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U.S. DEPARTMENT OF VETERANS AFFAIRS
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COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE
HEARING ON
QUALITY OF VA'S HEALTH CARE
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Chairman Tester, Ranking Member Moran, and Committee Members, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of the quality of care provided at the Veterans Health Administration (VHA). Like other healthcare systems, VHA's goal is to provide consistently high-quality care for every patient that it serves. While VHA is staffed with providers and support staff that honor and celebrate the mission to care for our nation's veterans every day, there are real challenges in delivering that care to a population with unique and more complex medical and psychological conditions than nonveteran patients. The OIG's commitment to conducting meaningful oversight is evidenced by the reports we publish that identify risks to patients and barriers that healthcare staff face when caring for veterans.

The OIG details its findings through a wide variety of publications, including hotline reports, national reviews, comprehensive healthcare inspections, vet center inspections, and Veterans Integrated Service Network (VISN) regional reviews. From the findings and recommendations detailed in these reports, VHA, veterans, their families and caregivers, and all stakeholders can gain a comprehensive understanding of the issues affecting the quality of care provided to veterans. The OIG's auditors also produce reports on the systems critical to supporting care, such as supply chain management that helps ensure medical supplies are available for patient care when and where they are needed.[1] OIG recommendations require VHA to develop action plans that address the associated findings. Those recommendations are closed as implemented only after VHA submits an action plan and sufficient evidence for OIG staff to verify remediations or new processes are in place, meet the intention of the action plan, and are sustainable. The status of all recommendations made to VA is provided on a public dashboard that is continuously updated on the OIG website.[2]

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[1] All OIG reports can be found on its website at www.va.gov/oig/apps/info/OversightReports.aspx. See, for example, *DMLSS Supply Chain Management System Deployed with Operational Gaps That Risk National Delays*, November 10, 2021.

[2] See. https://www.va.gov/oig/recommendation-dashboard.asp

The OIG's oversight work is often initiated in response to allegations from veterans and staff related to their perceptions of poor care, delayed care, or risks to patient safety. The true intent of impactful healthcare oversight is to support meaningful improvements in the quality, safety, and efficacy of care delivered to every veteran. VHA has significant challenges, but its personnel provide compassionate and high-quality of care and services to millions of veterans and their families.

VHA DELIVERS HIGH-QUALITY MEDICAL CARE TO VETERANS AND OTHER PATIENTS

VHA has been steadfastly meeting the needs of millions of veterans each year, particularly those with complex diagnoses related to their distinct histories of service to our country. Evidence-based mental health therapies and innovative approaches to treating victims of polytrauma and traumatic brain injury are just a few examples of where VHA has pioneered and successfully championed veterans with chronic and often catastrophic visible and invisible injuries.

The pandemic presented extraordinary challenges to all healthcare systems and VHA was no exception. OIG reports highlight the successes of VHA pandemic care planning and readiness, infection control practices, critical supply management, innovative space and staffing solutions, and transitions to telehealth platforms that provided safe continuity of care to address a wide range of patient needs. For example, during Comprehensive Healthcare Inspection Program (CHIP) reviews of VISNs 2, 5, and 6 from May to August 2021, most VHA leaders interviewed indicated that VHA Central Office and VISN communications and guidance were timely, and all leaders reported receiving VISN-level assistance when requested.[3] Finally, VA made tremendous progress in vaccinating veterans against COVID-19. VA announced initial COVID-19 vaccine distribution plans in December 2020. Over 4.2 million veterans had received at least one vaccination dose as of April 21, 2022.

VHA's integrative approach to caring for veterans is uniquely comprehensive. No other healthcare system attempts to meet the clinical needs in every encounter with veterans, while also addressing their needs for psychosocial support through repeated screenings with built-in triggers to connect veterans to a wide array of social support services.

Finally, it is important to recognize the services VHA provides in addition to its mission to care for veterans. VA's fourth mission is to serve the needs of local communities during national emergencies, which was repeatedly realized during the pandemic. VHA also provides other services to the broader

[3] *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 2, 5, 6*, April 7, 2022. This is the fourth report in a series. The other reports are *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 10 and 20*, March 16, 2021; *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Network 19*, July 7, 2021; *Comprehensive Healthcare Inspection of Facilities' COVID-19 Pandemic Readiness and Response in Veterans Integrated Service Networks 1 and 8*, November 18, 2021.

healthcare community—from training nurses, medical students, residents, and fellows to advancing cutting-edge clinical research. VHA health care is intimately tied to the nation's healthcare systems.

VHA HAS SIGNIFICANT CHALLENGES TO OVERCOME THAT REQUIRE IMMEDIATE ATTENTION

The critical role VHA serves in caring for veterans and in supporting our nation's healthcare systems underscores the need for the OIG's strong, independent oversight that has identified and reported on incidents and conditions in which quality of care and patient safety have been compromised, leaving veterans harmed or placing them at risk. The events leading to these failings are often nuanced and multifactorial. However, common contributing factors the OIG has identified are poor, inconsistent, or ineffective leadership that cultivate a complacent and disengaged medical facility culture in which the VHA goal of "zero patient harm" is improbable, if not impossible.

Incidents in Fayetteville, Arkansas, and Clarksburg, West Virginia, serve as devastating examples of the most catastrophic consequences of disengaged leadership and the dangerous culture that is fostered when leaders are not attentive to and invested in their staff and the veterans they serve. Dr. Robert Levy, the former pathologist at the VA Health Care System of the Ozarks in Fayetteville, Arkansas, was found to have misdiagnosed thousands of patients' pathological specimens while impaired, adversely affecting the diagnosis and clinical care of these veterans. In addition, in his position as chief of pathology, he was able to alter quality management documents to conceal his errors. Former VHA nursing assistant Reta Mays, entrusted with providing supportive care to patients in a Clarksburg facility, pleaded guilty to administering insulin to seven veterans with the intent to cause their deaths and attempting to murder an eighth veteran. Her activities went undetected for so long, in part, because clinical leaders and other staff involved in the victims' care failed to report and share their suspicions. These events will never define the care VHA delivers to veterans every day, but they must not be dismissed as one-offs. Leveraging the painful lessons learned into meaningful tools that further transform the system's culture must be prioritized, but such direction must come from the highest levels of leadership at VHA.[4]

CULTURAL TRANSFORMATION DEPENDS ON ACCOUNTABLE LEADERS AND ADHERENCE TO A MODEL FOR GUIDING THAT TRANSFORMATION

In February 2019, VHA rolled out a new initiative through its Office of Healthcare Transformation outlining definitive steps toward becoming a high-reliability organization (HRO). HROs are grounded by a basic tenet, "the Just Culture."[5] Within a just culture, personnel at every layer of a system understand and react to not just identifiable risks and errors but any vulnerabilities that could lead to patient harm. Leaders that promote such accountability and react with transparency and fairness to their

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[4] *Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*, June 2, 2021; *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, May 11, 2021.

[5] VHA High Reliability Organizational Reference Guide, March 31, 2021.

staff's misconduct and missteps help establish a culture in which staff feel not only responsible for, but also secure in, reporting all concerns.

In November 2021, the OIG published the first of a new type of oversight report that compares facilities in the same regional network (VISN) to examine those that historically ranged from relatively low-performing to relatively high-performing facilities using an analysis of VHA performance and other quality data.[6] In addition, the OIG compared HRO implementation progress between two facilities. This report corroborated findings from multiple OIG reports: the historically lower-performing facility had continuous turnover of its leadership team and did not have effective leadership succession planning. In contrast, the higher-performing facility had a stable leadership team and exhibited effective succession planning. Furthermore, the higher-performing facility had made significantly more progress toward HRO implementation when compared to the lower-performing facility.

Regardless of the model that guides leaders and staff during the necessary transformation, progress should be assessed. This is the first report that attempts to measure impact and advancement on transforming a culture. Though it is too early to draw broad conclusions on the effectiveness of HRO implementation, the OIG will continue to review and assess VHA's efforts.

PATIENT SAFETY IS THE CORE OF QUALITY HEALTH CARE AND REQUIRES MANAGEMENT OVERSIGHT AND TIMELY ACTION

Healthcare facilities committed to patient safety routinely follow protocols that prioritize high-quality care. They have a structured and proactive quality and safety management oversight team that collects, analyzes, and investigates all concerns related to patient safety. Critical tools such as the Joint Patient Safety Report (JPSR), which captures real-time incident data throughout the healthcare system, and root cause analyses (RCAs) that task a multidisciplinary team to review the cause of system or process failures, are core elements of every patient safety program. However, without routine oversight that ensures the timely and thorough review and resolution of reported concerns (including the information produced from these tools), VHA cannot ensure the safety of veterans. Failures to closely monitor staff compliance with all patient safety activities will undermine the necessary cultural transformation.

An OIG Comprehensive Healthcare Inspection Program (CHIP) report at the Tuscaloosa VA Medical Center in Alabama, published on September 27, 2019, made four recommendations related to significant inadequacies related to the completion of RCAs, the implementation of improvement actions specific to the RCA findings, and provision of feedback to those submitting patient safety concerns.[7] The OIG published another CHIP report on September 2, 2020 at the same facility and found no evidence that the

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[6] *Descriptive Analysis of Select Performance Indicators at Two Healthcare Facilities in the Same Veterans Integrated Service Network*, November 16, 2021.

[7] *Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama*, September 2, 2020; *Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center in Alabama*, September 27, 2019.

facility had resolved the 2019 recommendations. In September 2021, while conducting a separate healthcare inspection at the facility, the OIG received additional information indicating the facility failed to comply with VHA-mandated standards for the Patient Safety Program from October 1, 2020, through September 30, 2021. The oversight failures that allowed multiple findings of deficiencies to persist related to staff not applying critical patient safety tools, which placed patients at unnecessary risk. The OIG will continue to review these failures and will publish its findings when the work is completed. VHA leaders at all levels have, in the interim, been made aware of concerning events.

THE PANDEMIC HAS REDEFINED HEALTH CARE AND HAS EXHAUSTED A WORKFORCE

In March 2020, after declaring COVID-19 a pandemic, the World Health Organization highlighted the importance of maintaining the mental health and emotional well-being of healthcare workers caring for COVID-19 patients.[8] The OIG published a report based on the results of a survey of selected VISN, facility and clinical and nonclinical staff. The report identified areas of concern related to employee emotional well-being: mainly a generally diminishing awareness of supports in relation to organizational hierarchy, low utilization of support resources by leadership and frontline employees, as well as employee perception of inadequate support and responsiveness from leadership.[9]

The OIG found that about one-third of clinical and nonclinical staff respondents indicated they did not feel their leadership was responsive to their needs, and 51 percent of clinical staff and 41 percent of nonclinical staff respondents reported they did not feel adequately emotionally supported by their facility during the pandemic. Given that VHA reported in their COVID-19 Response Plan that 19 percent of staff reported burnout and 25 percent of staff experienced "high" or "extreme" stress levels associated with COVID-19, the OIG would expect VHA to be at risk for increased employee turnover.[10]

These results are even more concerning when considering preliminary results from OIG's review of VHA's occupational staffing shortages for FY 2022. We anticipate reporting on more severe occupational staffing shortages in FY 2022 than in FY 2021. Additionally, FY 2022 may be the first time that facilities identified more than 90 occupations as having severe shortages. The OIG will publish its report on occupational staffing shortages in the coming months.

VA has taken a number of actions to address burnout and staffing challenges that include the Reducing Employee Burnout and Optimizing Organization Thriving (REBOOT) initiative that focuses on employee wellness and implementing the RAISE Act to increase salary caps for nurses and physician

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[8] Blake, H. et al., "Mitigating the Psychological Impact of COVID-19 on Healthcare Workers: A Digital Learning Package," *International Journal of Environmental Research and Public Health,* 17, no. 9, 2997, (April 2020): 1–15.

[9] *The Veterans Health Administration Needs to Do More to Promote Emotional Well-Being Supports Amid the COVID-19 Pandemic*, May 10, 2022.

[10] VHA, COVID-19 Response Report-Annex B.

assistants. Even with these efforts, VHA is facing unprecedented challenges in competing for skilled healthcare workers in the aftermath of the pandemic. The OIG has emphasized the need for VHA to develop staffing models to support hiring decisions as well as decisions related to enhancing community care networks to meet the demands of the veteran population.

VHA also must continue to work through the backlog of healthcare services that were delayed or otherwise affected by the pandemic. In a report published February 16, 2022, that focused on the Martinsburg VA Medical Center in West Virginia, the OIG determined that the facility had a backlog of over 5,000 active community consults (referrals) spanning multiple specialty services. In assessing the circumstances surrounding the backlog, the OIG confirmed decreased access to care related to COVID-19 conditions.[11]

VETERANS RECEIVING CARE IN THE COMMUNITY RELY ON VHA COORDINATING THAT CARE

Coordination of the provision of medical care between the VHA care system and community providers remains a challenge. Persistent administrative and communication errors or failures among VHA and community care providers, as well as between the providers and their patients, challenge efforts to ensure a seamless experience for veterans.

At the Phoenix VA Health Care System in Arizona, the OIG found that staff did not review a patient's initial community care consult for a mental health evaluation within the required time frame. Although a third-party administrator eventually scheduled the patient once the referral was approved, the patient was scheduled for the wrong intervention.[12] These delays and processing errors resulted in missed opportunities to appropriately diagnose and address the needs of a patient who ultimately died by suicide.

At the New Mexico VA Healthcare System in Albuquerque, the OIG substantiated that between June 2018 and June 2020, VHA Community Care nurses were completing consults without scanning and attaching clinical documentation to the patients' electronic health records.[13] Of the 255 consults reviewed by the OIG, 230 did not have clinical documentation scanned and attached to the consult in the patients' records at the time of consult completion. While VHA care providers developed work-arounds to obtain information necessary to meet their patients' needs, such strategies distract from their primary

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[11] *Care in the Community Consult Management During the COVID-19 Pandemic at the Martinsburg VA Medical Center in West Virginia*, February 16, 2022. The OIG made eight recommendations and the VISN and facility directors concurred with six of them and concurred in principle with the remaining two. The directors provided acceptable action plans and the OIG staff will follow up until they are completed.

[12] *Deficiencies in Care and Administrative Processes for a Patient Who Died by Suicide, Phoenix VA Health Care System, Arizona*, March 23, 2021. The VISN and facility directors concurred with the OIG's seven recommendations and all have been closed as implemented.

[13] *Deficiencies in the Completion of Community Care Consults and Leaders' Oversight at the New Mexico VA Health Care System in Albuquerque*, July8, 2021. As of May 1, 2022, three of five recommendations are closed as implemented. OIG staff will continue to track the remaining two recommendations.

duties of delivering care to veterans and increase the risk of human error in coordinating safe and effective care.

Previously described burdens related to workforce fatigue and shortages, as well as the referral backlogs resulting from the pandemic, will only increase the demand for care in the community. Coordination of that care and reliable information sharing between VHA and non-VA providers are critical functions in ensuring that demand is met in a seamless and safe manner and accurate information is communicated to patients.

THE ELECTRONIC HEALTH RECORD MODERNIZATION EFFORT DEMANDS TRANSPARENCY AND LEADERS' COMMITMENT TO PATIENT SAFETY

No initiative better reflects the intersection of the many major challenges VA faces than the implementation of the new electronic health record (EHR) system. Recent OIG reports released in March 2022 on VA's efforts to deploy the new EHR detail significant concerns with the initial deployment at Mann-Grandstaff VA Medical Center in Spokane, Washington.[14] Most concerning are the issues the OIG identified that increase risks to patient safety. Deficiencies in data migration to the new system resulted in patients having inaccurate or incomplete medication lists in their records and made simple activities, such as refilling a prescription, more challenging. Initial data migration failures also affected the transfer of critical alerts within the patient record (flags) that identified veterans at high risk for suicide.[15] "Disappearing" laboratory orders made diagnostic evaluations and treatment planning more difficult. Tools and processes for frontline system users to report concerns (including those pertaining to patient safety) and track the resolution of identified issues repeatedly failed. Frustrated staff stopped reporting issues and relied on work-arounds to meet immediate needs, which was inefficient, sometimes bypassed security or safeguard measures, and increased the risk that known problems would remain unresolved. Failing to resolve the issues immediately could also affect system users in other VA facilities' future rollouts that should benefit from lessons learned at the Mann-Grandstaff VA Medical Center.

The success of this monumental effort is put in peril if leaders are not responsive to the concerns of the clinical staff that navigate and rely on the functions of the EHR for everyday clinical decision-making. Patient safety issues must be prioritized and corrected as they are presented. Strong leadership is necessary to help navigate fatigued staff through the expected frustrations of adopting a new EHR.

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[14] *Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, March 17, 2022; *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, March 17, 2022; *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VAMC in Spokane, Washington*, March 17, 2022.

[15] Some of the concerns with missing or unnoticed flags were due to system issues and others with training, as the flags were less visible in the new system. VA has since stated it has resolved this issue.

Leaders must ensure the basic tenets of patient safety are not compromised in order to satisfy timelines that have not accounted for operational challenges. In addition, VHA personnel must have a strong voice in ongoing decision-making around system functions that affect patient safety and quality of care. This requires identifying and responding to concerns raised by veterans and VHA system users by ensuring there are effective processes for transparently and promptly redressing them.

CONCLUSION

VHA continues to face enormous challenges in providing high-quality care to the millions of veterans it serves. Despite these challenges, the OIG has witnessed countless examples of veterans receiving the care they need and deserve—delivered by a committed, compassionate, and highly skilled workforce. VHA staff have repeatedly overcome extraordinary obstacles to meet the complex needs of veterans. The OIG continues to emphasize the need for a cultural transformation within VHA, guided by accountable and attentive leaders that prioritize the safety of each veteran they encounter.

This Committee and VA have made it a priority to improve the quality of health care delivered by VHA. The OIG will continue to focus its efforts in support of that shared goal on both incident-specific and systems-level improvements. VHA's HRO initiative, grounded in principles that can reduce risks to patient safety and improve quality of care when consistently practiced, is meant to guide VHA leaders and all staff toward a patient-first culture. The sense of urgency to effect change is understandable and justified. However, an effective and sustainable cultural transformation will take time. During all phases of the transformation, VA must remain vigilant to problems and take swift, responsive actions that address root causes and promote accountability. It should take advantage of every opportunity to learn from experiences and apply those lessons throughout the system. This includes not only the findings from internal reviews and reports but also all OIG and other oversight agencies' recommendations for even single incidents or facilities to determine if changes to practices, processes, and systems are warranted across VA. It should not take another tragedy like those in Fayetteville or Clarksburg to sustain that sense of urgency for lasting and meaningful change.

Chairman Tester and members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.