

**STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS**

SEPTEMBER 9, 2013

Chairman Miller, Ranking Member Michaud, Members of the Committee, other Members in attendance today, ladies and gentlemen. Thank you for the opportunity to participate in this oversight field hearing.

The Department of Veterans Affairs (VA) is committed to consistently providing the high quality care our Veterans have earned and deserve. VA operates the largest integrated health care delivery system in the country, with over 1,800 sites of care. Each year, over 200,000 Veterans Health Administration (VHA) leaders and health care employees provide exceptional care to approximately 6.3 million Veterans and other beneficiaries. The VA health care system is consistently recognized by The Joint Commission and numerous other external reviews as a top performer on key health care quality measures. We operate with unmatched transparency in public and private sector healthcare, fostering a culture that reports and evaluates errors in order to avoid repeating them in the future.

In delivering the best possible care to our patients, one of VA's most important priorities is to keep our patients free from injury during their time at our facilities. In some cases, we have not done so, and I am saddened by any adverse consequence

that a Veteran might experience while in or as a result of care at one of our medical centers. We send our sincerest condolences to those Veterans and their families.

When patient safety incidents occur at VHA, we are committed to identifying, mitigating, and preventing additional patient safety risks within the VA health care system. Where challenges occur, VA takes direct action to review each incident, and puts in place corrections to improve the quality of care provided and hold employees accountable for any misconduct. We work hard to incorporate lessons learned so that future incidents can be avoided or mitigated throughout the entire health care network.

In 1999, the Institute of Medicine (IOM) issued a landmark report on patient safety. Entitled “To Err is Human: Building a Safer Health System,”¹ the report estimated that 44,000 to 98,000 people die each year in hospitals across the country as a result of medical errors, making those errors the eighth leading cause of death in the United States. This report started a movement toward patient safety in medical facilities that has continued to grow to the present day. VA’s response to the report was swift, and has been cited² as a model for other health care organizations.

In the same year the IOM report was issued, the Department established a National Center for Patient Safety (NCPS) to lead our efforts in this area and to develop and nurture a culture of safety throughout VHA. Every VA medical center now has at least one patient safety manager. These managers work to reduce or eliminate

¹ Institute Of Medicine, Shaping the Future for Health, “To Err Is Human: Building a Safer Health System,” November 1999.

² Professionals from 285 U.S. organizations and agencies including the Department of Defense and American College of Surgeons, for example, have attended VHA patient safety training programs. Internationally, 12 foreign nations have participated in patient safety training including Denmark and Australia, which implemented national programs based on the VA model. The VA National Centers for Patient Safety partnered with Agency for Healthcare Research and Quality for several years in the development and delivery of the national Patient Safety Improvement Corps initiative, which trained state-based teams from around the country.

preventable harm to patients. They do this, in part, by investigating system-level vulnerabilities. There is strong evidence that system errors occur because of system failures rather than intentional efforts of individuals.

No hospital system can eliminate all individual errors, but our Department is designing systems that reduce the likelihood of preventable errors and lessen the potential harm to patients from errors that do occur.

VA relies on a tool called Root Cause Analysis (RCA) to determine the basic and contributing system causes of errors. RCAs study adverse events and close calls with the goal of finding out what happened; how it happened; why the systems allowed it to happen; and how to prevent what happened from happening again.³

When an RCA is needed, a team of experts from throughout the hospital and elsewhere work with those who are familiar with the situation in an impartial process to identify prevention strategies. They look at human and other factors, policies, underlying causes and effects, related processes and systems, and risks that are inherent in health care to find potential improvements in the way our facilities care for Veterans.

In order for VA's system to work properly, we have created an internal, confidential, and non-punitive reporting system, called the Patient Safety Information System, to make sure all VA employees feel protected reporting events and near misses so that we can learn, as an organization, from the concerns that have been raised.

³ <http://www.patientsafety.va.gov/CTT/index.html>.

We ask employees, Veterans, families, and visitors to our facilities to report not only incidents resulting in harm, but also close calls. We believe that a systems approach to problem solving requires a willingness to report problems or potential problems so that solutions can be developed and implemented—because we cannot improve what we do not know about. Because of our willingness to receive and review all reported incidents, more than a million reports (which include safety reports, aggregate logs and reviews, and RCA reports) have been generated and entered into our reporting system since it was established 13 years ago.

These reports are analyzed to address vulnerabilities that affect the system and spur system-wide improvements. The analysis of these reports is shared throughout VA, followed by notifications of lessons learned and the distribution of tools. For example, we have learned that errors in the operating room are often a result of poor communication. To address this issue, VA has established a program called medical team training to enhance communication among clinicians. Because we are an integrated system, lessons identified at one facility are communicated quickly across the entire VA health care system when necessary to reduce error risk. This results in an informed health care system that learns from past incidents in order to mitigate future adverse events.

When misconduct occurs, employees are held accountable through a range of actions and consequences that appropriately address the circumstances. For instance, actions may include counseling and training or severe discipline such as demotion and removal. Acts that are deemed blameworthy have clear consequences and accountability. Such acts include criminal acts, purposefully unsafe acts, professional

misconduct such as patient abuse, professional incompetence, substandard care, and acts resulting from alcohol and substance abuse. While these instances are rare across the VHA system, there are processes in place for accountability when they occur.

In addition, there are multiple layers of oversight within VA and VHA. VHA's Office of the Medical Inspector (OMI) is responsible for investigating the quality of medical care provided by VHA. VA's Office of the Inspector General (IG) conducts investigations, audits, and health care inspections to promote economy, efficiency, and effectiveness in VA activities, and to detect and deter criminal activity, waste, abuse, and mismanagement. The IG and the OMI have both been involved in several of the situations the Committee is reviewing in this hearing, and their recommendations have helped guide our responses to those situations.

At the same time, we are committed to ensuring a "Just Culture", in which accountability principles are clearly stated but people are not punished for making inadvertent errors. Calling for punishment and termination of employees is not supported by the literature describing Just Culture as a model for management of mistakes and errors. Ignoring what the science of safety tells us about the causes of human error encourages staff to cover up or not report such errors. Recognizing that open reporting can lead to improved systems and behaviors within complex environments this concept has been promoted by the VA National Center for Patient Safety and external entities such as the American Nurses Association.⁴ The Joint Commission standards specifically require that leaders create a "culture of safety by creating an atmosphere of trust and fairness that encourages reporting of risks and

⁴ January 2010 Position Statement - <http://nursingworld.org/psjustculture>;
<http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Just-Culture.html>

adverse events”. Professor Lucian Leape of the Harvard School of Public Health has testified before Congress that the single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.⁵

Our patient safety programs, and other actions we have taken to reduce harm at our hospitals, have resulted in a number of important recent accomplishments. In the past decade, VA has:

- Significantly reduced the rate of inpatient suicides in our hospitals nationwide, from 2.64 per 100,000 admissions to 0.87 per 100,000 admissions;⁶
- Developed a program to reduce the number of patient falls in our hospitals by engaging our facilities in best practices resulting, in the overall major injury rate from falls dropping by 62 percent;⁷
- Developed a new patient-centric prescription label that enhances Veterans’ ability to follow medication instructions provided on the label;
- Significantly reduced surgical morbidity and mortality in response to the feedback and information provided to facilities and their surgical programs⁸ using the Surgical Lessons Learned program, which is now being expanded to other specialty areas;⁹ and

⁶ Watts B. Archives of General Psychiatry 2012; 69:588-92.

⁷ Mills, P. et. al. “Reducing falls and fall-related injuries in the VA System”, Journal of Healthcare Safety, Volume 1, Number 1, Winter 2003.

⁸ Neily, J., et. al., (2010)

⁹ Neily J. et. al., JAMA 2010; 304:1693-1700.

- Developed an operative complexity model to assure adequate clinical infrastructure to support the complexity of surgery at VHA facilities. This model has now been implemented at all VA medical centers, and has been viewed favorably by other health care providers.

Because VA is committed to transparency of its quality goals and measured performance of VA health care we have established the VA Hospital Compare website for Veterans, family members and their caregivers to compare the performance of their VA hospital to other VA hospitals.¹⁰ The VA transparency program, ASPIRE, ensures public accountability and encourages continual improvements in health care delivery. ASPIRE is a dashboard that documents quality and safety goals for all VA hospitals. The data shows strengths and opportunities for improvement at the national, regional, and local facilities. Additionally, VA's Office of Quality, Safety, and Value publishes an extensive annual Quality and Safety Report that details all aspects of our health care quality and safety by facility. The success of the VA transparency approach is reflected in VA's receipt of the Annual Leadership Award from the American College of Medical Quality in 2010.

Mr. Chairman, VHA is the same system of care that an investigative reporter described, a few years ago, as providing "the best care anywhere".¹¹ In 2012, 19 of our hospitals were recognized as top performing by The Joint Commission on key health care quality measures. We pioneered the use of electronic health records. We've created a mental health care delivery system especially designed to meet the needs of

¹⁰ <http://www.hospitalcompareva.gov/index.asp>

¹¹ Best Care Anywhere, 3rd Edition: Why VA Health Care Would Work Better For Everyone by Phillip Longman

our returning Veterans. VHA operates one of the highest quality care systems for mental health services in the country. VHA recently hired an additional 1,669 new mental health providers under the President's Executive Order and established 24 pilot programs with community providers across nine states and seven Veterans Integrated Service Networks to improve access to mental health care. In addition, VA has been a pioneer in the use of telemental health, providing mental health services within primary care, and has developed and implemented services such as the Veterans Crisis Line, which provides 24/7 crisis counseling services by trained mental health providers. We have an outstanding reputation within the health care profession for providing high quality, patient centered care—and for keeping our patients safe.

But, as Secretary Shinseki has said, we can do better, and we must do better. Our internal reviews have identified, and we have informed the Committee about a number of instances in which, for one reason or another, we have not kept Veterans safe in our hospitals. In every case the Committee has identified, we—and I personally—have spent considerable time learning what happened and why it happened, and developing plans and procedures to keep the issue from happening again. Let me briefly discuss what we now know about the events in Atlanta, Buffalo, Dallas, Jackson, and Pittsburgh—and what we are doing, and will do, to prevent reoccurrences.

Pittsburgh

Since we are in Pittsburgh today, let me begin by discussing the events that have occurred at our medical center here relating to Legionella bacteria. I want to begin by

expressing my deepest regret and sympathy to the families of those patients with Legionellosis who died.

The Pittsburgh Healthcare System (VAPHS) is located in Allegheny County, PA, a region with one of the highest rates of Legionellosis in the country. Because of this challenge, VHA and VAPHS have worked for many years to develop guidance and implement mitigation efforts to prevent infection.

In late summer and early fall 2012, VA Pittsburgh noticed an unusual pattern of Legionella pneumonia cases. This observation led the facility to investigate a possible environmental link between its patient cases and water system. In mid-October 2012, VA Pittsburgh worked through the Pennsylvania State Health Department to submit three patient specimens to the Centers for Disease Control and Prevention (CDC) for genetic testing. On October 30, the CDC stated they had found genetic similarities between two of the patient samples and the environmental sample from VA Pittsburgh. This finding indicated that the patients may have acquired their infection while hospitalized at VA Pittsburgh.

On November 2, 2012, VA Pittsburgh invited the Allegheny County Health Department and CDC to participate in a formal collaborative review of recent Legionellosis cases at the facility and to assist with identifying a route of transmission. Upon determining that Legionellosis was present in the hospital water system, the CDC and Allegheny County Health Department recommended immediate remediation of VA Pittsburgh's potable water system. VA Pittsburgh promptly implemented an aggressive multiphase heat and flush and hyper-chlorination effort. The health care system then

instituted, and has continued, water testing every two weeks to monitor bacteria presence.

VA has one of the most comprehensive Legionellosis prevention and assessment programs in the nation. VA policy requires every Medical Center to evaluate its risk for Legionella once a year and also requires that any transplant facility also test its water system twice annually by collecting samples by water or swab.

Historically, VA Pittsburgh Healthcare System's environmental surveillance strategy for Legionella exceeded this twice a year requirement. In the April 23, 2013 OIG report pertaining to Legionnaires Disease at VAPHS, OIG recognized that VAPHS has a long history of comprehensive mitigation efforts for Legionnaires Disease. However, the report identified several areas for improvement and the Joint Commission found insufficient compliance in some areas. In addition to environmental testing, Pittsburgh conducts specific clinical testing of patients that is necessary to detect Legionnaires' disease because patients with Legionella pneumonia cannot be reliably distinguished from patients with other bacterial or viral pneumonias. Pittsburgh has tested at a very high frequency rate, indeed the highest in the VA system.

Prior to the outbreak, VA Pittsburgh testing procedures involved the use of swabs and smaller water samples. These procedures were in accordance with accepted standards, yet we now recognize that the pre-outbreak testing procedures are less effective at detecting water-borne Legionella than the one liter collection methods recommended by CDC and currently in use at VA Pittsburgh. Despite VA Pittsburgh's historical track record of testing for Legionella more frequently than required by VA policy, health care-acquired Legionella pneumonia contributed to the deaths of five

patients between July 2011 and November 2012. Every one of these deaths is a tragedy.

In July 2013, VHA reexamined the Pittsburgh facility for evidence of compliance with the IG's recommendations. Of the 60 areas reviewed, just four required additional work or documentation. These four areas did not involve water testing. Rather, they focused on using higher chlorine ranges; automating the plumbing system; improving construction projects and risk assessments; and documenting routine flushing of hot water fixtures.

There are still two investigations pending related to Pittsburgh. Once these investigations are complete, VA will determine whether additional actions will be necessary.

According to the CDC and the U.S. Environmental Protection Agency, there is no one dominant, evidence-based primary prevention strategy for controlling Legionellosis in health care settings. However, by following the recent recommendations of external and internal review teams, including VHA experts, The Joint Commission, and the IG, VA Pittsburgh has been able to aggressively monitor and successfully control the presence of Legionella bacteria in its water supply.

The facility posts pertinent updates and information on its website, and has established a hotline for Veterans and their families who have questions related to Legionellosis. In addition, VA Pittsburgh is conducting informational sessions with Veteran stakeholders, employees, congressional stakeholders and the media. VAPHS uses these sessions to relay timely information and updates about their Legionella surveillance and treatment efforts to local community partners.

Throughout VA, we have renewed our commitment to preventing health care-acquired Legionnaires' disease and are continually looking to update best practices for prevention. In addition, in Spring 2013, VHA formed the Legionella Expert Work Group to review existing policies, develop options and standards as necessary, and draft a new consolidated policy relating to Legionella. The Work Group has developed a new draft Directive. Due to the comprehensive nature and industry leading standards and processes contained in the draft, the Directive is undergoing expanded reviews. Existing Directives established guidelines for the use of basic engineering controls as a primary means for Legionella suppression. The draft Directive enhances and expands on engineering controls, establishes mandatory standards, and identifies required processes at a wider range of facility types. The breadth and scope of these elements reflect the CDC statement¹² that *"there is no safe level of Legionella in a water system."* On August 21, 2013, a memorandum was sent to all VA Medical Centers that provided a summary of anticipated core elements of the draft Directive to aid implementation planning. Specifically, the memorandum identifies the engineering and infrastructure resources needed for compliance with new policy.

Atlanta

I would like to convey my sorrow and apologies to the families of the three Veterans who received mental health services at our Atlanta facility last year and died. These are tragic events that VA takes very seriously.

In May 2012, VA's IG received a hotline complaint alleging mismanagement and lack of oversight of care provided by the DeKalb Community Service Boards (CSB),

¹² CDC Testimony, February 5, 2013, before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations, U.S. House of Representatives.

which offer mental health care to Veterans referred to them by the Atlanta VA Medical Center under a contract managed by the facility. Later, the IG received an additional complaint that mismanagement may have contributed to the death of a patient on the facility's inpatient mental health unit. In April 2013, the IG issued two reports based on their investigation of those complaints, finding that VA facility managers did not provide adequate staff, training, resources, support, and guidance for effective oversight of the facility's contracted and inpatient mental health programs. We take these findings seriously.

Three patient deaths, including two suicides and an accidental overdose, were linked to the problems identified in the reports. The two suicides were related to inadequate oversight of contracted care; and the accidental overdose was linked to inadequate supervision of inpatients. A fourth death, also a suicide, of a Veteran who had recently been treated at the Atlanta VAMC facility as an outpatient, was not related to the matters that were the subjects of the IG's investigations.

In response to these reports, VISN 7 and the Atlanta Medical Center have taken aggressive corrective actions to address all of the identified deficiencies. They have implemented system improvements to ensure patient safety both within the Medical Center and at its contract care facilities. The inpatient program improvements include new procedures for supervised urine drug screens, visitor and hazardous item management, and escorts for patients who are required to be off the locked inpatient unit. VA is also in the process of completing nationwide guidance on these same areas.

The Atlanta VA has significantly improved its monitoring and management of their contract mental health program. The facility has reduced the number of contracts

it has with mental health organizations from 26 to five, and strengthened the contract's quality assurance monitors. VA licensed clinical social workers are embedded in the CSB sites to coordinate care for Veterans, and the facility has created a database to track clinical and financial data for every referral.

At present, 90 percent of Veterans served by the Atlanta VA receive new non-urgent mental health care appointments within 14 days, and the average wait time for a new appointment is 7 days. The Medical Center has a new long-term plan and new initiatives in place to expand mental health services and enhance access for Veterans. Among these are the expanded outpatient mental health services at the new health care facility at Fort McPherson, and a domiciliary that will open there in late Fall. These corrective measures and new initiatives have already improved the safety and quality of services at Atlanta and will continue to do so.

The Medical Center provides same day access for Veterans with urgent mental health needs, through the facility's Mental Health Assessment Team and its Evaluation, Stabilization, and Placement Clinic for Substance Abuse Disorders. The Mental Health Evaluation Team fully evaluates all Veterans referred for contract care before a referral is made. Atlanta also has an emergency department annex for mental health needs—this annex is open 24 hours a day, 7 days a week.

Jackson

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

Three of the complaints concerned allegations relating to the Sterile Processing Department. The letter alleged that poor sterilization procedures existed; that VA made public statements mischaracterizing previous investigative findings about the facility's sterilization procedures; and that VA had failed to properly oversee corrective measures within the Sterile Processing Department. The letter also cited complaints alleging chronic understaffing of physicians in primary care clinics; lack of proper certification for nurse practitioners; improper nurse practitioner prescribing practices for narcotics; and missed diagnoses and poor management by the Radiology Department. All of these complaints were referred to VA for investigation pursuant to 5 U.S.C. § 1213.¹³

At the time the March 18 letter was received, VA had already investigated the three whistleblower allegations relating to the Sterile Processing Department, responded to OSC, and taken actions in response to these allegations. Jackson has implemented stringent oversight processes to ensure reusable medical equipment is cleaned and sterilized according to manufacturers' instructions before every use. The hospital has also invested more than a million dollars into state-of-the-art reprocessing equipment to ensure proper cleaning and sterilization, and has transitioned to the use of more disposable devices when those are available. After receiving the March 18th letter, VA initiated a quality of care review of the sterile processing services at the facility. The review found that the VAMC now utilizes effective systemic processes to

¹³ Pursuant to 5 U.S.C. § 1213, when the Special Counsel determines that there is a substantial likelihood that the information from a whistleblower discloses a violation of any law, rule, or regulation, or gross mismanagement, gross waste of funds, abuse of authority, or substantial and specific danger to public health and safety, the Special Counsel transmits the relevant information to the appropriate agency head and requires that the agency head conduct an investigation with respect to the information and any related matters transmitted by the Special Counsel to the agency head, and submit to OSC a written report setting forth the findings of the agency head.

safely perform the re-processing of all critical and semi-critical reusable medical equipment in the facility.

The other two complaints discussed in the March 18 OSC letter had been referred to VA on February 29 and March 5. The February 2013 complaint involved the Primary Care Unit at the Jackson VAMC, and the March 2013 complaint contained allegations concerning the accuracy of certain interpretations by a VA radiologist who is no longer a VA employee. In response to these OSC referrals, we appointed a review team from outside the VISN to conduct a full investigation of the two new cases.

VA's reports on these two investigations were delivered to OSC on July 16 and July 29 and are currently under review by the Special Counsel. The findings and recommendations from these reports have been shared with the facility and the VISN, and efforts are underway to implement all of the recommendations in the reports.

On May 24 and June 12, OSC referred two additional complaints to VA for investigation. These referrals concerned pharmacy operations and the credentialing and privileging processes at the Jackson VAMC. VA's report on the credentialing and privileging matter was delivered to OSC on August 15. The VAMC is revising its process to ensure it is consistent with VHA policy. The Medical Center will ensure all members of its Executive Committee of the Medical Staff have equal access to review all credentialing and privileging folders prior to submitting its recommendations to the Director for approval. The report concerning pharmacy operations was delivered to OSC on August 27.

On April 3, 2013, VHA hosted a town hall meeting in downtown Jackson. The Under Secretary for Health was among the speakers at the meeting, which was

attended by nearly 300 Veterans, facility staff members, and other community partners. During the town hall meeting the participants discussed many of the issues covered in the OSC letters and other issues of concern to Veterans. The Medical Center Director and other facility leaders maintain an open door policy for Veterans to speak with them about their concerns, and the Director has personally addressed the comments provided by them on comment cards at the town hall meeting.

Since October 2011, Jackson has undergone 108 consultative program reviews, site visits, and external surveys, including recent unannounced visits from The Joint Commission, the IG, the OMI, and the Occupational Safety and Health Administration. Recent recommendations have been minor, and Jackson is accredited by all appropriate agencies, including The Joint Commission.

Buffalo

On November 1, 2012, the Chief of Pharmacy at the VA Western New York Health Care System's Buffalo VA Campus discovered a collection of single-patient insulin pen injectors in the supply drawer of a medication cart without patient labels affixed to them. This type of insulin device was intended for individual patient use but was found to have been used on multiple patients by some nurses. Once the insulin pen misuse was detected, the facility removed all pens from usage on inpatient units. The Medical Center leadership immediately began the process to identify those Veterans admitted between October 19, 2010, when insulin pens were put into use, and November 1, 2012. In addition to this internal review, the facility convened a Root Cause Analysis to thoroughly investigate this medication administration practice.

The practice at Buffalo had been for the pharmacy to issue these pens to inpatient units at the facility, however, the pharmacy did not label the pens with instructions to be used “for individual patients only” prior to their distribution to the units. Nursing practice on the units was to print and place individual patient labels on pens when they were removed from the cart. According to an IG report on this event, some nurses did not follow the intended practice and assumed that the insulin pens operated the same as a multi-dose insulin vial, changing needles between patients while using the same insulin pen. This variation in usage was also identified by the facility’s leadership finding that deficiencies related to nursing education and medication administration surveillance were specific to the usage of the pen.

Inappropriately using single-patient use pens on multiple patients carries the potential of blood borne pathogen exposure. VA’s National Center for Patient Safety (NCPS) reviewed the extent of the problem VA-wide. This review noted the possibility that other VA medical centers could have potential patients at risk from insulin pen injectors. A review of system-wide data from fiscal year (FY) 2012 revealed that 90 percent of inpatient use of insulin pens across VA was concentrated in 5 VA medical centers, including VAWNYHS. Given the vulnerabilities identified in the use of these devices, each of these VA medical centers specifically reviewed their use of the insulin pens.

Eighty-two VA medical centers, accounting for the remaining 10 percent of inpatient use of insulin pens, had very low use in FY 2012 (average of 9 inpatients per VA Medical Center). A VA request for data on January 9, 2013, reported no insulin pen events in these low use facilities. In January 2013, the Buffalo facility identified at-risk

patients and began to notify 544 at-risk patients, consisting of those who had inpatient stays and orders for subcutaneous insulin during the two-year period the pens were in use. As of August 9, 2013, all patients have been contacted with the exception of two who have not responded to phone calls or mail. Veterans were informed of potential misuse of the pens, and offered testing for blood borne pathogens, and related care as needed. VA's Office of Public Health is conducting an epidemiological study using advanced genetic testing to draw any inferences about cause and effect.

As a result of the findings at the Buffalo VAMC, VA's NCPS published a Patient Safety Alert on January 17, 2013, prohibiting the use of multi-dose pen injectors, including insulin pens, on all VA patient care units with a few specific exceptions. The Alert also requires all facilities to update local policies regarding storage, labeling, and education of staff for safe use, which Buffalo has done. NCPS has communicated with the Food and Drug Administration to investigate potential safety improvements in the design and labeling of insulin pen injectors to ensure their safe use at all hospitals throughout the United States.

The IG report related to insulin pen usage at Buffalo states that the use of insulin pens on multiple patients was not a practice limited to VA. The report states that in January 2013, a private sector New York State hospital conducted an internal review in response to news media coverage of the Buffalo VAMC incident and determined that they may also have reused insulin pens. The private sector hospital identified more than 1,900 patients who required notification regarding potential exposure to blood borne pathogens.

Other patient safety organizations have since followed VA's lead. After NCPS worked with officials from the Institute for Safe Medication Practices¹⁴, on February 7, 2013, the Institute issued a recommendation that all hospitals, public and private, discontinue the usage of multi-dose insulin pens within inpatient settings. Additionally, on March 25, the New York State Department of Health released guidelines related to the safe usage of insulin pens to all hospitals within the state.

Buffalo itself identified the issue, ensured that the inappropriate practice was stopped immediately, performed its own investigation, and took proactive steps to notify patients. All corrective steps based upon the facility's own recommendation, and the IG's recommendations, have been implemented. The Joint Commission conducted an out-of-cycle quality management review in June, which confirmed that all corrective actions related to insulin pen usage were taken and are in place.

Dallas

In response to congressional concerns regarding the operations and management of the VA North Texas Health Care System (VANTHCS) in Dallas, VA formed a review team comprised of senior leaders from throughout the VA system to review the concerns.

The team conducted a site visit to the facility during the week of July 15, 2013. They performed a review of the following areas: organizational behavior, leadership, and communication at the facility; the facility's quality management and patient safety programs; the employee and staff work culture environment; and the facility's clinical

¹⁴ The Institute for Safe Medication Practices is the nation's only 501c (3) nonprofit organization devoted entirely to medication error prevention and safe medication use. ISMP is certified as a Patient Safety Organization by the Agency for Healthcare Research and Quality.

operations and patient outcome data. VHA will take any appropriate actions based on the recommendations of the review team.

Before I close, Mr. Chairman, let me address the issues of accountability and performance awards without going into any specific cases. The responsibilities of Network Directors and Medical Center Directors are vast and complex. No matter how well they do their jobs, they are certain to face adverse events in their areas of responsibility.

The performance of VA Senior Executives, including my own, is measured against a stringent and standardized performance measurement process. Both Network Directors and Medical Center Directors are evaluated using predetermined criteria in an annual performance plan contract. Performance awards are provided to senior leaders in response to their accomplishments as measured against their established performance contracts; their ability to lead change; and their impact on the organization's overall performance.

Individuals at all levels of our system, to include leaders, are empowered to take aggressive corrective actions that are necessary at each facility. When adverse events occur, there are many ways to hold people accountable, including removing the person from the position in which they serve. I can ensure you we are holding the appropriate people accountable as a result of management and oversight issues at the facilities that are the subject of this hearing. Because this is an open hearing, with members of the public present, by law I am not at liberty to provide specifics about what has been done in individual cases.

In fiscal year (FY) 2012, VHA treated 6.3 million unique patients at our 152 hospitals, 821 community based clinics, and 300 Vet centers. VHA had more than 700,000 Veterans admitted to our facilities as inpatients in FY 2012 and 83.6 million outpatient visits occurred at our hospitals and clinics.

The overwhelming majority of those visits were successfully completed, and we know Veterans and their families were satisfied with the outcomes as evidenced on our patient satisfaction surveys, which consistently show that our patients experience a level of satisfaction comparable to the private sector. The preponderance of evidence affirms that at the system level, Veterans are being well-served through a highly-effective integrated health care system that is administered by a caring and effective workforce.

What I can commit to you today is that VHA will never be satisfied when something—anything—goes wrong at one of our facilities, and the issue is in any way remotely our fault. I am always deeply concerned, as is my staff, whenever I learn of adverse events Veterans have experienced as a result of medical or system errors.

We will continue to train all VHA employees in proper patient safety techniques, and we will continue to investigate and make full disclosures following any injury to a patient.

We will continue to build a health care environment in which staff understands what constitutes an adverse event, and in which senior leaders endorse a culture of safety; one in which staff feel safe to report patient safety risks, and are empowered to make changes that will prevent those events in the future. Such an environment is characterized by increasing reporting and monitoring.

Finally, we will continue to identify, mitigate, and prevent vulnerabilities within our health care system, wherever we find them. And when adverse events do occur, we will identify them, learn from them, and improve our systems to prevent these incidents from happening again. This is commitment that requires constant vigilance, self-reporting, openness, and accountability.

Mr. Chairman, this concludes my testimony. VA will continue to ensure accountability and seek continuous improvement as it delivers high quality health care to our Nation's Veterans. I appreciate the Committee's continued interest in the health and welfare of America's Veterans. At this time, my colleagues and I are prepared to answer your questions.