Department of Veteran Affairs (VA)
Questions for the Record
House Veterans Affairs Committee on Oversight and Reform
Subcommittee on Government Operations

"Ensuring Quality Healthcare for our Veterans"

June 20, 2019

Questions for the Record from Chairman Connolly

Question 1: What steps have you taken to develop a matrix, as requested by Chairman Connolly, to help Congress and the Office of Inspector General (OIG) track your progress on the areas of greatest concern identified in previous OIG reports?

VA Response: Please see the attached draft matrix of open Washington, DC VA Medical Center (DC VAMC) Office of Inspector General (OIG) recommendations developed in response to Chairman Connolly's request.

DC VAMC OIG
Open Recommenda

Question 2: Have you engaged with the OIG staff and committee staff to ensure that the requested matrix includes the correct information and allows for easy tracking of your progress?

VA Response: OIG is an independent arm of VA. As such, it would be inappropriate for OIG and the DC VAMC to collaborate on this type of item. VA submitted the draft matrix to the House Committee on Oversight and Government Reform on July 23, 2019. VA is currently in the process of scheduling a meeting with committee staff for review and comment.

Question 3: How do you ensure that all leaders and supervisors at the Washington, D.C. Veterans Affairs Medical Center (DC VAMC) engage with the workforce to understand employee concerns?

VA Response: VA and DC VAMC routinely survey staff through our quarterly Best Places to Work Survey and our annual All Employee Survey. This year, DC VAMC leadership was able to increase participation in the All Employee Survey from 38 percent to 75 percent and will be establishing staff-led teams to address the concerns identified as being top priorities for the organization. DC VAMC leadership encourages all employees to report concerns to their first line supervisor or through the Patient Safety Reporting system. The DC VAMC Director and senior leaders review these issues daily and discuss them in morning huddles. All members of the senior leadership team at the DC VAMC have an open-door policy. Employees are

encouraged to use the open-door policy as a mechanism to raise concerns that have not been addressed adequately by supervisors or that the employee felt could not be brought to the employee's immediate supervisor. Often, these issues are referred to the supervisor with closer coaching and scrutiny from a responsible senior leader. DC VAMC also has a robust Equal Employment Opportunity (EEO) program that encourages dispute resolution through trained mediators. The senior leadership team reviews all EEO complaints and meets with EEO staff monthly to review trends and focus on early identification and intervention in employee-management issues. The DC VAMC Director requires all supervisors to attend Office of Personnel Management (OPM) supervisory training. As a condition of employment, new supervisors are required to attend supervisory training within 12 months of employment. The DC VAMC Director speaks frequently with leaders at all levels about periodic performance counseling of staff and the importance of timely formal and informal feedback to staff. DC VAMC also implemented the Office of Resolution Management's Civility in the Workplace training to improve the overall climate of the facility. Lastly, the DC VAMC Director meets quarterly with the three unions representing DC VAMC employees to discuss common issues across the facility. The 2019 All Employee Survey exceeded prior year participation in the first 10 days of the survey period. Additionally, in the Joint Patient Safety Reporting (JPSR) system, 97.3 percent of the reports from the current fiscal year are signed by the discloser despite the option to report anonymously.

Question 3a: How do you hold these leaders accountable for seeking out employee feedback, and then, addressing those concerns and implementing solutions?

VA Response: A performance element for supervisors and senior leaders, Leading Change, is where leaders are provided the opportunity to demonstrate their commitment to seeking out feedback and implementing solutions. Leaders are instructed to provide a self-assessment and are then provided feedback by their direct supervisor at the middle and end of each fiscal year. Success in this area also requires significant mentoring and coaching of younger leaders to ensure they are having productive discussions with their subordinates. Monitoring the completion of performance plans, mid-point counseling, and performance appraisals provides timely information on which leaders are meeting OPM standards and which leaders are struggling. The DC VAMC Director has frequent discussions with staff to provide back briefs on critical information. For example, when the facility changes a policy or procedure in an area, the DC VAMC Director will visit the area and ask staff to discuss the change to include the reason and any concerns about the change. This provides valuable feedback on how quickly issues are being resolved and how clearly leaders are communicating with their staff.

Question 4: How have you personally sought employee feedback across all levels and divisions of the DC VAMC?

VA Response: In addition to an open-door policy where staff frequently bring feedback, the DC VAMC Director routinely visits different areas of the hospital to observe work and engage with staff. The DC VAMC Director welcomes all new

employees and explains the open-door policy and encourages staff to use it. The DC VAMC Director conducts quarterly employee town halls and hosts focused town hall forums if there is a concern or a trend emerges in a work unit. The DC VAMC Director also worked closely with participants in the facility's Leadership Development Institute to champion a project that almost doubled participation in the annual All Employee Survey. This team of five frontline staff was essential in identifying the concerns many staff had about taking the survey, allowing better communication about the anonymity of the survey, and how facility leaders intend to use feedback to improve DC VAMC.

Question 5: What actions are you taking to recognize and reward employees who report wrongdoing or flag near miss incidents?

VA Response: Every week, and sometimes several times a week, the DC VAMC Director sends an email message to All Staff with the subject "Tell Me Something Good." The facility routinely highlights staff members who go above and beyond the call of duty or who have made what we call a "Good Catch." When possible, those staff are invited to the Friday morning Leadership meeting to be recognized for their efforts.

Question 6: What actions are you taking to ensure the entire leadership team at the DC VAMC holds its employees accountable?

VA Response: The DC VAMC Director models a Just Culture, demonstrating to leaders in the organization that when a mistake happens, we need to look to determine if a process is to blame or if a process was not followed. When a process breaks down at the facility, we look for an opportunity to fix it, and when the problem is a person not following an established process, we take appropriate administrative action. Staff at all levels need to feel safe in reporting concerns or admitting when they have made a mistake. When a mistake occurs due to complacency or willful non-compliance with a policy or procedure, we then evaluate the severity of that error and take appropriate administrative action.

Question 7: How will you know when you personally have achieved success in changing the "culture of complacency" described in the OIG's report on "Critical Deficiencies at the DC VA Medical Center"?

VA Response: One of the elements that must be addressed in requesting closure of the OIG Critical Deficiencies report is sustainment. Before OIG will accept our recommendation for closure, we have to demonstrate that robust processes are in place for the sustainment of the improvements that have been made. In most cases, this is done through our governance structure by requiring that routine reports are submitted to their respective committees and routed to appropriate leadership. The facility's leadership team expects to see significant improvement in key critical performance elements. Our mortality, readmissions, and adverse events will trend down significantly, and our patient and staff satisfaction scores will increase. Once these metrics rise to the level of the top 10 percent of VAMCs nationally and sustain that level of

performance for 2 to 3 years, the DC VAMC Director will be confident the culture change underway has taken hold across the organization.

<u>Question 8</u>: According to documents provided to the subcommittee, as of May 2019, just five months into the year, the D.C. facility reported four suicide deaths and 99 suicide attempts by veterans who had received care at the facility. In the prior five years, the number of suicide attempts ranged from 98 in 2014 to 128 in 2018 for the entire year.

<u>Question 8a</u>: Why has the DC VAMC seen this large number of suicide attempts in 2019?

<u>VA Response:</u> The increase in reported suicide attempts can be attributed to improved screening. In the past, DC VAMC was not capturing the true number of suicide attempts because Veterans did not always share that information. DC VAMC also asked about attempts over the past 6 months and now uses a standardized suicide risk assessment that screens Veterans for suicide risk and specifically asks about attempts up to 12 months ago. This valuable information has allowed DC VAMC to better identify Veterans who are at high risk to seamlessly coordinate the appropriate services for each patient in our care.

<u>Question 8b</u>: What actions will the DC VAMC take to address this trend at the facility?

<u>VA Response</u>: The information from the improved screening tool allows staff to better identify high-risk Veterans and engage with those Veterans through our Suicide Prevention Coordinators. When one of those patients misses an appointment, the Coordinators reach out to locate the Veteran and ensure they are not in crisis. The Coordinators also serve as a direct point of contact for both the Veteran and their families. If a Veteran or family member has a concern about the Veteran's safety, they can call the Coordinator and receive immediate assistance and intervention.

<u>Question 9</u>: Do patients who visit the DC VAMC receive instructions in how to provide feedback to your organization or how to get assistance from patient advocates?

<u>VA Response</u>: Yes, the Patient Advocacy staff provide information to patients on the various ways to provide feedback to DC VAMC. In addition to the information that is available and provided to visitors by our information receptionist staff, our Office of Patient Engagement and Advocacy (Patient Advocacy Office) is working with the DC VAMC Office of Public Affairs to create additional posters, signs, and digital media opportunities to further diffuse the information. Facility staff are encouraged to refer Veterans/visitors to the Patient Advocacy Office when they have feedback, after they have attempted to speak with management at the point of care/service. Additionally, through the program VET Signals, Veterans are randomly surveyed after their appointments by phone and mail to provide feedback on their visit or hospital stay.

Written comments from these surveys are provided directly to the DC VAMC Director for awareness and engagement.

Question 10: How do you ensure the patients are aware of the Patient Advocacy Office and the services it provides?

VA Response: Currently all staff are aware of the Patient Advocacy Office and staff, as well as the volunteers. New employees complete training with the Patient Advocacy staff as part of our New Employee Orientation. Staff are encouraged to resolve Veteran concerns at the lowest level and to refer the Veteran to the Patient Advocacy Office if they cannot resolve the issue on the spot. Additionally, the facility Web site has information (Customer Service link), Public Affairs (Social Media monitor), Information Desk inquiries, and informational sessions; such as department in-services.

Question 10a: Does the patient Advocacy Office have adequate resources and staffing to meet the demand of patient needs?

VA Response: The Patient Advocacy Office needs more space to ensure privacy for those seeking assistance and for staff security. DC VAMC recently hired three additional advocates to meet patient demand. As customer service and resolution of patient complaints at the clinic or work unit level improves, DC VAMC will transition some Patient Advocacy staff to complete more training and mentoring of frontline staff.

Question 11: The Associate Director at the DC VAMC, who oversees many essential administrative services, will be leaving this summer. How will you ensure that his departure will not allow the D.C. facility to slip backwards in this area of work?

VA Response: Over the last 10 months, DC VAMC has had a stable senior leadership team in place. This has allowed the facility to fill the leadership one level below the Associate Director (AD) with permanent staff hired and mentored by the AD. The DC VAMC Director is confident the team is focused on the mission and purpose and will continue to improve and elevate the performance of their work areas until a permanent AD is on board. The departure of the AD will also shift some of the DC VAMC Director's focus to be more directly engaged in some of the departments reporting to the AD. This will ensure the facility sustains the progress made and continues to improve in these critical areas.

Question 11a: What is your succession plan for the Associate Director position?

VA Response: The DC VAMC Director does not anticipate there will be a problem filling the AD positions once vacant. There are several, highly-qualified service chiefs within DC VAMC who are capable and prepared to serve in either role. While these transitions are challenging, they are essential to help grow the next generation of VA medical center leaders, which is an important responsibility of any VAMC Director.

<u>Question 12</u>: Can the VA provide the organizational chart, prioritized hiring list, and staffing analysis plan provided to the OIG in response to Recommendation 19 of the "Critical Deficiencies" report?

<u>VA Response</u>: Please see the attached organizational chart and staffing plan. The organizational chart and staffing plan were submitted to OIG in support of the closure of Recommendation 19 in June 2019. The DC VAMC is addressing the prioritized hiring list over two fiscal years. Currently, we have hired 179 of the 285 positions prioritized for FY 2019. Of the remaining 106 positions for FY 2019, all of them are in various phases of recruitment or pre-employment.

DC Signed Org Chart 4-5-18.pdf

Facility Org Chart Signed July 18 2019.

<u>Question 13</u>: The VA said in the hearing that the authorized position counts by organization provided to the subcommittee were not accurate. Please provide an updated record of vacancies against a revised and cleared number of authorized positions.

<u>VA Response</u>: The staffing plan submitted in response to the prior question contains an accurate representation of the vacant positions that have been approved for recruitment by our Position Management Committee. As of June 2019, our staffing is at 2,604 full-time employee equivalents (FTEE), and the facility has another 451 approved FTEE for recruitment. The HRSmart system is the database of record for all authorized positions at the facility. To improve the accuracy of the HRSmart system, the facility is in the process of aligning its staffing plan with the authorized positions in the database. The facility is also identifying positions that are no longer needed to support the facility. These positions are being coded accordingly so funded and unencumbered positions in HRSmart will represent the facility's true vacancy rate.

<u>Question 14</u>: What barriers prevent the DC VAMC from hiring them most qualified staff and from filling critical vacancies in offices with shortages?

<u>VA Response</u>: There are several issues that impact the filling of critical vacancies. One major challenge was having the mid-level supervisors in place to select and manage the recruitment of frontline staff. With these positions filled, the facility has leaders who can focus on recruitment strategies. Pay in our title 5 positions also is a barrier in some critical areas. This is a result of either variation in classification of positions across Federal Government activities in the local area or current pay scales. This has impacted the facility's ability to hire facility engineers, radiation safety officers, and our emergency management position. Most notably, the DC VAMC Director requested a special salary table for its police officers that, if approved, will increase the average salary by nearly 17 percent. Without this increase, we cannot compete with other Federal police services in the local area.

<u>Question 15</u>: Are there specific challenges at the DC VA related to hiring medical personnel? Non-medical professionals?

<u>VA Response</u>: The DC VAMC is very competitive in hiring medical professionals. There are several hard-to-fill positions, such as interventional radiology, psychiatrists, and infection control nurses, but these are shortage specialties across the community. The DC VAMC Director is concerned about the availability of nurses within the community and the facility's competitiveness in attracting nursing staff. The facility recently completed a nursing salary survey and is evaluating the data to determine what adjustments may be needed to make to its salary tables. The greatest challenge to recruiting medical professionals is the length of time it takes to on-board a candidate. The facility's average hiring time is 3 to 4 months, and many of these professionals are entertaining multiple job offers. The facility's partnership with the Veterans Health Administration's (VHA) Workforce Management & Consulting Service has helped manage this to some degree, but only a fully functional human resources (HR) system and staff at DC VAMC will resolve it completely. That is why filling the significant HR vacancies at the facility remains one of the DC VAMC Director's top three priorities.

<u>Question 16</u>: Many of the problems outlined in the OIG "Critical Deficiency" report were a result of failures in the Sterile Processing Services and Logistics.

<u>Question 16a</u>: Are you satisfied with the progress made in these departments?

<u>VA Response</u>: Yes. The OIG Reporting Analytics Performance Improvement & Development Team confirmed that processes are robust, and the Department is headed in the right direction. We have strong leadership in Sterile Processing Services (SPS) that has built a motivated and high-performing team. We have drafted more than 200 standard operating procedures (SOP) on equipment sterilization and trained all staff on these procedures. The DC VAMC Director expects the two remaining OIG recommendations in the SPS area to be closed by September 30, 2019. Staffing has significantly improved, and all SPS leadership positions are filled. One hundred percent of all trays have completed count sheets, and 100 percent of all instruments and trays have completed SOPs. The facility attests the Reusable Medical Equipment inventory is adequate to meet the needs of the facility's surgical and clinical program. SPS staff competencies of assigned tasks have been validated by the facility.

The DC VAMC Director is also pleased with the progress Logistics has made, particularly in completing inventories of all equipment and supplies, adding all the supplies to the Generic Inventory Package and converting our medical and surgical supply items to VHA's Prime Vendor contract. The facility's Prime Vendor utilization matches VA's national average, and it will continue to improve as the facility's utilization data mature. The facility has completed equipment inventories and assigned accountable officers for all Equipment Inventory Lists (EIL). The facility is now ensuring all quarterly EIL inventories are completed by accountable officers on a recurring basis. The DC VAMC Director also expects the three remaining Logistics recommendations to be closed by September 30, 2019.

Question 16b: If not, what more can be done?

VA Response: While the DC VAMC Director is pleased with the progress made in SPS and Logistics, each area still requires close monitoring and leadership attention to ensure sustained performance. Within SPS, the facility is in the middle of a major renovation of its workspace. That project should be completed in March 2020 and will remove the final concerns the DC VAMC Director has in this area. The facility continues to work closely to ensure that the project is completed on schedule.

Logistics is still dependent on 20 contract staff to fill the facility's supply tech vacancies. That contract will remain in place until all 20 of our permanent staff are on board. The facility also needs to mature the use of the Prime Vendor contract. As the facility converts supply items to procurement through the Prime Vendor, it takes the contractor 60 to 90 days to develop a robust enough stock level to meet facility demands. During that period, the facility must closely watch for requisitions that the vendor cannot fill to ensure the facility does not run short of an item.

Question 17: In reference to a redacted whistleblower case provided to the subcommittee, what are the DC VAMC leadership and the Veterans Health Administration findings on the following claim: "Chief of Staff instructed surgery staff not to schedule patients, instead of scheduling patients and having to cancel them for lack of supplies"?

VA Response: The allegation was carefully reviewed and was not substantiated. The Chief of Staff did not instruct surgery staff not to schedule patients.

Question 18: What steps has the Veterans Health Administration headquarters taken to support the DC VAMC in fostering a culture of accountability?

VA Response: Veterans Integrated Service Network (VISN) and VHA leadership have been actively engaged in fostering the culture change necessary to make DC VAMC the flagship of VHA. The VISN has made a significant financial investment to ensure we can bring on board the staff needed to meet our mission. VHA requires a weekly "hot topics" report that summarizes critical challenges at the facility, actions taken, and requests for support. DC VAMC leadership and VISN staff review the OIG Critical Deficiencies report progress and hot topics report weekly to discuss progress and identify areas of concern. Quarterly, the Executive in Charge and senior VHA staff meet with the VISN and DC VAMC leadership to review the progress made on the OIG Critical Deficiencies recommendations, to validate completion, and to inquire about what additional assistance is needed. Early in his tenure, the DC VAMC Director scheduled an Executive Team Development with the National Center for Organizational Development (NCOD). This resulted in a 6-month engagement between the facility and NCOD that built a strong leadership team, established team and facility priorities, and developed communication plans for the facility staff regarding progress. Leadership at the DC VAMC have recently requested to participate in VA's Voices program, which

provides trained facilitators to implement customer service training across the facility, and we are confident they will be added to this program.

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