STATEMENT OF
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Good morning Chairwoman Brownley, Ranking Member Bergman and the Subcommittee. I appreciate the opportunity to discuss the oversight and accountability of VHA's medical facilities. I am accompanied today by Dr. Gerard Cox, Assistant Under Secretary for Health for Quality and Patient Safety and Dr. Teresa Boyd, Director, Veterans Integrated Service Network (VISN) 20.

The COVID-19 pandemic exposed global and US supply chain weaknesses and we expect the manufacturing and distribution disruptions to extend into Fiscal Year (FY) 2023. As the virus spread, overall consumer demand decreased and industrial activity, in turn, decreased due to the lower consumer demand and effects of COVID-19. With the increasing level of vaccination globally and the end of lockdowns in many nations, consumer demand increased dramatically, while supply chains continue to face big challenges, including worker shortages and limitations in access to raw materials and key components. VA is actively addressing these challenges, implementing near-term methods to ensure internal VA supply chain resiliency, including increased demand signal monitoring, identification of alternatives for preferred products, and treating medical products as enterprise assets. Effective national response requires a resilient public health supply chain, anchored in domestic manufacturing capabilities so that care and preventive measures can reach patients. Sustaining the resilience of the supply chain is critical for national security, and VA is working with the White House and Executive Branch agencies to develop and implement the actions identified in the National Strategy for a Resilient Public Health Supply Chain.

Despite the challenges associated with the global pandemic, VA is committed to ensuring Veterans receive safe, high-quality health care. VHA has undergone a tremendous transformation over the last several years, operating with a renewed focus, unprecedented transparency and increased accountability as part of our High Reliability Journey. Today, as demand for our services grows, Veterans are telling us they see a real difference and their trust in us is higher than ever. We remain committed to earning and sustaining that trust.

Operating the Nation's largest integrated health care system, VHA has a record in the health care industry of providing high-quality and safe medical care for the Nation's Veterans. VHA outperforms most private sector hospitals in many core measures of inpatient quality of care, achieves lower overall inpatient mortality and achieves superior levels in patient safety compared with the private sector. In fact, multiple peer-reviewed scientific studies demonstrate that the quality of health care Veterans receive from VA is as good, if not better, than what is available outside the VA system. For example, a 2018

study[1] published in the *Journal of General Internal Medicine* found that VA hospitals generally provided better quality care than non-VA hospitals and that VA's outpatient services were of higher quality when compared to commercial, Medicaid and Medicare health systems. A study[2] published in the *Journal of Surgical Research* in 2020, which compared surgical safety and patient satisfaction indicators at 34 VA Medical Centers (VAMC) with 319 nearby non-VA hospitals in 3 disparate regions of the United States, found that the VAMCs matched or outperformed neighboring non-VAs in surgical quality metrics and patient satisfaction ratings in all three areas of the country.

A 2019 study[3] published by *Medical Care* focused on the quality of VA mental health care and concluded that patients hospitalized on inpatient psychiatric units in community-based general hospitals were twice as likely to experience adverse events or medication errors than Veterans on inpatient mental health units in VA hospitals. Although adverse patient outcomes occur in every hospital and every large health system, studies like these and others show that VA's overall quality of care compares favorably with the rest of American medicine.

VHA's transparency is unmatched in American health care, fostering a culture that reports and evaluates errors and near misses to better understand and improve system-wide vulnerabilities. When an adverse event occurs, VA facilities conduct a prompt review to understand why the adverse event occurred so that system improvements can be made. If employee misconduct is found to be a factor, appropriate action is taken. Infrastructure and standardized processes have been established across all levels of the VHA organization to make improvements in patient safety and quality of care at VA medical facilities. Direct communication along service lines from VHA Central Office to VISNs and facilities is encouraged.

This system of transparency and cross-disciplinary coordination also supports VHA on our journey to becoming a High Reliability and learning organization, so that we perform at our best and deliver the highest level of service to Veterans.

High Reliability Organization (HRO)

VHA undertook an enterprise-wide initiative in February 2019, the *High Reliability Organization (HRO) Journey to Zero Harm*, to enhance the overall culture of safety and decrease patient harm events across the organization. The most significant characteristic of an HRO is an unrelenting focus on reducing mistakes that may lead to preventable harm. HROs achieve this goal by creating a "just culture" that balances individual accountability with systems thinking; by using continuous process improvement methods to identify and fix problems and reduce waste; and by developing leaders who empower all their staff to achieve results. Currently, less than 3 years into VHA's Journey to High Reliability, we are seeing improvement outcomes driven by actions implemented by individual facilities and VISNs, which is expected in this early phase of HRO cultural transformation. However,

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[1] Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings - PubMed (nih.gov)
[2] A Comparison of Surgical Quality and Patient Satisfaction Indicators Between VA Hospitals and Hospitals Near VA Hospitals - PubMed (nih.gov)
[3] Comparing Rates of Adverse Events and Medical Errors on Inpatient Psychiatric Units at Veterans Health Administration and Community-based General Hospitals - PubMed (nih.gov)

these HRO efforts are now leading to improvements that are beginning to be shared across facilities, VISNs, the VHA enterprise and even with external audiences.

VHA uses the principles of HRO to support its response to the COVID-19 pandemic. These principles, which focus on reducing human error and increasing safety, had already been identified as important prior to the pandemic. When COVID-19 pandemic increased the need to ensure safety for patients and employees, HRO principles were adopted more broadly throughout VHA. The COVID-19 pandemic highlighted the value of HRO principles and practices, as the unknowns of the COVID-19 virus increased the need to follow a high-reliability framework that helped VHA leaders and frontline teams safely meet the needs of Veterans amid the complexity of the pandemic.

Our organization's commitment to becoming an HRO is a journey over time. We are making a long-term commitment to our goal of "Zero Harm" through this culture change that is focused on leadership commitment, safety and continuous process improvement.

Addressing Findings from External Reviews

VA appreciates independent investigations that help us to further improve patient safety and look for opportunities to apply lessons learned across the enterprise. Transparency and accountability are key principles at VA, and they guide our efforts in this regard. What happened at the Louis A. Johnson VA Medical Center (VAMC) in Clarksburg, West Virginia, and the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas, was unacceptable, and we must ensure that Veterans and families know that they can trust their care at VA. These incidents do not represent the quality health care Veterans have come to expect and deserve from VA.

Office of the Inspector General Report: Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia

This VA Office of Inspector General (OIG) report focuses on events that occurred from July 2017 to June 2018. After these events occurred, VA put in place safeguards to enhance patient safety, including medical chart audits, checks and balances within pharmacy quality assurance processes and quality management reviews. VA takes the OIG recommendations very seriously and the Louis A. Johnson VAMC is implementing each of the OIG's recommendations, which are expected to be completed by March 31, 2022. The facility has emphasized building a culture of safety in line with the national HRO initiative, and Clarksburg's new leaders have implemented HRO practices including all employee forums, patient safety rounds and leadership "We Care Rounds" to promote that safety culture.

In addition, the facility executed the following improvements to prevent similar problems in the future:

- Revised and published its Standard Operating Procedure for the management and care of patients requiring a one to one (1:1) observation status.
- Developed a templated interdisciplinary treatment team (IDT) clinical note to ensure coordinated patient care discussions.

- Used the Veterans Health Information Systems and Technology Architecture Automatic Replenishment System for inventory medication management.
- Developed an updated charter for improving morbidity and mortality review reporting to ensure adverse events are reported and thoroughly reviewed.

VA also has made several changes at the headquarters level to improve our processes across the entire enterprise to include:

- Making significant strides since 2018 to establish consistent standards for personnel security and in ensuring that work related to vetting applications for suitability of employment is properly resourced;
- Evaluating the storage and security of high-alert medications and reviewing the use of a rescue medication flagging system to evaluate unexplained adverse patient events; and

- Ensuring its systems promote local willingness to raise and to investigate unusual or unexpected deaths by supporting more effective local review and higher-level oversight and planning automation of the notification of potential mortality and safety triggers to allow more prompt local response, with feedback systems to escalate concerns if warranted.

OIG Report: Pathology Oversight Failures at the Veterans Health Care System of the Ozarks (VHSO) in Fayetteville, Arkansas

The investigations into this matter revealed the pathologist involved sought to deceive the Government, and VA was not aware of the actions he took to conceal his errors. Once the full extent of his actions was known, VA worked immediately to implement process changes at VHSO and nationally that would prevent any provider from causing tragic patient harm. VA has begun the process of addressing many of the OIG's recommendations and expects to complete action on all recommendations by May 2022.

VA has strengthened internal controls by ensuring no provider can review his or her own work and by providing more stringent oversight, policy, and processes, to include:

- Implementing a VA-wide policy requiring facilities with two or fewer providers in any given specialty to have provider reviews performed at an alternate VA facility with similarly qualified specialty providers, ensuring independent and objective oversight;
- Evaluating current guidance related to impaired health care workers and exploring the possibility of a mandatory alcohol testing policy;
- Ensuring processes are in place in the new electronic health record to alert relevant staff and leadership when clinically significant changes to pathology reports are made;
- Evaluating quality management processes related to external, non-VHA pathology consultant assessments, a process that is encouraged and helps maintain high quality patient care standards for Veterans, and defining procedures that ensure relevant parties are notified of significant discrepancies in interpretation that might affect patient care decisions; and

- Increasing oversight and monthly reporting by VHSO Pathology and Laboratory Medicine services to the Medical Executive Council, VA's governing body for all clinical services, to prevent future fraudulent documentation by any Pathology and Laboratory employees and ensure the integrity of information provided to governing or accrediting bodies such as the College of American Pathologists or The Joint Commission.

In addition, based on HRO best practices, VHA conducted an enterprise-wide Safety Stand Down during the month of June 2021. The Stand Down focused on safety practices and reaffirmed the organization's commitment to delivering safe and highly reliable care for Veterans. The VHA Safety Standdown was intended to assess risk reduction in all risk areas identified by recent OIG and Administrative Investigation Board (AIB) investigations in Clarksburg and Fayetteville. These areas include psychological safety; accountability and just culture; teamwork, communication and alignment; and continuous learning.

The focus of this Safety Stand Down was for all organizations across VHA, clinical and administrative, to consider the underlying cultural, procedural and systemic deficiencies that must be addressed to ensure excellent care, every time. VA is committed to continuously improve our safety practices, processes and culture.

VHA's Healthcare Operations Center

VHA demonstrated the benefits of being an integrated health care system during the COVID-19 global pandemic. This integration is possible using our Healthcare Operations Center (HOC), which serves as a fusion center for collecting, analyzing, planning and disseminating data and information to all stakeholders. The HOC is a key enabler for VA's ability to quickly cross-level staff and material between VAMCs and to regions most in need. As we continue to address the challenges of the COVID-19 pandemic—from surges to variants, from PPE supply to vaccine administration—the integration of our health care system has enabled VHA to sustain medical operations and be responsive to support national readiness and overall U.S. health care. Through the HOC we make informed, data-driven decisions to appropriately offer services based upon relative risk in the community, thereby meeting the demand for services in a safe, measured and sustainable way for Veterans, caregivers and employees.

Conclusion

In our ongoing efforts to identify which processes work and which do not, VA continues to examine how our VAMCs are designed and functioning and how processes can be configured to function in a manner that ensures the highest-quality and safest care possible for the Veterans we serve. We will continue our drive to be an agile learning organization, using lessons learned to provide world class health care for America's heroes.

Veterans' care is our mission. We are committed to always providing high-quality health care to all Veterans including during these unprecedented times. Your continued support is essential to providing this care for Veterans and their families. This concludes my testimony. My colleagues and I are prepared to answer any questions you may have.