ELIJAH E. CUMMINGS, MARYLAND
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ONE HUNDRED SIXTEENTH CONGRESS

JIM JORDAN, OHIO
RANKING MINORITY MEMBER

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225–5051
MINORITY (202) 225–5074

http://oversight.house.gov

MEMORANDUM

June 17, 2019

To: Members of the Committee on Oversight and Reform

Fr: Majority Staff

Re: Hearing on "Ensuring Quality Healthcare for our Veterans"

On **Thursday, June 20, 2019, at 2:00 p.m., in room 2154 of the Rayburn House Office Building,** the Subcommittee will hold a hearing to examine longstanding critical deficiencies at the Washington, D.C. Veterans Affairs Medical Center (DC VAMC). In April 2019, the Chairman of the Committee on Oversight and Reform referred the examination of care of veterans at the DC VAMC to the Subcommittee on Government Operations.

I. PERSISTENT PROBLEMS FOUND BY THE INSPECTOR GENERAL

The DC VAMC cares for nearly 100,000 veterans each year, employs more than 2,700 people, and has an annual budget exceeding $550 million. The Department of Veterans Affairs (VA) clusters its medical centers into 23 regions called the Veteran Integrated Service Network (VISN). The DC VAMC falls under the management of VISN 5.[1]

At the end of fiscal year 2018, the DC VAMC ranked as a one-star facility in overall quality, among the bottom 10% of 146 Veterans Health Administration (VHA) medical centers. VHA uses the Strategic Analytics for Improvement and Learning (SAIL) model to summarize a medical center's performance. SAIL evaluates criteria such as "death rate, complications, and patient satisfaction, as well as overall efficiency and physician capacity" to arrive at a star rating between 1 and 5.[2]

The Department of Veterans Affairs Office of Inspector General (IG) has found persistent problems that compromise patient care at the DC VAMC. In its report last year, the IG noted,

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[1] Briefing by Michael Heimall, Director, Washington, D.C. Veterans Affairs Medical Center, to Chairman Gerald Connolly, Rep. Eleanor Holmes-Norton, and Staff, Subcommittee on Government Operations, House Committee on Oversight and Reform(May 3, 2019).

[2] U.S. Department of Veterans Affairs, *Quality of Care: End of Year Hospital Star Rating FY 2018* (online at www.va.gov/QUALITYOFCARE/measure-up/End_of_Year_Hospital_Star_Rating_FY2018.asp).

"From 2013 to 2016, the Medical Center and VISN 5 received at least seven written reports detailing significant deficiencies in the Medical Center Logistics, Sterile Processing, and Nursing Services."[3]

Prompted by a confidential complaint describing equipment and supply issues at the DC VAMC, the VA IG began an in-depth investigation in March 2017 and took the unusual step of publishing an interim summary report in April 2017 warning of "a number of serious and troubling deficiencies at the Medical Center that place patients at unnecessary risk." Critical vacancies in the DC VAMC management team hampered its ability to address ongoing issues. These vacancies occurred in the following positions: the Associate Medical Center Director, Associate Director for Patient Care Services, Chief of Human Resources, Chief of the Business Office, Chief of Mental Health, Chief of Voluntary Service, Chief of Integrated Health and Wellness, Chief of Police, and Chief of Radiology.[4]

In March 2018, the IG published its final report, which found that leadership failures and pervasive understaffing underpinned widespread problems in inventory management, sterile processing, and patient safety. The IG also found continual mismanagement of protected information and significant government resources, putting them at risk for fraud, waste, and abuse. In the March 2018 report, the IG issued 40 recommendations to the DC VAMC Director, VISN 5 Director, and VA Under Secretary for Health. As of June 2019, the IG has closed 28 of those recommendations, and 12 recommendations remain open.[5]

In May 2018, the IG returned to the DC VAMC to conduct a routine Comprehensive Healthcare Inspection Program (CHIP) review and developed recommendations for six of eight clinical operating areas. It also deployed a Rapid Response Team (RRT) to focus on the concerns from the March 2018 Critical Deficiencies report. The IG noted that the facility had made some progress toward implementing the IG recommendations, but additional time and oversight were needed to fully evaluate remediation of the deficient conditions.[6]

The IG's health care inspection team returned to the DC VAMC in early June 2019 and will share the results of that review at the hearing. The IG will likely testify that they are encouraged by progress, including improvements in patient safety incident reporting, better processing and preparation of medical equipment in the operating room, and additional leadership steps to address the organization's culture of complacency.

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[3] U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Critical Deficiencies at the Washington DC VA Medical Center* (Mar. 7, 2018) (online at www.va.gov/oig/pubs/vaoig-17-02644-130.pdf).

[4] U.S. Department of Veterans Affairs, Office of Inspector General, *Interim Summary Report* (Apr. 12, 2017) (online at www.va.gov/oig/pubs/VAOIG-17-02644-202.pdf).

[5] U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Critical Deficiencies at the Washington DC VA Medical Center* (Mar. 7, 2018) (online at www.va.gov/oig/pubs/vaoig-17-02644-130.pdf).

[6] U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center* (Jan. 28, 2019) (online at www.va.gov/oig/pubs/VAOIG-17-01757-50.pdf).

II. EXTREME RISKS TO VETERANS HEALTHCARE

The IG found that several of the hospital's practices put patients at unnecessary risk for harm, including the cancellation or delay of medically necessary surgical procedures.[7] Many of the problems outlined below deal with the availability of supplies, for which the IG found moderate improvements in their May 2018 review.

A. Sterile Processing Service

An ineffective Sterile Processing Service (SPS) department contributed to delays or postponements of procedures caused by unavailable instruments. Problems included: discolored or broken instruments reaching clinical areas; incomplete documentation of competencies for technicians; an ineffective quality assurance program; and no reliable way to ensure that instrument sets sent back to clinical areas were complete and ready for use. In one case, a patient received general anesthesia for a procedure only to have it cancelled after the medical staff in the operating room determined that a required instrument had not been sterilized. The DC VAMC still has open recommendations from the "Critical Deficiencies" report to maintain updated and accessible procedures within SPS and to ensure all employees have demonstrated a proficiency to perform their assigned duties.[8] Director Heimall briefed the Chairman of the Subcommittee and Rep. Norton that he aimed to have these recommendations resolved this month. The IG CHIP report demonstrates progress in this area and we expect the IG to confirm its improvement at the hearing.

B. Inventory Management

The lack of an accurate inventory impeded health care providers' efforts to deliver quality patient care because important supplies and instruments were not consistently available in patient care areas. The IG noted cases of needless hospitalizations caused by cancelled patient procedures, urgent scrambles to obtain needed supplies from a hospital "across the street," and procedures conducted without preferred techniques due to lack of available equipment. In August 2017, the VISN Chief Logistics Officer stated that only 783 out of 6,694 items maintained in all the primary storage areas were entered in the VHA-authorized inventory system, the Generic Inventory Package (GIP). Personnel routinely struggled to locate needed items because GIP did not accurately reflect available equipment or the location of that equipment. The DC VAMC still has two open recommendations to ensure supply, instrument, and equipment availability in patient care areas when and where they are needed and to confirm the full utilization of its authorized inventory system.[9] Director Heimall briefed the Chairman of the Subcommittee and Rep. Holmes-Norton that these recommendations should be addressed by September 2019.

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[7] U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Critical Deficiencies at the Washington DC VA Medical Center* (Mar. 7, 2018) (online at www.va.gov/oig/pubs/vaoig-17-02644-130.pdf).

[8] *Id.*

[9] *Id.*

C. Patient Safety Incident Reporting

Over a 32-month period between 2014 and 2016, the IG found evidence of at least 376 patient safety events related to supplies, instruments, or equipment, but not all incidents were reported. The Patient Safety Manager failed to properly document all patient safety events in the National Center for Patient Safety (NCPS) database or assign proper Severity Assessment Codes (SAC) during the period in which the IG conducted a review. These reports are critical for the DC VAMC and VHA headquarters in determining trends and addressing unsafe conditions. The IG has closed two Critical Deficiencies report recommendations related to improving accuracy and accountability in patient safety reporting.[10]

D. Prosthetics

As of March 31, 2017, the DC VAMC had 10,904 open or pending consults (requests by clinic staff to order items for patients) for prosthetic items ranging from eyeglasses and hearing aids to surgical implants and artificial limbs. From those consults, IG staff conducted a detailed analysis of 472 consults that were determined to present a higher risk of harm to veterans who had to wait more than 45 working days for the prosthetic appliance (VHA requires the closure of pending prosthetic consults upon the earlier of 45 working days or 60 calendar days). In one case, primary care providers had multiple consults for a patient who needed a new artificial leg because of pain with his existing device. This patient, however, waited more than a year without having a proper prosthetic leg ordered for him, and he eventually moved to a new state where a different VA facility promptly filled his request.[11] In May 2018, the Rapid Response Team reported that the prosthetics backlog had been eliminated and closed this recommendation.[12]

III. GOVERNMENT WASTE, FRAUD, AND ABUSE

The IG documented an extensive list of incidents that warrant further review of government waste and mismanagement at the DC VAMC. In August 2017, only 12% of inventory items were entered into GIP, and throughout 2017, the IG found ongoing inaccuracies between GIP's inventory levels and physical inventory, rendering the software completely useless. The IG shared evidence of ordering excess inventory caused by mismanagement, staff time wasted rummaging through extremely disorganized supply closets, last-minute supply purchases, and medical supplies stored in unsanitary conditions.[13]

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[10] *Id.*

[11] *Id.*

[12] U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center* (Jan. 28, 2019) (online at www.va.gov/oig/pubs/VAOIG-17-01757-50.pdf).

[13] U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Critical Deficiencies at the Washington DC VA Medical Center* (Mar. 7, 2018) (online at www.va.gov/oig/pubs/vaoig-17-02644-130.pdf).

The IG also documented approximately $92 million, or 89% of purchase card procurements, for supplies and equipment without proper controls. The IG found evidence that the DC VAMC frequently underutilized prime vendors established for bulk purchasing and the best government rates primarily because of ineffective inventory management. In one case, the DC VAMC purchased butterfly needles for $899, which is more than $600 more per needle than the negotiated rate available through the prime vendor. The DC VAMC and VISN 5 still have three IG recommendations outstanding related to utilization of the prime vendor, proper maintenance of equipment inventory, and improved documentation of purchases.[14]

Finally, there were multiple incidents of inappropriately controlled environments that put expendable goods at risk of spoiling. In 2017, approximately $300,000 worth of flu vaccines spoiled because of a refrigeration failure and lack of following proper procedures.[15]

IV. CULTURE OF COMPLACENCY

The Critical Deficiencies report described a "culture of complacency among VA and VHA leaders at multiple levels who failed to address previously identified serious issues with a sense of urgency or purpose." According to the IG, the ineffective leadership contributed to an environment that "placed both patients and assets of the federal government at risk."[16]

Since April 2017, the DC VAMC has been led by five directors, including the current one, Director Michael Heimall, whose tenure began in October 2018. Excessive vacancies in leadership positions and other pervasive staffing issues across multiple departments, including Logistics, Sterile Processing Service, Human Resources (HR), and Environmental Management Services, hampered the delivery of quality healthcare to veterans. The Critical Deficiencies report said the HR Department at the DC VAMC was not taking steps to address hiring issues effectively. In May 2017, the HR department reported an overall 35% vacancy rate, but DC VAMC leadership was not able to provide more details about shortages because of inaccurate organizational charts. The VISN 5 Regional Director has a significant role in staffing decisions, and still has two recommendations outstanding from the Critical Deficiencies report to complete with DC VAMC leadership. These human resources recommendations require leadership to develop a staffing plan based on clinical and administrative workload and to account for high attrition rates, and to ensure staffing deficiencies in Logistics and SPS specifically are resolved.[17]

In March 2019, the Partnership for Public Service and Boston Consulting Group published a study examining the relationship between employee engagement and agency performance in the federal government, using data from 2016 through 2018 from nearly 150 VA

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[14] *Id.*

[15] Congressional Inquiry Response from Department of Veterans Affairs, Subcommittee on Oversight and Investigations , House Committee on Veteran Affairs (Oct. 27, 2017).

[16] U.S. Department of Veterans Affairs Office of Inspector General, *Veterans Health Administration: Critical Deficiencies at the Washington DC VA Medical Center* (Mar. 7, 2018) (online at www.va.gov/oig/pubs/vaoig-17-02644-130.pdf).

[17] *Id.*

medical centers, including the DC VAMC. This study found that medical centers with stronger employee engagement had higher patient satisfaction, better call center performance, and lower turnover among registered nurses.[18]

According to 2019 SAIL scores, data for the DC VAMC appear to echo the correlation outlined in the study. The DC VAMC had the lowest employee engagement score of all medical centers based on the 2018 survey results. The DC VAMC engagement score is currently 44 out of 100, while the average for all facilities is 65. The DC VAMC also has negative results for the performance outcomes found to have a significant relationship to employee engagement. In the first quarter of 2019, the DC VAMC had a 5.3% Registered Nurse (RN) turnover rate, well over the 3.4% RN turnover rate for the best 10% of facilities. For two patient satisfaction ratings on inpatient care and specialty care providers, the DC VAMC scored well below the 50th percentile of hospitals. Finally, its call center response speed is 101 seconds, while the 50th percentile of hospitals respond in 45 seconds.[19]

VHA published 2017 survey results asking patients if they would recommend the DC VAMC to their friends and family. For the DC VAMC, only 49.5% replied "Definitely, Yes," while the total VHA average was 67%.[20]

V. VA RESPONSE TO MENTAL HEALTH INCIDENTS

Local media have also investigated and reported on facility and patient safety incidents at the DC VAMC, using information from employee whistleblowers, patients, and Freedom of Information Act requests.[21] Several reports show evidence of improper handling of mental health cases by DC VAMC employees. In one May 2019 example, a psychiatric patient escaped from a locked area of the facility through the ventilation system and was then able to get a DC VAMC employee to call him a cab to Virginia. Also in 2019, a veteran with substance abuse issues committed suicide in the week after being discharged from the DC VAMC, calling into question DC VAMC policies and staff actions when dealing with veterans at risk of suicide.

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[18] Partnership for Public Service & Boston Consulting Group, *A Prescription for Better Performance: Engaging Employees at VA Medical Centers* (Mar. 21, 2019) (online at https://ourpublicservice.org/wp-content/uploads/2019/03/BPTW18_VA-issue-brief.pdf).

[19] U.S. Department of Veterans Affairs, *Quality of Care: Strategic Analytics for Improvement and Learning (SAIL)* (online at www.va.gov/qualityofcare/measure-up/strategic_analytics_for_improvement_and_learning_sail.asp).

[20] U.S. Department of Veterans Affairs, Office of Inspector General, *Veterans Health Administration: Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center* (Jan. 28, 2019) (online at www.va.gov/oig/pubs/VAOIG-17-01757-50.pdf).

[21] *See Changes at DC VA Medical Center After Patient's Escape,* NBC News4 Washington (May 29, 2019) (online at www.nbcwashington.com/investigations/Changes-at-VA-Medical-Center-After-Patient-Escapes_Washington-DC-510587422.html); *Three Deaths Raise Questions about DC VA Medical Center Following Up with Patients After Discharge,* NBC News4 Washington (Apr. 17, 2019) (online at www.nbcwashington.com/investigations/3-Deaths-Raise-Concerns-About-DC-VA-Med-Center-Following-Up-With-Patients-After-Discharge-508714891.html).

The Subcommittee on Government Operations Chairman and Ranking Member requested information from the DC VAMC on suicide prevention and mental health issues in May 2019.[22] In response, the VA provided policies about mental health treatment, data on suicide attempts, whistleblower complaints, staffing levels of mental health offices, and a summary of their internal review of the aforementioned mental health incidents. The data showed evidence of an increasing number of suicide attempts in 2019, a 46% vacancy rate in the DC VAMC police service, an appointment wait time for new mental health patients about two days above the national average of 11.6 days, and several examples of potential mismanagement failures discussed in redacted whistleblower claims.

VI. WITNESSES

Mr. Michael S. Heimall
Director
Washington, D.C. Veterans Affairs Medical Center

The Honorable Michael J. Missal
Inspector General
Office of Inspector General
U.S. Department of Veterans Affairs

Staff contacts: Alison Arnold, Wendy Ginsberg, Kristine Lam, and Madeline Meckes at (202) 225-5051.

[22] Letter from Chairman Gerald E. Connolly, Subcommittee on Government Operations, House Committee on Oversight and Reform to Michael Heimall, Director, Washington D.C. Veterans Affairs Medical Center (May 10, 2019).