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VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

September 24, 2024

Good morning, Chairwoman Kiggans, Ranking Member Mrvan, and Members of the Subcommittee. I appreciate the opportunity to discuss the Hampton VA Medical Center (VAMC). I am accompanied today by Dr. Frederick "Rick" Kotler, Medical Inspector, Office of the Medical Inspector, and Mr. Walt Dannenberg, Acting Medical Center Director, Hampton VAMC.

The Hampton VAMC has served the Veterans of Hampton Roads for more than 150 years. As one of the fastest growing VAMCs in the Nation, the northeast Virginia corridor of VISN 6 serves a Veteran population of 300,000. The number of enrolled Veterans served by the Hampton VAMC increased by 40 percent between 2013 and 2023, and Veteran enrollment continues to increase. This complexity teaching facility serves 17 county equivalents in eastern Virginia and nine counties in northeastern North Carolina.[1] Currently, the Hampton VAMC provides health care to 73,188 unique Veterans; it provides primary care, acute inpatient medicine, acute psychiatric care, chronic spinal cord injury care, and domiciliary care, and it is home to a long-term Community Living Center/hospice care unit. In addition, the Hampton VAMC serves a rapidly growing population of women Veterans, who make up 21 percent of all Veterans seen in FY24. The facility has a state-of-the-art Women's Clinic and on-site mammography services. Additional expansions at the VAMC include state-of-the-art Spinal Cord Injury and Mental Health units. With its rich history and unique geographic location, the Hampton VAMC is dedicated to improving the lives of Veterans and their families.

At VA, we believe that Veterans deserve timely access to world-class health care, and we will never settle for anything less. We recognize that even with the best intentions, there are times where we fall short in delivering the care that Veterans deserve. When we fall short, we—as a high reliability organization—are transparent about our errors, correct our mistakes, and learn from them.

VA has been actively addressing surgical care issues at the Hampton VAMC. Clinical, quality management, and peer reviews have been completed, and VISN leaders have made multiple site visits to evaluate and review the surgical service at the Hampton VAMC. In late 2022, the Office of Inspector General (OIG) received

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[1] A 1c facility has medium-high volume, medium risk patients, some complex clinical programs, and medium-sized research and teaching programs.

allegations about the quality review process in the surgical department, which prompted a thorough review by facility and VISN leadership. Since the fall of 2023, VISN 6 officials have engaged in bi-weekly meetings with the Hampton VAMC facility and surgical service leadership to complete comprehensive action plans focused on all aspects of performance and processes to improve health care delivery for Veterans.

After issues were identified in surgical service, the Chief of the surgical service stepped down in July 2024. The VAMC Director has been detailed pending an ongoing internal investigation as of July 2024, and the former Chief of Staff resigned in late July 2024. The acting Medical Center Director brings a wealth of experience and knowledge regarding high reliability and servant leadership skills. We are confident that he is able to address the critical issues and continue to move the facility forward. These actions reflect VA and the Hampton VAMC's commitment to maintain the highest standards of safety, transparency, and excellence in our health care services. VA concurred with all 12 of OIG's recommendations in its July 2024 report, "Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia" (OIG Report 23-00995-211)[2] and VA has focused attention on implementation of these recommendations with a goal of completion by December 2024.

VA values the OIG's review and fully supports its findings. We take allegations of misconduct seriously and have strengthened our policies and procedures to ensure consistent, high-quality care from licensed professionals. VA uses rigorous credentialing, privileging processes, and administrative reviews to maintain care quality and integrity. Our mission is to deliver world-class health care to Veterans through skilled and compassionate professionals, and we are committed to upholding these standards.

The Hampton VAMC also recognizes its shortage of anesthesiologists and understands the need for additional anesthesia providers to support surgical operations for Veterans. The Hampton VAMC Department of Surgery, with the assistance of the Executive Leadership Team and VISN 6 Leadership, is aggressively working to recruit anesthesiologists. To enhance anesthesia coverage, the facility and VISN have taken multiple actions. In addition to continuous recruitment postings, VISN 6 has coordinated details for anesthesiologists from neighboring VISN 6 facilities to assist in the interim. As of September 2024, a detailed chief of anesthesiology has been identified and arrived to facilitate restructuring of the service line, recruit additional staff, and provide direct patient care. Ongoing efforts to leverage the Integrated Critical Staffing Program (ICSP) are underway, and the facility can use ICSP to support up to three full-time equivalent anesthesiologists to address the acute needs of Veterans in the Hampton VAMC catchment area while permanent staff are recruited and onboarded.

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[2] https://www.vaoig.gov/sites/default/files/reports/2024-07/vaoig-23-00995-211_0.pdf

Certified Registered Nurse Anesthetists (CRNA) are important members of the medical staff at all VAMCs and are responsible for collaborative care of Veterans in the periprocedural periods—a time of great Veteran vulnerability. However, the CRNAs employed at Hampton VAMC are not licensed independent practitioners because they are licensed in Virginia, which does not authorize CRNA independent practice. As such, to comply with overarching State licensure mandates, these clinicians work under a scope of practice consistent with their State of professional licensure in Virginia. Per VHA Directive 1123, National Anesthesia Program (April 2, 2024)[3], CRNAs whose State license does not authorize independent practice must work "in collaboration with a physician" or "under physician supervision" and cannot provide services independently.

Effective December 20, 2023, Hampton has been on emergency room (ER) and operating room (OR) diversion until additional anesthesiologists are hired. In the event of an emergency after hours, Veterans will be stabilized in the ER with the assistance of surgical staff on call and transferred to another facility; this is done with a verbal hand-off between surgeons at the Hampton VAMC and the receiving facility. Emergencies that present during normal anesthesia tour of duty hours (7:30 am to 4:30 pm) will be stabilized and taken immediately to the OR for surgical intervention. As additional staff are identified and onboarded, this status will be re-evaluated in the coming weeks.

Cases that do not require immediate surgical intervention are admitted to the surgical or medical service, as appropriate, and then accommodated on the OR schedule as possible. For Veterans requiring emergent surgical care, the on-call surgeon specialist will guide and support the ER or medical staff on the best way to manage that care.

In consultation from VISN 6 leadership and the VHA National Anesthesia Office, the Hampton anesthesia team will function with a supervisory ratio appropriate for patient and procedural acuity, ensuring anesthesia provider deployment which will optimize access to anesthesia coverage. A local Standard Operating Procedure has been developed to ensure appropriate CRNA to anesthesiologist supervisory ratios. Furthermore, the Hampton VAMC utilizes two or three of the five main ORs. In addition to the main ORs, anesthesia also provides daily monitored anesthesia care to the endoscopists who utilize the minor procedure room in the same area as the main ORs.

Office of the Medical Inspector (OMI)

OMI is responsible for assessing the quality of VA health care through investigations of VA facilities Nationwide. OMI investigates after receiving allegations or disclosures, including those referred by VA employees and leadership, the Office of Accountability and Whistleblower Protection (OAWP), OIG, the Office of Special Counsel, and Congress. OMI issues comprehensive reports of the health care investigations that generally include the allegations investigated, necessary background

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[3] Directive 1123 went through its routine recertification in April the policy regarding CRNAs is unchanged. Supervision is still required if required by license.

information, factual findings, conclusions, and actionable recommendations for corrective action or improvements to the quality of Veterans' health care.

When OMI uncovers evidence of potential senior leader misconduct or poor performance during one of its investigations, it refers the allegations and evidence to OAWP for investigation of the alleged misconduct or poor performance. OMI generally does not make specific recommendations related to discipline. Instead, it focuses on issues related to oversight and improvement of Veterans' health care.

OMI has conducted four investigations at the Hampton VAMC over the last two years, one in December 2022, and three between December 2023 and February 2024, with reports issued in May 2023, May 2024 (two reports), and June 2024, respectively. Topics included oncology care, provider staffing, senior leadership response to quality of care and patient safety issues, care of a Veteran in the ER, anesthesia care, and the surgery service. The number of recommendations made for each of the reports and the status for each is as follows:

- May 2023: Action plan received June 12, 2023. OMI made four recommendations, two of which are complete and have requests for closure, and two remain open.
- May 2024: No action plan requested. OMI made no recommendations.
- May 2024: Action plan received July 9, 2024. OMI made one recommendation, which is open.
- June 2024: Action plan received August 15, 2024. OMI made eight recommendations, all of which are open.

Conclusion

Madam Chair, Ranking Member, thank you again for the opportunity to join you for this important discussion. VA remains dedicated to providing exceptional health care services to our Nation's heroes in Hampton Roads and beyond. We are committed to upholding our mission of serving those who have served by continuously striving for excellence, innovation, and accessibility in the services we provide. My colleagues and I look forward to addressing your questions.