DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

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FOR THE OFFICE OF HEALTHCARE INSPECTIONS
OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
HEARING ON
"VA ACCOUNTABILITY: WHAT HAS HAPPENED TO HAMPTON?"
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Chairwoman Kiggans, Ranking Member Mrvan, and committee members, thank you for the opportunity to discuss a recent series of reports by the Office of Inspector General (OIG) highlighting deficiencies at the Hampton VA Medical Center (Hampton VAMC) in Virginia, and the underlying issues contributing to them. For each of the last three years (2022–2024), the OIG's Office of Healthcare Inspections has published reports on the Hampton VAMC that substantiated a range of concerning allegations related to inadequate clinical care. Any one of these reports would be disturbing for a medical center to experience. Taken together, they represent failures by VA leaders at multiple levels to recognize and provide support for a struggling facility. These reports collectively uncovered lapses in care coordination, communication, quality of care, administrative and clinical oversight, quality assurance, and overall employee engagement. Ultimately, these failings contributed to increased risks to patient safety and adverse outcomes. Although the facility has taken steps to address identified problems, the OIG will continue to monitor progress at the Hampton VAMC, as well as at other struggling facilities, to help ensure all VA patients receive the timely, high-quality care they deserve. To move forward in this mission, however, VHA must address weaknesses in leadership and accountability.

Earlier this month, Inspector General Michael Missal testified before the full committee about the need to improve VA accountability.[1] He discussed five core elements of accountability that reflect effective leadership: governance, processes, staffing, IT and other infrastructure systems, and quality assurance. A number of OIG reports have shown VA facility leaders did not take necessary and prompt action in response to reports of patient harm, while others have had difficulties creating a culture in which every

[1] VA OIG, Statement of Inspector General Michael J. Missal before the House Committee on Veterans' Affairs, September 10, 2024.

employee feels empowered to report problems. Additionally, VA often does not enforce controls that effectively and consistently ensure quality standards are met. Breakdowns in quality assurance and monitoring relate not just to systems and processes, but to personnel as well—particularly when reviewing complaints of substandard care and taking actions to restrict or revoke providers' privileges when appropriate.[2]

Deficits in these core elements of accountability are disclosed in the OIG's recent reporting on the Hampton VAMC, as well as the lack of oversight by the VA Mid-Atlantic Health Care Network, which is the Veterans Integrated Service Network (VISN) responsible for supporting the facility.[3] Although the reports highlighted in the sections that follow focus on the Hampton VAMC and related VISN, OIG recommendations are often a road map for other facilities and offices across VA to help prevent or correct similar undetected or unaddressed problems. It is vital that OIG findings are routinely shared with VA leaders across the enterprise to promote positive change and efficiencies within their respective programs and operations.

THREE OIG REPORTS ON THE HAMPTON VAMC FOUND LEADERS FAILED TO APPROPRIATELY ADDRESS CLINICAL CARE CONCERNS

When patient care delays and deficiencies are reported to OIG staff, it often becomes apparent that VHA leaders are in the process of taking appropriate action to correct the issues. What OIG healthcare inspectors find most troubling are instances when facility managers and leaders are either unaware of personnel and patient safety matters or do not ensure the required quality management processes are carried out that would detect and correct them. This was the case in the OIG's three Hampton VAMC inspections. All three stemmed from complaints or concerns shared with the OIG by facility personnel or veterans receiving care and asserted that facility leaders were either not cognizant of problems or had not properly responded. This suggests the facility did not provide a safe and supportive environment for individuals' reporting risks and wrongdoing and was not responsive to those that did come forward.

In February 2019, VHA's Office of Healthcare Transformation outlined definitive steps toward becoming a high reliability organization grounded by the basic tenet of a "just culture." Within a just culture, personnel at every level understand and react to not just identifiable risks and errors, but any vulnerabilities that could lead to patient harm. Leaders that promote such accountability and react with transparency and fairness to their staff's misconduct and missteps help establish a culture in which staff feel not only responsible for, but also secure in, reporting all concerns. Conversely, if leaders do not

[2] Clinical privileging is defined as the process by which a VA facility authorizes a physician to independently (i.e., without supervision or restriction) provide healthcare services on a facility-specific basis. Clinical privileges are based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.

[3] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. (See www.va.gov/HEALTH/visns.asp.)

encourage reporting and are not aware of adverse singular events or more systemic challenges, they cannot ensure the appropriate steps are taken to safeguard patients. Implementing quality improvements to address specific patient safety issues requires open and honest communication from, and among, staff at every level of a facility.

Hampton VAMC's Quality Assurance Staff Failed to Take Appropriate Actions

First, in the 2022 Hampton VAMC report, the OIG received a complaint focused on the delay in a single patient's diagnosis of prostate cancer.[4] The inspection team identified multiple healthcare providers, including the patient's surgeon and primary care providers, who did not appropriately communicate abnormal test results to the patient and failed to recommend and order follow-up evaluations. As a result, there were multiple missed opportunities to diagnose the patient's prostate cancer earlier, although the OIG could not determine if doing so would have affected the patient's ultimate outcome.

This healthcare inspection revealed that those tasked with the responsibility to ensure quality care did not take the measures required by VHA and the facility. According to VHA, a facility's patient safety program aims to prevent harm to patients by reporting and reviewing adverse events, identifying underlying causes, and implementing changes to reduce the likelihood of recurrence.[5] The facility's policy requires that all staff complete patient safety reports as soon as adverse events are discovered. The OIG determined that facility staff and section leaders were aware of deficiencies in the patient's care; however, they did not initiate or submit patient safety reports. Further, quality management staff did not screen for and initiate peer reviews in a timely manner consistent with VHA policy, delaying facility leaders' ability to (1) identify staff who may need additional training, (2) improve the quality of care, and (3) ensure patient safety. The chief of Quality, Safety and Value reported becoming distracted by other work and forgetting to inform the risk manager of the need for peer reviews.

The OIG made seven recommendations for the facility to make the needed improvements in its patient safety program. All recommendations have been closed as implemented.

Oncology Leaders Failed to Implement Needed Functions to Deliver High-Quality Care

In a second report published in 2023, the OIG substantiated that a patient at the Hampton facility experienced a delay in diagnosis and treatment for a new lung mass that was highly suspicious for cancer.[6] The inspection team determined that facility leaders were unaware of the patient's case until the notification that OIG personnel were examining the matter. The team identified deficiencies in primary

Commented [MP1]: So was this a review or an inspection? Earlier you refer to 3 reviews, but as drafted this says inspection. Also don't need "OIG" twice in sentence.

[4] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, June 28, 2022.

[5] Facility Policy 590-11-28, Patient Safety Improvement Program, April 30, 2020.

[6] VA OIG, *Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia*, September 29, 2023

and specialty care services' prompt scheduling and coordination of care that led to 77 days elapsing between the initial chest imaging that showed a suspicious lung mass and the patient being seen by a pulmonology specialist. Furthermore, 60 days elapsed between the pulmonologist ordering a biopsy and completion of the biopsy procedure that definitively diagnosed metastatic lung cancer. More effective care coordination might have resulted in an earlier diagnosis and treatment.

Hampton VAMC staff also had not entered a patient safety report until after the OIG alerted facility personnel to its oversight work. A root cause analysis conducted by the facility failed to identify care coordination deficiencies as contributing factors to the delay in diagnosis and treatment of the patient's lung cancer.

In addition to the substantiated delays in the patient's care, the OIG found multiple critical, required elements of the facility's cancer care program were absent. VHA's Oncology Program policy "seeks to ensure that the delivery of VA cancer care is provided following a national standard of practice," which includes the requirement that each facility have a facility-level cancer committee, tumor board, and cancer registry.[7] VHA policy mandates the use of the VA Cancer Registry System to monitor all cancers diagnosed or treated in VHA.[8] As such, each VA medical facility must identify and report data on patients with cancer diagnoses. The OIG found that, at the time of the inspection, the facility did not have an operational cancer committee, tumor board, or a cancer registry.

A cancer committee is a formal multidisciplinary group that meets to monitor, assess, and identify the needs of a facility's oncology program. The facility's chief of staff told the OIG team that the lack of a cancer committee was due to an "oversight." However, the facility director stated that a cancer committee had not been chartered earlier due to a lack of continuity in relevant staff. Tumor board conferences are also a multidisciplinary forum for providers to discuss "diagnosis, staging, and management" for patients with cancer.[9] The OIG concluded that without an active facility cancer committee and tumor board, the facility was unable to conduct the additional review that assists with identifying and assessing cancer patients' needs. As a result, facility staff may have missed opportunities to ensure patients received the highest quality of oncological care available. Of note, the OIG learned during the course of the inspection that the facility chartered a cancer care committee and tumor board on July 13, 2022, one month after the OIG announced it would be conducting its review.

The core components of accountability were clearly lacking in the Hampton facility. Leaders did not create an environment that fostered individual responsibility and continuous improvement, and failed to ensure that critical elements of a high-performing oncology program were functioning. Two of the seven

[7] VHA Directive 1415, VHA Oncology Program, April 9, 2020.

[8] VHA Directive 1412(1), Department of Veterans Affairs Cancer Registry System, May 29, 2019, amended April 7, 2020; VHA Directive 1415.

[9] VHA directive 1415 VHA Oncology Program, April 9, 2020.

recommendations remain open (not yet fully implemented) to ensure compliance with Patient Aligned Care Team process requirements and to review a root cause analysis for completeness with appropriate responsive actions being taken, if warranted. The OIG continues to follow the facility's progress in executing the corrective actions.[10]

Facility Leaders Did Not Understand or Properly Employ Basic Processes That Support the Delivery of Safe Health Care

The third report, released in July 2024, demonstrates that Hampton facility leaders did not suitably address clinical care concerns and subsequent privileging actions involving the assistant chief of surgery.[11] In the course of this inspection, the OIG determined the facility mishandled the processes for professional practice evaluations of surgeons, the surgical service's quality management, and institutional disclosures to patients or their representatives of an adverse event that resulted in harm.

Facility leaders made numerous process errors when determining whether changes were needed to the assistant chief of surgery's clinical privileges. For example, facility leaders failed to document any of the three focused clinical care review results in the appropriate system, did not provide the results of two of the reviews to the Medical Executive Committee (MEC), and delayed reporting the results of the third. These errors limited the MEC's knowledge of all reviews, which could have more fully informed members' decisions and recommendations about whether to reduce or revoke any of the assistant chief of surgery's privileges. The three focused clinical care reviews also were not completed by multiple reviewers to ensure interrater reliability and an objective evaluation of the assistant chief of surgery's clinical care.[12]

A summary suspension of privileges was issued to the assistant chief of surgery, but the OIG identified several inconsistencies between the MEC meeting minutes and suspension letters, as well as improper procedural actions taken by the facility director.[13] These inconsistencies had the potential to affect patient care because the assistant chief of surgery was unaware of which privileges were suspended, impacting the level of services available for patients.

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[10] At quarterly intervals commencing 90 calendar days from the date of the report's issuance, the OIG sends a follow-up status request to the VA office overseeing corrective action asking for an implementation status report. The OIG follow-up staff provides VA with 45 calendar days to respond. Nothing precludes VA from providing interim progress reports. The next OIG request for an update on this report will be on or about September 29, 2024.

[11] VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, July 23, 2024.

[12] Interrater reliability is the extent to which two or more independent raters or observers consistently obtain the same result when using the same assessment tool.

[13] A summary suspension is a "summary action" taken by the VA medical facility director to suspend clinical privileges when the failure to take such action may result in an imminent danger to the health and safety of any individual. A summary suspension may be applied to one or more selected privileges or all privileges depending on the circumstances and clinical concern.

While attempting to reduce the assistant chief of surgery's privileges, facility leaders did not send letters to the assistant chief in the correct order and did not include all required elements in the proposal letter to provide the necessary due process. As a result of these errors, facility leaders rescinded the proposed actions and restored the associate chief of surgery's clinical privileges. When the assistant chief of surgery transferred to another VA facility, their privileges at the Hampton VAMC ended and facility leaders therefore could not take additional privileging actions.

Hampton facility leaders did not timely report the assistant chief of surgery to the state licensing board as required. Failing to report physicians with identified incidents of substandard care to the state licensing board may result in medical facilities, within and outside of VHA, hiring providers who do not meet generally accepted standards of clinical practice, increasing risks to patients. Additionally, it could create the appearance of VA sheltering or protecting its professionals from reasonable reporting standards that apply in the non-VA healthcare community.[14]

An institutional disclosure enables facility leaders to inform a patient or their personal representative that an adverse event has occurred. This refers to an event that "resulted in, or is reasonably expected to result in, death or serious injury" and the disclosures are meant "to maintain trust between patients and VA healthcare professionals."[15] The VHA directive on informing patients of adverse events outlines the required elements of an institutional disclosure, which includes entry of a templated note in a patient's electronic health record to document the institutional disclosure discussion.[16] The OIG team determined that facility leaders generally did not communicate and document required elements of an institutional disclosure, such as advising the patient or family about potential compensation or the option to obtain outside medical or legal advice. In fact, of the 10 institutional disclosures completed at the facility from July 1, 2022, through May 31, 2023, the OIG found that nine did not include "advisement about potential compensation." Such omissions could result in patients or their personal representatives being unaware of their rights and options for recourse. Simply put, these types of lapses undermine VA's commitment to build and restore patients' trust.

The findings of this healthcare inspection highlight failures of facility leaders to make certain that they and their staff understood their roles and carried out their required responsibilities. They also revealed leaders' lack of a basic understanding of the quality assurance processes that support the delivery of safe health care. This underscores that negative outcomes can occur when such fundamental accountability elements are not present—including strong governance and an understanding of roles and responsibilities, effective quality assurance and monitoring, and leadership that fosters continuous improvement.

[14] VHA Directive 1100.18, Reporting and Responding to State Licensing Boards, January 28, 2021.

[15] VHA Directive 1004.08, Disclosure of Adverse Events to Patients, October 31, 2018.

[16] VHA Directive 1004.08.

The OIG made 12 recommendations, including 11 to the facility director on issues related to focused clinical care reviews, summary suspensions, proposed reduction or revocation of privileges, state licensing board reporting, patient safety reporting, and institutional disclosures. The OIG made one recommendation to the VISN director to ensure that the facility does not conduct management reviews and peer reviews concurrently. VA concurred with the OIG's findings and recommendations and has provided acceptable action plans and completion timelines. VA's progress in implementing these recommendations will be monitored until sufficient evidence is provided to warrant closure.[17]

THE CURRENT VISN STRUCTURE DOES NOT ENSURE ACCOUNTABILITY

The OIG's Office of Healthcare Inspections routinely reviews and publicly reports on risks to patient safety and the quality of VHA health care at facilities across the nation, such as those conducted in Hampton.[18] Many of these reports spotlight the lack of oversight by VISN leaders and staff as a key contributor to identified deficiencies or adverse patient outcomes. Given its importance, the OIG has intensified its focus on VISN leaders' roles and actions in supporting facility leaders and staff to deliver high-quality care, as reflected in its testimony before the Subcommittee on Health in June of this year.[19] This work has continually revealed inconsistent practices and inefficiencies that run counter to VHA's initiative to transform into a high reliability organization.

When conducting work at VHA facilities, OIG teams often interview VISN leaders to gauge their understanding of the issues affecting their local facilities, and their role in supporting any needed improvements. Many VISN leaders' responses demonstrate at best a loose understanding of problems related to staffing shortages, patient safety, and workplace culture. Repeatedly, quality management officers and chief medical officers within VISNs suggest problems can be attributed to failures of facility leaders to *bring* issues to their attention or request support—pointing to their lack of authority to require facilities to report events. A structure that permits such passive oversight will repeatedly fail to meet the needs of its patients.

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[17] The OIG will make the first request for an update on the status of recommendations in this report on October 22, 2024.

[18] The following reports are a sample of the types of patient quality and patient safety concerns reviewed in recent OIG healthcare inspections: VA OIG, *Deficiencies in Documentation of Reusable Medical Device Reprocessing and Failures in VISN 22 Oversight of Sterile Processing Service at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico*, April 30, 2024; VA OIG, *Chief of Staff's Provision of Care Without Privileges, Quality of Care Deficiencies, and Leaders' Failures at the Montana VA Health Care System in Helena*, February 6, 2024; VA OIG, *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, June 24, 2024; VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, June 24, 2024; VA OIG, *Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama*, February 27, 2023; VA OIG, *Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida*, March 30, 2023.

[19] VA OIG, Statement of Principal Deputy Assistant Inspector General Julie Kroviak, M.D. before the House Committee on Veterans' Affairs, Subcommittee on Health, June 26, 2024.

In the case of the Hampton VAMC, over the past three years the VISN leaders should have been aware of the three reports published by the OIG, multiple reviews by the Office of Medical Inspector (VHA's internal healthcare oversight office) and VA's Office of Accountability and Whistleblower Protection, as well as inquiries from Congress resulting from concerns brought forward by facility staff and veterans who use the Hampton VAMC. Their failure to provide direct and proactive support to the facility highlights the shortcomings of the current VISN oversight structure.

VA recently published a revised directive that includes an update to the roles and responsibilities of VISN directors and medical center directors, including management and oversight duties. However, the OIG did not find the new directive to be substantive or adequate to address the long-standing concerns of a passive VISN oversight role. Furthermore, the directive fails to delineate responsibilities of other key VISN roles. The policies and procedures regarding VISN oversight of medical facilities continues to lack clearly defined and standardized responsibilities, which allows inconsistent oversight and deficient engagement with facility leaders to persist.

The OIG strongly encourages VA leaders at every level to use all oversight reports as risk assessment tools to proactively identify and address similar vulnerabilities in their own offices, networks, and facilities. The findings should also stimulate discussions about improving the VISN structure and its role in ensuring and supporting the delivery of consistent high-quality care to veterans in every facility.

UPCOMING CYCLICAL INSPECTION OF THE HAMPTON VA MEDICAL CENTER

Building on prior proactive evaluation methods, the OIG recently established a cyclical review program called Healthcare Facility Inspections (HFIs). The HFI teams review VHA medical facilities on an approximately three-year cycle to measure and assess the quality of care provided within five domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. HFI inspections also apply VHA's high reliability organization principles to assess facility leaders' commitment to a culture of safety and reliability, and the well-being of patients and staff. Further, this on-site work allows staff to learn more about the OIG and encourages direct communication by facility staff with OIG healthcare inspectors to relay any additional concerns.

An HFI team performed an on-site inspection of the Hampton VAMC in August 2024 and is continuing the review of facility data and documentation. The OIG expects to release the HFI report on the Hampton facility in early 2025 and will make this subcommittee and other congressional members and staff aware of the team's findings and recommendations.

CONCLUSION

The OIG recognizes that VHA has recently made changes to the leadership team at the Hampton VAMC, and that a course correction and change in culture at the facility will take time, sustained efforts, and the support of the facility's stakeholders. Meaningful reforms will require the full engagement of effective leaders who encourage transparency and accountability, as well as proactive VISN support and

sufficient resources. Congressional attention to the issues at the Hampton VAMC helps ensure prompt and appropriate action is taken and compels leaders to begin the hard work of rebuilding the trust of veterans and facility staff. The OIG's Office of Healthcare Inspections staff will continue to follow up on open report recommendations until they are fully implemented and will monitor and review any newly reported concerns. These ongoing oversight efforts are expected to advance VHA efforts to establish a more stable Hampton facility with involved, responsive leaders who help foster a culture of continuous improvement and accountability. The veterans who rely on Hampton and every other VA medical facility deserve the highest quality of care that VISN and facility leaders can deliver.

Chairwoman Kiggans, Ranking Member Mrvan, and members of the subcommittee, this concludes my statement. I would be happy to answer any questions you may have.