NPOSP is also in the process of leading a national initiative consisting of a point-in-time audit, follow-up training, and a VISN audit – all occurring in the next 90 days. These events will assist in establishing reliability of the SPS audit tool and ensure NPOSP has a complete and accurate data set indicating the current performance of all SPS facilities. To assist in identifying facilities at risk, NPOSP is developing a risk assessment tool that will be available for testing in approximately 90 days.

NPOSP recognizes deficiencies and is aggressively creating cultural changes in quality improvement processes, as well as strengthening executive communication with all levels of executive leadership in order to expedite effective change and accountability.

VA is leveraging long-standing staffing models for primary care, mental health, and nursing and is developing, evaluating, and refining additional staffing models for other functional areas. VA will continue to evolve its clinical staff modeling and workforce planning for other practice areas such as SPS.

Additionally, VA is establishing a manpower-capacity tracking system for the entire Department and is committed to deploying a position management solution for both clinical and non-clinical requirements. An updated, efficiently-aligned position categorization structure will enable VA facilities to more precisely define their clinical and non-clinical staffing requirements. Such a structure will also enable staffing predictive power on the part of VAMCs and VISNs.

SPS programs have significantly improved the efficiency and safety of health care of our Veterans. Patient safety and infection control will be improved because surgical instruments are being reprocessed correctly. In order to sustain these efforts, we ask Congress for continued support of VA modernization. It is critical that we continue to move forward with the current momentum and preserve the gains made thus far. Your continued support is essential to providing care for Veterans and their families. Mr. Chairman, this concludes my testimony. My colleague and I are prepared to answer any questions.