S. HRG. 117–616

EXAMINING QUALITY OF CARE IN VA AND THE PRIVATE SECTOR

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

MAY 11, 2022

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.govinfo.gov

U.S. GOVERNMENT PUBLISHING OFFICE

51–398 PDF WASHINGTON : 2023

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EXAMINING QUALITY OF CARE IN VA AND THE PRIVATE SECTOR

WEDNESDAY, MAY 11, 2022

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3 p.m., via Webex and in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Brown, Blumenthal, Hirono, Manchin, Sinema, Hassan, Moran, Boozman, Cassidy, Rounds, and Tuberville.

OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. I call this meeting to order.

Good afternoon. Evaluating the quality of care provided to veterans, both within the VA and in the community, will help ensure they are getting the top-notch care that they have earned. Consistently, studies have shown that the quality of care at VA often is comparable to, or better than, care that is provided in the private sector.

I have said many times, but it is worth saying again, VA can outsource the work when it makes sense, but it cannot outsource responsibility for quality care our veterans receive in the community. So I want to hear more about what the VA can do to protect veterans seeking care in the community, but I recognize that VA care is not without challenges.

In the last few years, incidences at VA facilities in West Virginia, Arkansas, and more recently, at a community living center in Montana have shown VA needs to do a better job of monitoring care at the local level. We will hear from the Inspector General that VA also needs to do a better job appropriately resolving IG recommendations.

I look forward to a discussion with the VA about how its High Reliability Organization initiative encourage team-based error prevention, implements site-specific safety planning, and empowers employees to report harm and wrongdoing. I am encouraged by this initiative and its commitment to zero harm, but I would like to hear more about how it has progressed since its launch in 2019 and if it is actually working on the ground.

We will also discuss how VA collects data related to quality, and part of that discussion needs to include holding community care providers to the same quality standards as we do VA. We must ensure veterans have the information they need to make an informed

decision about where to receive care. I hope to hear from the VA and our outside experts about existing tools veterans have to compare quality between VA facilities and community providers and any gaps in that information. If we determine the information currently provided is insufficient, we will need to work together to address that shortcoming.

With that—hang on here. When Senator Moran comes, he will be able to do his opening statement. In the meantime, we are going to start with panel one. Okay?

And I want to welcome Dr. Carolyn Clancy, who is Assistant Under Secretary for Health for Discovery, Education and Affiliate Network. She is accompanied by Dr. Erica M. Scavella, Assistant Under Secretary for Health for Clinical Services, Chief Medical Officer, and Kristine Groves, which did not make it. Oh, she is online. Okay, cool. Kristine Groves, Executive Director, Office of Quality Management.

Thank you all three for being here. Dr. Clancy, you have the floor.

PANEL I

STATEMENT OF CAROLYN M. CLANCY ACCOMPANIED BY ERICA M. SCAVELLA AND KRISTINE GROVES

Dr. CLANCY. Good afternoon, Chairman Tester, Ranking Member Moran, members of the Committee. I appreciate the opportunity to discuss VHA's efforts in ensuring veterans receive high quality health care. As the Chair noted, I am accompanied by Dr. Erica Scavella and Ms. Kristine Groves.

Our employees come to work every day to serve veterans, their families and caregivers, and all of us at VHA know the importance of patient safety and quality exhibited by the incredible work our employees have done during the pandemic. At the beginning of the pandemic, when personal protective equipment, or PPE, was running low for healthcare professionals, we created reusable, 3-D printed PPE and dispatched it directly to the front lines. When it was not safe for veterans to come into our facilities, we cared for them remotely by rapidly ramping up telehealth to unparalleled levels. And additionally, when we were informed that local community hospitals became overwhelmed, VHA provided beds and cared for hundreds of nonveterans as part of our fourth mission, and when vaccines became available, VHA vaccinated millions of Americans.

As we slowly, but surely, emerge from COVID–19, VA has the opportunity to help redefine the future of health care delivery by focusing on our infrastructure and technology as well as the quality and safety and type of care we provide and where we provide it. And as we discuss the future of VA health care delivery, we are thinking about how can we best deliver high quality care in ways that work for our veterans, whether that means providing care using telehealth, inpatient care at a hospital, at one of our hospitals or one of our local community based outpatient clinics, or a referral to community partners. Our overarching goal is to assure that these options are integrated for a seamless experience, and

success means that veterans have good information to make the best decisions for themselves.

I am so proud to be part of an organization that has the capability and willingness to help not just our veterans but our fellow Americans who have been impacted by this virus. During these times, the Nation needs to know the VHA is not just leading in health care but also in compassion and readiness to help the community.

We are very grateful and appreciative for independent investigations and oversight to improve safety and look for lessons and opportunities to apply lessons learned across the enterprise. Transparency and accountability are key principles, and they guide our efforts in this regard. This system of transparency and cross-disciplinary coordination also supports VHA on its journey to becoming a high reliability and learning organization that works to ensure the delivery of the highest quality and level of service to veterans. In other words, our ultimate aspiration is you fix the problem where it occurs but share and spread everywhere across our system.

Consistently safe, high quality care for the veterans we serve demands a culture grounded in transparency and depends on employee feedback regarding their concerns, risks, potential patient harms, and what we sometimes call near misses. That cultural transformation is a work in progress. We have made great strides. We are not done yet.

Patient safety characterizes our culture and permeates the organization. Leadership meetings begin with safety stories so lessons learned can be shared widely and connect the work of every employee to our important mission. In other words, we leverage our integrated system to help build that high reliability through strong practice sharing and organizational learning. We have made substantial strides in ensuring our veterans, their families and caregivers receive quality care as evidenced by independent assessments comparing the care we provide with the private sector and peer-reviewed research independent of us, comparing outcomes for veterans receiving care within VA with those seen in the community.

Veterans care is our mission and our purpose. We are committed to ensuring that it is the most accessible, convenient, and high quality care possible through the VHA system as well as through the community providers to whom we refer veterans for care and that we do that in a transparent, veteran-centric way. Your continued support is essential to providing this care for veterans and their families.

This concludes my testimony, and my colleagues and I are prepared to answer any questions that you have.

[The prepared statement of Dr. Clancy appears on page 41 of the Appendix.]

Chairman TESTER. Thank you for your testimony. Appreciate it. Once again, appreciate you for being here.

My first question is for you, Dr. Clancy. Inspector General Missal and his team produced reports outlining problems at VA facilities. Those reports provide recommendations to correct problems and

prevent similar mistakes from happening again. Dr. Clancy, how does the VA ensure that IG recommendations are followed in a timely manner?

Dr. CLANCY. That is a terrific question. Thank you. I will start, and then I will ask Dr. Scavella to chime in.

Every recommendation has a specific recommendation for the facility in question or for the specific issue that they have been investigating, and an action plan is proposed in return. So we see these draft reports, and we actually negotiate with the Inspector General in terms of what is the right timing and what do we need to do to show them that we have actually accomplished this recommendation. In other words, this is way more than a paper exercise.

And we follow that through, and we provide them periodic updates in terms of how we are doing. And there are times when we are saying, "We think that we have accomplished this. Can we close this recommendation?" And at that point, they are pretty tough.

And anything you want to add, Dr. Scavella?

Dr. SCAVELLA. Sure. Thank you, Dr. Clancy. Additionally, we do share the lessons learned in each of these investigations in multiple formats, including daily morning meetings where we are convened across the country, with leadership across the country, so that we can not only discuss what has happened at a facility but what corrective actions we have taken to prevent that situation from happening at that facility and also at other facilities. So we are a learning organization, and we want to make sure we empower our leaders to learn from other people's challenges.

Chairman TESTER. So the Inspector General puts forth recommendations, and let us say you do not agree with the recommendations. Do you still implement solutions?

Dr. CLANCY. We have a conversation, and sometimes we will respond in a way that says, "We concur in principle, but we think it might be better to do it this way," but that is where we have a negotiation. And by and large, I would say those are very productive conversations.

Chairman TESTER. Does it ever come down the pipe where the IG makes a recommendation and you just say, "The hell with it. We are not going to do it"?

Dr. CLANCY. I am told that this happened once before I started at VHA, about eight and a half years ago. It is not often, no.

Chairman TESTER. Okay. Not under your watch, right?

Okay. Many IG recommendations could be applied across the VA to ensure that similar problems do not occur at other facilities. Does the VA review IG reports and look for ways to prevent potential problems across the system?

Dr. CLANCY. We do indeed. As Dr. Scavella pointed out, we have long had these daily meetings about what is happening and what are we hearing from the field, but this was more of a headquarters activity. Right?

During the pandemic, this became the glue that held the system together, and it has had a fundamental impact on our High Reliability journey as well as our ability to provide care to veterans during the pandemic because it became a matter of sharing equip-

ment and people as we needed it. But that also became the place to say, we have had a problem here, and people ask questions. That is a new thing over the past couple of years.

Chairman TESTER. Do you have any examples of problems that occurred in one VA that you have applied solutions to other VA facilities?

Dr. CLANCY. Certainly, there are a number of issues related to sterile processing, which is a fairly complicated and I think underappreciated part of the entire enterprise, in terms of keeping equipment clean and having a regular process and quality management process for it. That would be one example.

Reporting of problem provider to the National Practitioner Data Bank or State licensing boards and so forth is another issue that comes up a lot.

Dr. Scavella?

Dr. SCAVELLA. So, Dr. Clancy, to add to that, I think just any of the cases where we have seen things that we think other organizations can learn from we will share. I think you stole the two examples that came to mind as the question was being asked.

Chairman TESTER. Okay. Good. The VA MISSION Act required VA to establish quality standards for VA-furnished care and also extended these same standards to community providers. You had talked about that vets need good information, and that is true. If they do not have good information, they are going to make bad decisions as to where to get care. At present, is VA reporting its quality measures as required under the law of the MISSION Act?

Dr. SCAVELLA. Sure, I will take this question. So, yes, we are. We do have a website that reports the MISSION Act requirements for quality. It is AccessToCare.VA.gov. There is a specific page that includes the quality metrics. It allows veterans to compare the data for timeliness and quality at their facility against what is present in the region and in the country.

Chairman TESTER. Okay. Thank you.

Senator Tuberville.

Dr. CLANCY. I would just add one thing, sir.

Chairman TESTER. Yes, go ahead.

Dr. CLANCY. We also report on CMS's compares sites. There are sites for hospitals, for nursing homes, and so forth. So literally, on one page, you can see how VA compares with hospitals in the region and so forth.

Chairman TESTER. Okay. Senator Tuberville.

SENATOR TOMMY TUBERVILLE

Senator TUBERVILLE. Thank you very much, Mr. Chairman.

Chairman TESTER. You are welcome.

Senator TUBERVILLE. Thank you for being here today to talk about quality of care for VA. It is important to all of us.

Dr. Scavella, what metrics does the VA use to evaluate the effectiveness of the VA's substance use disorder treatment program? Can you tell me that?

Dr. SCAVELLA. Yes, so thank you for that question, Senator Tuberville. We have multiple metrics that include how well patients are actually doing as a result of having received our care, and we look at those metrics to determine how well they are doing

in a plethora of things, including how they are doing related to other things that affect the decisions to have a substance use disorder, such as mental health disorders. So we do look at those things across the system, and we can compare our outcomes to the outcomes in the community.

And we do see a benefit to our active engagement. We have programs in place, such as Whole Health, that allows our veterans to use other modalities to both reduce pain and also to address any types of stressors they may have in their lives that may be contributing to the decisions to use substance use disorder, and through the Whole Health program we have seen reductions in the use of substance use disorder.

Senator TUBERVILLE. We are having good results?

Dr. SCAVELLA. We have good results.

Senator TUBERVILLE. Good, good.

Dr. CLANCY. And if I just might add, Senator, briefly, the entire system got a very well-known award last year for the work that we had done way ahead of the private sector and healthcare system in terms of getting—I keep calling it NARCAN—you know, the reversal to veterans' patients and their families and have saved quite a phenomenal number of lives, and we had the data to show it, which is really why we got the award.

Senator TUBERVILLE. So how do we measure, either one of you, success or failure for substance, for this substance disorder? How do we measure that?

Dr. SCAVELLA. So I would have to get back to you with the specific metrics. I just know that there have been several publications indicating that veterans are doing better and that they are using—they are not enrolled or receiving such prescriptions or proving to be misusing such prescription medications, but I would have to get back to you with that specific——

[VA response to Senator Tuberville appears on page 107 of the Appendix.]

Senator TUBERVILLE. Do you know—go ahead.

Dr. CLANCY. Well, I was going to say, ultimately, what you would like to know is how many veterans were able to treat this disorder and stay off substance use. Now that will probably never be 100 percent, but what we can see are promising signs early on. So that is what tends to get reported as quality metrics, but we could also be looking into longitudinal follow-up because I think that is what everyone wants to know.

Senator TUBERVILLE. If you get to 100 percent, we can find a way to get you the Nobel Peace Prize.

Dr. CLANCY. There you go. Well, it is really tough, yes.

Senator TUBERVILLE. How does the VA improve upon its substance—how do we improve it? I mean, do we have any ideas now that since we have been in this for a while? How do we improve it?

Dr. SCAVELLA. I think we continue to do evidence-based research to see what is working, what is helping to reduce that. I think a lot of us were surprised by some of the gains that the Whole Health program did provide as far as this particular area is dis-

cussed. So I think we need to continue to look at the research and determine what other modalities may be helpful.

It makes sense that if someone is having a stressful set of circumstances, as well as chronic pain, that managing those two through exercise, counseling, other types of therapy, yoga, things like that, that those would actually improve one's pain as well as one's stress levels. So there are probably other things that we have not already incorporated into this program, but we do see improvements in the numbers of patients who are reporting lower amounts of pain, who are involved in this program.

Senator TUBERVILLE. In my former life as a coach, exercise was a huge factor. We had problems, you know, in this same area, and I think it is a good alternative.

Dr. Clancy?

Dr. CLANCY. I was just going to say the power of a large system as well is we have seen remarkable reductions in the prescription of opioids across our system in the past six or seven years, which is nice to see and safer, and much lower doses than previously. When docs are very, very busy, it is easier to just keep writing the prescriptions rather than have those difficult conversations. But we have a couple of very active what we call communities of practice who get on the phone or video every couple of weeks to share tips, and we take advantage of telehealth for the purpose of education so that people feel empowered to be able to do that and have that difficult conversation, that this is really not helping.

Senator TUBERVILLE. Yes. Well, thank you for work in this area. It is obviously one of the main things that we have problems with in any hospital, in anything, any business. Substance abuse. But, thank you very much.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Manchin.

SENATOR JOE MANCHIN

Senator MANCHIN. Chairman Tester, thank you for holding this hearing today on quality care and patient safety for all of our veterans across the country. I worked hard as a member of the Committee to ensure the horrific murders that occurred in my home State of West Virginia and specific problems that led to these murders never happen anywhere else in the country. We must make meaningful changes at the VA so that veterans in West Virginia and across the country can begin to rebuild their trust in the VA's care. This is the first time since the Clarksburg VA murders that we are having a comprehensive look at the accountability and culture of the VA, and I thank you; I truly do.

Today, we will get to talk to the Veterans Health Administration and the VA Office of Inspector General. We look forward to that.

I am also pleased that the Joint Commission is here today. As you all know, the Joint Commission, which accredits VA facilities across the country, gave Clarksburg VA a consistently passing score before and during the murders of more than seven veterans at the facility. Before and after. In fact, the Joint Commission did an onsite review at the Clarksburg VAMC on May of 2017, and Clarksburg passed the review. Less than eight weeks later, the vicious trail of veteran murders at the Clarksburg facility began.

Oversight is our duty on the Committee. We must hold those responsible for incidents that have placed our veterans at risk accountable, and I look forward to hearing from our panelists on how we can prevent these mistakes from occurring absolutely ever again.

Dr. Clancy, later in the hearing, we are going to hear from the VA Inspector General, Mike Missal, with which I had great conversations throughout this whole process, and I appreciate that.

But in the written testimony, Inspector Missal states that when it comes to incidents like Clarksburg the 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 VA's goal of zero patient harm is improbable, if not impossible." That is clearly the case of Clarksburg VA, and yet, individuals in positions of leadership were able to simply resign, able to simply resign, and keep their valuable VA benefits, like retirement benefits.

I will never forget the setting when all this was unveiled and we heard. We learned more in the one week that Mr. Missal was there than we had from the administration who had been there forever and the head of nursing. And I looked at the head of nursing, and I said, "Sir, with all due respect, you are either lying to me or you are totally incompetent, one of the two, but you have no right of sitting here." That was in that hearing. It was that bad.

So how do we hold the VA leaders responsible with incidents like the murders at Clarksburg? How do those people stay in the system? How are they able to retire with the benefits with such disrespect and such neglect and malfeasance of doing their job?

Dr. CLANCY. Senator, you have just said very well—and I certainly do not need to tell you—what a horrific, horrific tragedy this was. And in my view, the only way we can possibly, possibly honor the experiences of those veterans and their families—I cannot even imagine what it felt like to be told your loved one would be exhumed.

Senator MANCHIN. What are we doing to cure that so that people that would make these grave——

Dr. CLANCY. Yes.

Senator MANCHIN [continuing]. Horribly grave mistakes and intentionally or unintentionally would be able to be benefited by doing such an incompetent job?

Dr. CLANCY. We have a whole new leadership team in there, as you know, as well as a number of new nursing leaders. We have made some very concrete, specific changes in how things are done so a nursing assistant would not be able to get in and get insulin or other kinds of drugs to do the kind of horrible things that——

Senator MANCHIN. Well, I am saying legislation that I think we are talking——

Dr. CLANCY. Yes.

Senator MANCHIN [continuing]. And Mr. Missal and I talked about that allows us to subpoena those people and if we find them in error and they are responsible they would not get the Federal pension. They are losing that for giving such horrible treatment to our veterans. Is that accurate?

Dr. CLANCY. Yes.

Senator MANCHIN. We passed that, so hopefully, that should help tremendously.

Also, when a quality of care incident like what happened at either Clarksburg or in Arkansas occurs, how do you all apply the lessons learned after evaluating so they do not continue to repeat themselves? Is that an alert? Do you have a nationwide alert to all the VA hospitals and CBOCs and everything else?

Dr. CLANCY. The lessons learned from Clarksburg and from Fayetteville were discussed widely and continue to be, and when Dr. Scavella mentioned our daily calls and when we have, you know, big leadership meetings, we start with a patient safety story. And we are talking now about tough issues that are not so easy to say in front of colleagues and things we did not discuss, I would say, several years ago.

We had a problem. We did this wrong. You all have got to pay attention because it should not happen at your place, and we screwed up.

Senator MANCHIN. I am just saying it is just inconceivable that absolute murders happened in a hospital in VA, intentionally.

Dr. CLANCY. Yes.

Senator MANCHIN. Not by accident. Intentional. More than seven, but we knew seven we confirmed.

When I was Governor, we had mine disasters. It got to the point I had to close every mine down just for safety reasons until—not let any miner go back in that mine.

Something that atrocious happened. You would think that it would be raised to a level where you just had absolutely automatic, every VA, every review process, how your nursing supervisors—the control of all of your substance and all of your medical equipment and all of your drugs, if you will. That should have been reviewed immediately through every VA. I mean, shut it down and tighten it up until it is right. That is the only thing I would say.

I know my time has run out, but I will have another round, hopefully. I thank you all for being here, and I am glad we are finally doing this. The country needs to know that we are not going to allow this to happen to any of veterans anywhere in this country.

Dr. CLANCY. And, Senator, if I might, I want to thank you and the Inspector General because it is—these events are, thankfully, of this magnitude of horror, rare.

Senator MANCHIN. Yes.

Dr. CLANCY. But it is even rarer to hold the right people accountable, and I think it is a tribute to the Inspector General, the attorneys, and yourself, so thank you for that.

Senator MANCHIN. Thank you.

Thank you, Mr. Chairman.

Chairman TESTER. Yes. Senator Manchin, just so you know and for IG Missal, too, the subpoena, IG subpoena power bill passed the Senate, and the House is due to take it up next week.

Senator MANCHIN. That is tremendous, what we have done to bring these people back and hold them accountable.

Chairman TESTER. It will be a game-changer.

Senator MANCHIN. Yes. And they cannot collect the pension if they have done just irreparable harm to our VA, to our veterans.

Chairman TESTER. Senator Brown.

SENATOR SHERROD BROWN

Senator BROWN. Thank you, Mr. Chairman, Senator Tester.

Thank you both for joining us. Dr. Clancy, good to see you, I guess the second week in a row.

We talked last week about workforce shortages and healthcare provider burnout at VA, which the broader medical profession sees as well, as you know so well. I would like to talk about holistic care veterans receive at VA and what I heard about veterans' experiences in the community in light of the potential closing at Chillicothe VA Medical Center south of Columbus, an hour south of Columbus. I have been there three times in the last probably 40 days.

The recent recommendation to close the hospital will likely mean more veterans in central and southeast Ohio relying on community care. Some of them can go to Huntington in Senator Manchin's State. Most of them, an overwhelming number, want to go in Ohio. That is where their relationships are, stay at the VA in Chillicothe.

The VA's own publicity available—I am sorry. In the VA's own publically available hospital compare data tool the Chillicothe VAMC ranks a majority of the closest hospitals and community hospitals in care. My concern is that we move forward with closures in some part of the country; we would be sending veterans into healthcare systems that are frankly inferior, that do not provide the same comprehensive quality care our veterans deserve. How are you ensuring that that community care, that the providers, the community care providers are adhering to the same high VA standards that you set?

Dr. CLANCY. So we are putting in place a program—and we cannot apply this everywhere—for States that are sparsely populated and that there are few community providers. This is a tougher sell. I do not think this would apply to the great State of Ohio or many of parts of it.

Senator BROWN. That part it might, but go ahead.

Dr. CLANCY. Where we have preferred providers so that they are meeting—they are doing better than the 50th percentile in a number of different quality metrics. This is in addition to the routine things that the providers we contract with have to do in terms of credentialing and privileging and making sure that their doctors' licenses are up-to-date and all of that kind of aspect. That is *de minimis*, right? But this actually—this preferred provider program actually looks more at ongoing quality measurements, which I think is a good thing.

I am quite sure, I do have to say, that a number of people in our system I have met who cared deeply and passionately about quality all have roots in Chillicothe. This has not escaped my attention, and it is not our intention to leave any market.

And it is also important to note that a lot of care that was provided in hospitals when I was training is all outpatient now. You know, having your gall bladder out used to be this very big deal. You were in the hospital for a couple of weeks, and you know, you were out of work at least six weeks. And now you do not even stay overnight anywhere, right? It is a day procedure. And we are going to be seeing more and more of that.

So I do not see that veterans in that area will be deprived, but that is all going to be part of the commission process in terms of how do we make sure that for every part of this country veterans have the opportunity to get the right care.

Senator BROWN. Well, they are certainly locally unconvinced of that, as you know. No surprise.

Dr. CLANCY. I——

Senator BROWN. And I also would note that Chillicothe has a reputation bigger than their size in their region in mental health treatment, particularly important, perhaps no more in that part of the State than Montana or West Virginia or Hawaii or Alabama, but known to be very important with all the problems around.

Let me follow up on Senator Tester's question related to VHA and OIG negotiations. If VHA disagrees with an OIG recommendation, what are the steps of negotiating? What do those steps look like, and what happens when you disagree?

Dr. CLANCY. In general, what the Inspector General's team will come over and do is make a presentation of what they found and here are the draft recommendations, and then we discuss them among ourselves, and we will get back to them. I would say we probably agree with the majority, and more of our negotiations are about how rapidly we can do it and how robust does our response need to be to be persuasive to them. And you can see they set a pretty high bar, that we have really changed whatever the issue is, you know, that we have made a meaningful change across the system or at a particular facility.

I mentioned that we sometimes say "Concur on principle. We agree with you. This should not have happened, but we think there might be an alternative to fix this problem." Again, I am relying on memory, serving as Acting Under Secretary, but I would guess that is 10 to 15 percent of the time. And that is where we have a good conversation.

Senator BROWN. Good. Thank you.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Hirono.

SENATOR MAZIE HIRONO

Senator HIRONO. Thank you, Mr. Chairman. As I sit here, focusing on VA care, it just occurs to me that it is kind of a perennial concern, the quality of care, the veterans that need to be outreached to, and all of that.

So I am wondering, Dr. Clancy. You have worked at VA for some eight years or so in various capacities. And when you took on this position, current position, what was your first goal that you wanted to accomplish in this position, and how are you doing in achieving that goal?

Dr. CLANCY. My biggest goal was to make sure that the future health professionals that we train we have a big impact on the future workforce in this country across like 60 disciplines and the research we support, which is quite considerable thanks to the generosity of the Congress, is very tightly connected to the day-to-day care for veterans so that when we are supporting research on how to improve care for veterans or testing new treatments that that is translated into practice as rapidly as possible. We are not just

a research organization sitting out here. We are actually embedded in a very important system, the Nation's largest integrated system. So that was my idea.

We also have a group that focuses a lot on healthcare innovations, looking at very different ways of providing care, and that too has to be grounded in the day-to-day operations.

Senator HIRONO. So are you moving toward those goals? Are things happening that let you say, aha, we are getting there?

Dr. CLANCY. Yes, I would say that we are getting there.

Senator HIRONO. I think the research aspects are really important because you have really a way that your research can be applied to the services that you provide. But you talk about staffing. That is a perennial issue, the fact that you have a shortage of staffing. So we have even provided you more flexibility in how the VA goes about hiring people, and yet, here we are. You know, it is a perennial issue.

And you talk about one of the goals was for you to have your staff, and I take it there is always turnover and all that. So how are you attaining that goal in terms of the training that you do? And by the way, there is a shortage of nurses in the VA system, isn't there?

Dr. CLANCY. Yes, I would say just about every health system in this country right now either has a shortage of nurses or I think it is coming next week, and they are probably right. A lot of this is the emotional impact and burnout from the pandemic.

Senator HIRONO. Yes.

Dr. CLANCY. Some of it is—and I think this may be true in our own system—not being thoughtful enough about how to give nurses more flexibility in their work schedules and so forth. These are solvable problems, but we are clearly going to need more nurses because——

Senator HIRONO. Yes.

Dr. CLANCY [continuing]. Many of them are approaching retirement age.

Senator HIRONO. And when you have staffing shortages, it is pretty hard to be flexible in terms of their work hours, et cetera.

Do you recruit nurses from the Philippines, by the way?

Dr. CLANCY. I do not know. I know this country does. I would have to take that and get back to you, Senator, and I would be happy to do that.

[For VA response to Senator Hirono, see Question 2b on page 97 of the Appendix.]

Senator HIRONO. I think, my understanding is, that there are a lot of Filipino nurses that I would think would want to come to this country, but there are probably visa issues and all kinds of things that we could possibly help you with.

The other thing that is a perennial issue is your electronic health record modernization. I remember when Secretary Gates, Secretary of Defense, and Secretary Shinseki, VA Secretary said we are going to have this seamless electronic health record system that combines and tracks the active duty person and then into the VA, and after a billion dollars are spent, pretty much zip.

So now you have the modernization that you are doing, and we just had a recent incident where I think the system crashed and it impacted hospitals. One hospital even stopped admitting patients, and that certainly has an impact.

So are you taking steps to move us forward in having this kind of electronic system so that the kind of care that you provide is based on that person's health records, accurate health records?

Dr. CLANCY. Absolutely, we are. One thing I learned when I was working very closely with Secretary McDonough when he first came in as Acting Deputy Secretary, is we talked to a lot of people in the private sector, and to a person, they all said the initial deployment of an electronic record is painful and chaotic and everyone hates it and wonders why are we doing this. We got that part.

But we are being quite vigilant. We have restructured how this works, and it reports right up to the Deputy Secretary now, Donald Remy. And by and large, we have not had recent system crashes. We have had times when the system slows down, but there are already built-in processes for people to be able to handle that so that patient care is not disrupted. So I am quite optimistic at the moment that once we get through the painful part this is going to make care much better for veterans, and frankly, I think it is going to make it easier for us to detect the impact of current and future exposures to toxic substances or other military experiences.

Senator HIRONO. We just have to get it right.

Just one comment, Mr. Chairman. Relating to the prescription refills, the delays, and prescription drugs through the mail, so I hope that this is a—when I looked at your website, it says, prescriptions usually arrive within three to five days of being ordered and maybe 60 hours from filling to delivery, but there has been recent reporting that there are a lot of delays. It could take up to four weeks, and of course, that is going to impact the patients, patient care. So I hope that you are taking steps to not only address these delays but figure out a way to alleviate these delays for our veterans.

Dr. CLANCY. Well, we do not actually control the postal service——

Senator HIRONO. Oh, I know that.

Dr. CLANCY [continuing]. But our pharmacy team is on this at all times and regularly reviewing how rapidly are prescriptions being delivered to veterans. What that has meant is that we have moved up when we provide refills and so forth, and in some cases, we will overnight it if it is that urgent. But by and large, our track record has been great, but again, we are not just counting on that we got it straight for a day. This is a focus of continuous vigilance.

Senator HIRONO. Yes. Thank you.

Thank you, Mr. Chairman.

Chairman TESTER. Senator Manchin, if you have additional questions for Dr. Clancy, I would defer to you.

Senator MANCHIN. Thank you, Mr. Chairman.

Dr. Clancy, in recent years, our veterans have experienced massive breaches of trust in all the employees, especially in Clarksburg, and the employee who murdered multiple veterans at Clarksburg never went through a proper hiring process. What I am

speaking to you about is the hiring process, the need that we have, and the shortages that we are having.

So how has the VA updated its hiring process to reflect basically lessons learned, vetting? They only had to make one phone call, and they could have caught this woman before she ever got in the door. So how are you doing that, and how is your retention?

Dr. CLANCY. We have been going through a pretty extensive human resources modernization over the past several years, and I am happy to say that we are starting to see progress. It was not easy in the beginning, to put it mildly, because hiring is a problem, but a lot of our leaders are both reinforcing the importance of this vetting. As you say, a phone call almost certainly would have prevented this, which is unbearably painful to think about.

But also, coming up with ways to speed the whole process up, the pandemic allowed us to do—to postpone some aspects of the usual hiring process, which can take a number of weeks, to bring on rapidly because we needed that. We now have been expressing in a hearing here last week additional flexibilities that might be helpful and look forward to working with that committee on this.

Our retention, by and large, particularly for nursing is much better than the private sector, but we have seen it start to drop a bit, which is why we are very worried about the nursing workforce.

Senator MANCHIN. Let me go to the security of the cameras and holding people accountable and all that that we talked about. We have a piece of legislation we have all worked together on, the Chairman, myself, and others. Senate Bill 2041 is the VA Provider Accountability Act. I think you are aware of that Senate Bill 2041. And what it would do in the VA healthcare system by instituting requirements to keep VA and healthcare providers accountable, it is monitoring and cameras. It would give the Office of Inspector General the tools they need to make sure when they do their investigation they have all of the real-time information.

First of all, I know you all supported this, this legislation. Do you find it to be favorable, would be helpful?

Dr. CLANCY. I would have to check on that. I honestly——

Senator MANCHIN. Okay, Okay.

Dr. CLANCY. Yes.

Senator MANCHIN. Well, we would like to get your input on that if not.

Dr. CLANCY. Sure.

Senator MANCHIN. It is bipartisan. I think that we have a great deal of this Committee that is on that piece of legislation, and I wish you would look into that to give us the support that we need to make sure you do not believe it interrupts or interferes. That is not what our purpose is. Our purpose is to make sure that we have the proper information at the proper time.

Dr. CLANCY. We will follow up with that.

Senator MANCHIN. If you would do that, I would appreciate it.

Those are all the questions I have, Mr. Chairman. I appreciate it.

Chairman TESTER. Well, thank you.

We will get our second panel. And I want to thank the three participants in this panel for being here, virtually and in person.

And we look forward to seeing you next week, Dr. Clancy, as long as it has been two weeks, might as well make it three in a row. No, I do not think you are on the agenda for next week, but who knows. Maybe you are.

Dr. CLANCY. Thank you.

Chairman TESTER. And we will get the second panel settled in here, and I will do a little introduction of them. We are going to hear from officials from the VA Office of Inspector General as well as from outside experts on quality care on this panel.

First, we have Inspector General Michael J. Missal, who is somebody that we have gotten to know pretty well in this Committee, and not to let somebody else steal you away from the VA, but somebody who I think is incredibly competent and professional at the job that he does. And we appreciate you, Mike, and we appreciate you being here today.

He is accompanied by Dr. Julie Kroviak, who is Deputy Assistant Inspector General at the IG's Office of Healthcare Inspections.

We also have Dr. Jonathan Perlin, who is President and Chief Executive Officer at The Joint Commission and former Under Secretary for Health at the VA.

And joining us virtually, we have Dr. Gregg Meyer, who is President of the Community Division and Executive Vice President of Value Based Care at Mass General-Brigham, and Professor of Medicine at Massachusetts General Hospital and Harvard Medical School.

We appreciate all of you for being here, both in person and in Dr. Meyer's case, virtually. We will hear from Inspector General Missal now.

PANEL II

STATEMENT OF THE HONORABLE MICHAEL J. MISSAL ACCOMPANIED BY JULIE KROVIAK

Mr. MISSAL. Thank you, Chairman Tester and committee members. I appreciate the opportunity to discuss the OIG's oversight of the quality of care provided by VHA. Testifying with me is Dr. Julie Kroviak, Deputy Assistant Inspector General for Healthcare and a former VHA physician.

We know VHA staff strive to provide high quality, compassionate care to over six million veterans each year. However, there are real challenges in delivering care to veterans with generally complex medical and psychological conditions often related to their military service. VHA's integrated approach to caring for veterans is unique in its attempt to meet their clinical needs while providing an array of support services. The OIG is grateful to VHA staff for delivering such comprehensive care, especially during the pandemic.

VHA's critical role in supporting our Nation's health care delivery underscores the need for the OIG's strong and independent oversight. That oversight routinely identifies incidents and conditions in which quality of care and patient safety have been compromised. The events leading to these failings are often nuanced and multifactorial. However, a common theme is poor, inconsistent, or ineffective leadership which cultivates a complacent and dis-

engaged culture in which VHA's goal of zero patient harm is improbable.

Consider, for example, incidents in the Fayetteville, Arkansas VA facility, where oversight failures allowed a former pathologist to misdiagnose over 3,000 veteran specimens over multiple years while he worked impaired. In another VA medical facility in Clarksburg, West Virginia, a former nursing assistant pled guilty to killing seven veterans by administering insulin. Although by no means typical, these tragic examples demonstrate how disengaged leaders and the lack of a culture of accountability can put patients at risk of serious harm. Our reports consistently chronicle less devastating, but often widespread or persistent, problems affecting patient care that only effective leadership can address.

Healthcare facilities committed to patient safety have strong leaders who engage staff and empower reporting, sustain a supportive culture, and promote continuous improvements. They have a structured and proactive quality and safety management team that investigates concerns. They capture real-time incident data and task multidisciplinary teams to conduct root cause analyses. Reported concerns are reviewed thoroughly and promptly resolved.

While VHA has taken actions to address recruitment and staff burnout, staffing challenges persist. Even before the pandemic, the OIG emphasized the need for VHA to develop effective staffing models to inform hiring and community care decisions. Continued staff fatigue and shortages, as well as referral backlogs, increase the demand for community care. Yet, the coordination of care between VHA and community providers remains a challenge. Persistent administrative and communication problems undermine safe, seamless, and quality care for veterans.

No initiative better reflects the many challenges VA faces than deploying the new electronic health record system. Our three recent reports on the initial deployment in Spokane detail significant concerns. For example, data migration deficiencies resulted in patients having inaccurate or incomplete medication lists in their records and made simple activities, such as refilling a prescription, more challenging. Leaders must be responsive to clinical staff who rely on the system, and patient safety cannot be compromised to satisfy timelines that fail to account for remediating identified problems.

This Committee and VA are committed to improving the quality of veterans' health care. The cultural transformation being pursued within VHA must be guided by accountable and attentive leaders that prioritize the safety of each veteran they encouraged. The sense of urgency to effect change is understandable and justified, but the reality is it will take some time. The OIG will continue to focus on both incident specific and system-level improvements and make meaningful recommendations for corrective action that VA should promptly carry out. Veterans and their families deserve nothing less.

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

[The prepared statement of Mr. Missal appears on page 46 of the Appendix.]

Chairman TESTER. Thank you, IG Missal, and there will be questions after we hear from our next two panelists. Dr. Jonathan Perlin, President and Chief Executive Office at The Joint Commission—and just so you know, The Joint Commission accredits both VA and private sector facilities.

The floor is yours, Dr. Perlin.

STATEMENT OF JONATHAN B. PERLIN

Dr. PERLIN. Thank you, sir. Good afternoon, Chairman Tester, Ranking Member Moran, and distinguished members of the Committee. I was privileged to work with some of you during my tenure as Under Secretary, and I cannot sit here now with you in this room without hearing the echoes of the voices of Senators Akaka, Isakson, and Rockefeller. My gratitude to them and to you as champions for VA's mission of service to veterans.

I would like to address two themes in my immediate comments. First, I will discuss The Joint Commission's role in advancing quality and safety, and second, I will share my perspective about quality and safety in the Veterans Health Administration.

The Joint Commission conducts unannounced surveys of hospitals on a three-year cycle to assess compliance with standards relating to the safe delivery of health care, standards derived from evidence for achieving the better patient outcomes, as well as from a number of regulatory authorities. Demonstrating compliance with standards leads to accreditation.

A survey lasts three or more days depending on hospital size, and survey teams generally include a physician, one or more nurses, a hospital engineer, and other experts. Hospitals are surveyed for documentary evidence of compliance with critical processes, like infection prevention, medication management, and fire safety. So for example, the team assesses whether appropriate sterilization of surgical instruments has been recorded, whether records of medication use are adequate, and whether there is a safety plan for fire or other hazards.

But this is not just a paper exercise. A survey expert traces how sterilization is performed, how medications are managed, and even inspects for holes in firewalls.

While I have been on the receiving side of many surveys before, this past week, I observed a survey a mid-sized hospital. The most frequent request I heard surveyors make of staff was, show me. Show me how you would sterilize an instrument. Show me what you would do if there were a fire.

I made a number of observations. First, the caregivers and the other staff were caring and mission-driven. That said, there were more times than I expected that individuals did not know critical information.

This leads to an important point. The surveys are not only meant to demonstrate accountability but to be educational. The care teams know these things now.

If deficiencies are found, they are recorded as requirements for improvement. Some deficiencies are minor and can be resolved right away. More serious breaches are termed immediate threats to life and safety and require immediate remediation. Any deficiency requires a plan of correction, and hospital leadership is not only re-

sponsible for making corrections but for maintaining continuous compliance between surveys.

The routine triennial survey is like a general physical exam. It surveys all systems, and the sampling of a complex medical center may miss something.

On the other hand, The Joint Commission conducts "for cause" surveys for unreported Sentinel Events which are defined as safety events that can result in death or permanent harm. Like an examination for heart disease, these surveys go deep on a particular issue. Organizations are strongly encouraged, but not required, to report Sentinel Events to us. Health systems with a policy of reporting Sentinel Events is a best practice as our teams can assist in a thorough root cause analysis.

Now let me offer a perspective on quality and safety in VA. There are quite a number of documented areas where VA outperforms private sector and many others where care is on par.

That said, here are some suggested opportunities for further improvement. First, VHA should extend its SAIL analytics to continuously look at outcomes by nursing unit, by care provider, and by procedure to systemically identify both problem and best practices. This is especially important as more care goes to the community and internal procedure volumes decrease. In short, the more you do the better you do, a phenomenon known as the volume-outcomes relationship.

Second, VA has more insight into care quality internally than it can have externally. Deep clinical performance data are not available publicly, and private sector has not developed the performance measurement systems that VA has in place. While this makes it difficult to direct veterans to the very best clinician specifically, some data may predict higher performing hospitals. VA must be vigilant in information sharing to assure that care is both well-coordinated across VA and non-VA sites and attuned to veteran-specific issues.

Third, an issue that concerns me greatly is obtaining the best leadership at every level of the organization. Noncompetitive compensation for administrators divides the ranks into those who are highly competent and are at VA for mission and others who may be more junior or less skilled than colleagues in comparable roles in private sector. I recommend that VA establish a mentoring program that pairs it's both seasoned and successful administrators with less-seasoned colleagues, especially at hospitals that have had challenges.

That brings me to my final recommendation. If something is an issue on one unit, assume that it may be a risk throughout the hospital, and if something is an issue at one hospital, assume that it is a risk systemwide. The goal is not to disparage or to add work but, rather, to add value by addressing risk before becoming manifest as problems. This is essential throughout health care and especially so as a grateful nation cares for those who have borne the battle.

Thank you.

[The prepared statement of Dr. Perlin appears on page 54 of the Appendix.]

Chairman TESTER. Thank you, Dr. Perlin.

Next, virtually, we have Dr. Gregg Meyer, who, I guess he most easily said, is from the private sector.

So, Gregg, the floor is yours.

STATEMENT OF GREGG S. MEYER

Dr. MEYER. Good afternoon, Chairman Tester, Ranking Member Moran, and distinguished members of the Committee. Thank you for the opportunity to testify today about the quality of health care provided to our Nation's veterans.

My responses reflect my perspective as a physician and proud U.S. Air Force veteran who has dedicated my career to improving the quality and safety of health care. In my testimony, I will briefly address four questions.

The first is: How does the quality of health care provided to veterans in Department of Veterans Affairs facilities and civilian facilities compare? Although there have been times where the VA has clearly fallen short, for example, the access crisis leading to the passage of the Veterans Access, Choice, and Accountability Act and, more recently, the horrific tragedy at the Clarksburg VA, it is important to not lose sight of the VA's leadership in health care quality.

A 2003 report of the Institute of Medicine recommended that Federal direct care programs, including the Veterans Health Administration and the Military Health System, be used to evaluate policy options for improving quality and value. In fact, the VA had already been a quality improvement leader prior to that publication. For example, the VA was an early adopter of electronic health records and telehealth. Given that history and the debt we owe our Nation's veterans, it is safe to conclude that the VA has an obligation to lead in quality and safety.

A straightforward question is whether direct care in VA is good value for the veteran and taxpayer, but patient preferences, geography, availability of services, along with other factors, can bias comparisons and lead to erroneous conclusions. As a result, the findings of studies investigating this question are more directional than dispositive.

With that caveat in mind, a review of VA versus civilian care in all six domains of quality—safety, effectiveness, patient-centeredness or, in the case of the VA, veteran-centeredness, timeliness, efficiency, and equity—reveals a relatively consistent direction.

In terms of the safety and effectiveness quality domains, these comparisons suggest that direct care in the VA has comparable and, in many cases, superior quality and safety of ambulatory and inpatient care compared with civilian alternatives.

In terms of veteran-centered care, studies have generally found that VA facilities again matched or outperformed their civilian counterparts.

Studies of efficiency in the VA generally demonstrate good value in terms of expenditures. One widely cited study by the National Bureau of Economic Research found that veterans cared for in VA hospitals had lower mortality rates and 21 percent lower spending relative to civilian health care.

The two domains where the VA faces the greatest challenge in comparison with civilian care are equity and timeliness. Timeliness remains a persistent challenge, but the most recent assessments of wait times suggest improvement. But this remains an area where Congress should focus attention over time.

The second question is: What measures should be used to compare VA versus civilian care? Despite a legitimate desire for clarity and simplicity, there is no single measure or thermometer which can capture all the domains of quality which must be assessed to ensure veterans are receiving the high quality care they deserve from both VA and civilian facilities. As a result, Congress should continue to be provided with information covering all six domains of quality.

Availability of data in community care, especially rural areas with less data infrastructure, will remain a challenge. In assessing VA versus civilian care, Congress should be aware of this limitation and, to the extent possible, provide both the resources and requirements for quality reporting on metrics of interest as part of its expectations of civilian facilities caring for veterans.

It is also essential that Congress avoid the temptation of extrapolating isolated failures to be universally indicative of widespread problems. In this regard, the recent tragedy at the Clarksburg VA is neither a distraction nor is it indicative of a failure of care within the VA overall. The ongoing demand for transparency, focus on systems, and addressing issues across the system to ensure learning from failures are appropriate expectations we have of the VA, but perfection is not.

The third question is: How can the quality of care provided in VA facilities be improved? While comforting in terms of aggregate quality in general, the majority of studies comparing VA with civilian health care share another feature with civilian healthcare studies: There is often wide variation across facilities. This is a place where congressional oversight is essential.

A review of the tools used by the VA to improve care at its facilities demonstrates they are on par or better than the majority of civilian health systems. When compared with the measurement dashboards used within my own system, the two areas where additional metrics should be considered are those related to equity and workforce safety. Addressing the variation in quality within the VA also requires appropriate resourcing and support for these activities, another area for congressional attention.

The VA also has a rich history of leadership in health care quality research, and examinations of quality and cost of VA as compared with civilian care should be encouraged.

The fourth question is: What are the future best practices for collecting and analyzing quality in the VA? This is one area where the VA can once again take a lead in quality. The VA should leverage its capabilities in data science, the availability of clinical data from electronic health records, and its close relationship with veterans to move beyond the current set of metrics it and the majority of civilian health facilities employ to a new more meaningful generation of electronic clinical quality measures. In addition, the VA could become a leader in the collection of patient-reported outcome measures.

In conclusion, I would say the American public should be both reassured, yet unsatisfied, with the quality of care provided to its veterans. Reassured that the care provided by the VA direct care system is comparable to, and often times better than, that available through civilian facilities in most of the domains of quality. Yet unsatisfied that we can do better for our veterans by continuing to improve care, learning from failures, and working to ensure that veterans will receive high quality care regardless of where they access the system.

Finally, a fulsome assessment of the value of VA-based care compared with that available in the civilian sector for veterans should incorporate an assessment of the full range of benefits and learnings the VA systems affords. This includes not only the direct impact of that care on veterans and their families but also an appreciation of the potential leadership role of the VA in defining and delivering care that our veterans deserve, which can help the VA meet its ongoing responsibilities and serve as a national model.

That concludes my statement. I look forward to your questions.

[The prepared statement of Dr. Meyer appears on page 65 of the Appendix.]

Chairman TESTER. Thank you, Dr. Meyer and Dr. Perlin and IG Missal, for your testimony.

I am going to start with you, Mr. Missal. I would like to take the opportunity to thank you for your work that the IG does to improve VA care overall.

The questions I have are going to be similar to the ones I asked Dr. Clancy, only from your perspective. Is there anything the VA could improve upon when it comes to implementation of your IG report recommendations?

Mr. MISSAL. Yes, several things I can think of. One is when we include a recommendation, we are looking to address a certain issue. So when we close out a recommendation, that means that VA has convinced us that they have implemented the recommendation as proposed and it is sustainable.

One thing that I think they could do to really help with the recommendations is to ensure it is accomplishing the goal to which it was made so that they can continue to look at it down the road to see if it is continuing to meet its objective.

Secondly, I think they can do a much better job circulating and distributing our findings and recommendations to other facilities. VHA is an extremely decentralized system, and as a result, information does not flow down or up as well as it could. And we have found issues where information from our reports does not go to the other facilities as well as it should.

Chairman TESTER. Thank you. It is my belief that if you are finding certain problems at one VA facility they are bound to exist at others. I think Dr. Perlin expressed that same sentiment. Inspector General what is your sense of whether the VA takes your recommendations and does implement them systemwide?

Mr. MISSAL. Some of our recommendations are systemwide recommendations so that those would be implemented across the system, but again, I think we found that certainly looking at whether or not other facilities are aware of our reports, our findings, our

recommendations, we have found that it is not as well as it should be.

For example, in our CHIP report, our Comprehensive Healthcare Inspection Program, talks to leaders, one of the things they talk to them about is other oversight work that is being done. And what we found is just a general lack of awareness of the work we do, GAO, and other oversight bodies, and so I think they could do much better ensuring that findings and recommendations are distributed across the entire system.

Chairman TESTER. So let me ask it to you this way. Are you finding problems that you flag in one report occurring at other facilities in another report later down the line?

Mr. MISSAL. Yes, and let me give you a couple of examples. A few years back, there were massive inventory failures at the D.C. Medical Center. They did not have a working inventory system. It was so critical to patient safety that we put out an interim report, which was very unusual, to make sure that the whole system knew there could be inventory problems outside of D.C. as well. We then published the final report. So now we have two reports out there. We were very disappointed when about a year later we found similar inventory issues at yet another VA facility.

More recently, deficiencies in patient safety programs have been an issue, both in Clarksburg, Fayetteville, and elsewhere. Secretary McDonough was very concerned about the findings. He asked Dr. Kroviak, Assistant Inspector General, Dr. David Daigh, and me talk to VISN directors about the issues and how they need to focus in on patient safety. We spoke to all the VISN directors, and the message was: patient safety programs are critical to the quality of care. We found these deficiencies. Please check to ensure yours are up and running.

And we recently found that one facility did not have a patient safety program. The person in charge was essentially absent. We are finishing up the work in that area, and we will be publishing a report in the near term.

Chairman TESTER. Dr. Perlin, you noted challenges with leadership turnover and stability. If you could, as briefly as you could, but as comprehensive as you could, expand on this and provide recommendations for the VA.

Dr. PERLIN. Yes. Well, first, Mr. Chairman, let me thank you and Senator Boozman for his work on the RAISE and the WISE Acts. The compensation in VA is not on par with private sector, and that is a fundamental problem in attracting talent.

In four statements: One, I would benchmark competencies at leadership levels with private sector to assure that the best talent is in place. Second, I think VA has great learning organization but can further build its pipeline of leadership development. Third, develop mentorship programs that would be effective in helping to cultivate the next generation of exceptional leaders. And, I would encourage more exchange with private sector so that individuals can cultivate an understanding of some of the complexities of medical center operations such that they can have that sixth sense of experience that would identify problems be they at Clarksburg or Fayetteville or elsewhere. Thanks.

Chairman TESTER. Thank you.

Senator Moran.

SENATOR JERRY MORAN

Senator MORAN [presiding]. Chairman, thank you.

Dr. Meyer, let me start with you. In your written testimony, you advocate for an approach that balances quality measures. You go on to write that the large number of measures, quote, threatens to shift resources from improving quality in areas of greatest need to cover a plethora of measures that may have limited impact on veterans. That captures my attention because surely we ought to be focused on the things that have the most—the greatest level of consequence.

Can you explain how the VA should balance measures to make certain areas with the greatest needs are at the forefront? Which measures do you feel are more important to veterans than the civilian population?

Dr. MEYER. First of all, I would begin by saying this is a challenge in the civilian sector and, as you know, for the VA. And the reality is that we have gotten very good at collecting information, at least in some organizations, and particularly with the VA with its electronic systems.

With that said, that can lead to what I would call measurement distraction. And what I would advocate for is that the VA to focus on something important in each of those domains, in safety, effectiveness, efficiency, veteran-centeredness, equity, and timeliness, but not to have 15 measures of each, just to have two or three.

In addition, one of the things that we heard consistently over the course of the testimony this afternoon is the importance of focusing on leadership. And the VA has been a leader in collecting information on safety, culture, and engagement of its employees, and I think in both of those areas that is very important qualitative data that has not surfaced in many of the current benchmarks that people follow.

And so I would suggest focusing on fewer measures in each of those domains, making sure that we are paying attention to culture, which is a direct reflection of leadership, and finally ensuring that we are looking that we have an engaged and safe workforce.

Senator MORAN. Thank you. Thank you for your devotion to this topic in this hearing.

Dr. Perlin, good to see you again. I am interested in hearing about the "for cause" survey process as it pertains to VHA facilities. What are some examples of events that could trigger a "for cause" survey?

Dr. PERLIN. Thank you, Mr. Ranking Member. A "for cause" survey will occur if there are allegations of something that is quite egregious, if there are a cluster of complaints, or frankly, if there is, as I mentioned, a Sentinel Event, something that either resulted in death or could have had the potential of death or permanent harm. The Joint Commission will come in and go very deep to look at a particular system.

Since it has come up a number of times, let us tackle the issue of Clarksburg. The Joint Commission learned about Clarksburg in August 2019, well after the events occurred. Had The Joint Commission learned at an earlier point, we would have come in and

helped to conduct a root cause analysis to understand what some of the contributing factors were in terms of the lapses that led to the hiring of the individual.

But we consider it then a best practice not to wait for a media event, not to wait for complaints, but at the moment a failure is recognized or at the risk of a serious failure, to call The Joint Commission and have our experts go through the root cause analysis to understand what the failure modes were and, most importantly, to build robust defenses so those modes will not happen again. This is a matter of policy, by the way, in the Department of Defense. Thanks.

Senator MORAN. Has The Joint Commission ever performed a "for cause" survey to a VHA facility as a result of an OIG report or patient safety concern, and have any of those facilities or programs lost accreditation as a result of failing that survey?

Dr. PERLIN. Well, I am two months into the role and do not know the specific genesis of any of the "for cause" surveys. My understanding is that The Joint Commission, over the past decade, has conducted about 10 percent of its surveys as "for cause" surveys or special surveys. That would be about 29 surveys.

Senator MORAN. Maybe you could follow up if——

Dr. PERLIN. I would be happy to provide that information.

Senator MORAN. Thank you very much.

Dr. PERLIN. Thank you.

[The Joint Commission response to Senator Moran appears on page 77 of the Appendix.]

Senator MORAN. In 43 seconds, Mr. Missal, I have always admired your work, and I appreciate your presence here today. I think you and your office are hugely important to this Committee and, more importantly, hugely important to the veterans that the Department of Veterans Affairs serves.

While conducting a particular review—let me give a little background in the few seconds I have. Mr. Missal, your office recently published a report on purchases of smartphones and tablets for veterans used during COVID–19 pandemic. This report and that review found that the VHA, through the Office of Connected Care Officials, incurred approximately $2.3 million in wasted taxpayer funds for purchased iPhones and iPads that remained in storage with activated data plans instead of being sent directly to intended veterans.

While conducting this review, did your office look specifically into any quality of care issues that occurred within this specific program? For example, did veterans who resided in rural or highly rural areas of the country experience more quality of care issues due to lack of connectivity than their urban counterparts?

Mr. MISSAL. Well, first, Senator Moran, thank you so much for your words. The answer to the question is we did not look at quality of care in that project. What we were looking at was the cost of the smartphones and the iPads for veterans experiencing homelessness.

However, we have looked at connectivity issues in several other work projects. In one of them, we did find serious issues given that VA was doing more and more telehealth work in rural areas. And

in July 2020, as the pandemic was really starting and VA announced that they were going to be moving more and more toward telehealth, what we did was we looked at 16 highly rural CBOCs that were having connectivity issues to see whether or not there would be adequate community care resources available to them, and what we found in 12 of the 16 they did not have the kind of community care services that you would hope for in these highly rural areas.

Senator MORAN. Thank you for your answer.

The Senator from West Virginia, Senator Manchin.

Senator MANCHIN. Thank you, Chairman Moran.

First of all, I want to thank the second panel for being here. And, Mr. Missal, as the VA Inspector General, you and I have had a lot of conversations, and they have been vital to patient safety and quality of care at VA. And I appreciate very much all your work to keep me updated on specific issues that we are facing in West Virginia.

Dr. Perlin, I really appreciate you being here, and I will say this, you are new. You were not there when all this happened. So I want to make sure we clarify that because my remarks were not that kind to The Joint Commission after this. But you are new, and I hope that these changes will come.

As you know, I am extremely concerned about the current state of the relationship between The Joint Commission and the VA. Like I said at the beginning of this hearing, The Joint Commission consistently gave the Clarksburg VA a passing score for accreditation before and after the horrific murders occurred at the facility.

The Joint Commission was even onsite at the Clarksburg VA for a review which Clarksburg passed. They passed it. That was less than eight weeks before the murders began. That year, the VA paid The Joint Commission almost $6 million for their services. That really does not set right with me, knowing the amount of money that we have invested there and the return we got.

As a Senator or as a West Virginian, it all comes back to accountability. It really does. And I look forward to hearing your answers to my questions, and I will start with Dr. Perlin, with you, on this question here. How did The Joint Commission miss this blatant oversight during their May 2017 onsite survey? And, sir, you were not in charge at that time, and I want to clarify that again.

Dr. PERLIN. Thank you, Senator. First, let me thank you for your passion around this topic. My career has largely been devoted to VA as Under Secretary for Health and otherwise, and I join you with outrage and also join you in sympathy to the families of those veterans so tragically affected.

I have had reason, obviously, to review the history of The Joint Commission's presence there. As I mentioned, a broad survey sort of skims the surface. It is a vehicle for accountability.

I did not appreciate exactly how strong a vehicle for accountability it was until I personally went on a survey, on the survey side, this past week. And I saw that you see things that you do not see in the place you live or work. I mean, it is like your home, where you may know that I do not plug in the toaster with the coffee pot because it blows the fuse. Only, this is health care. This is

people's lives. And The Joint Commission, when we are onsite, can see those sorts of things.

In the survey done, the broad exam of the facility in 2017—and as I understand it, that particular nurse tech was hired in 2015—it is like that that particular chart would not have come up for review. In retrospect, clearly, there were HR issues. Clearly, there were medication management issues.

When VA came back, not at the time that the Inspector General was available to evaluate in 2018, but when it found out with the rest of the public late in 2019, as I understand it, based on your passion and the passion of VA leadership, a lot of things were in place. So there is an artifact of timing.

That said, I am not comfortable with an organization that cannot go deeper on these sorts of things.

Senator MANCHIN. We are hoping you make these changes. Here is the problem if these changes do not—The Joint Commission standards and ability of your surveys to identify violations do not align did not align, with protecting patient safety. That makes me wonder why we continue to use The Joint Commission while there are several other accreditation bodies, including State surveyors through the Centers for Medicare and Medicaid Services, that seem to have done and been able to do a better judgment for our veterans and their families.

I will finish with this one. Has The Joint Commission ever revoked accreditation status? As you look back in the history, has that ever happened?

Dr. PERLIN. I am unaware that VA has revoked accreditation—that The Joint Commission has revoked VA accreditation.

Senator MANCHIN. Did The Joint Commission issue any corrective action for Clarksburg VA following these murders?

Dr. PERLIN. I believe that there were issues that were identified that would relate to the issues——

Senator MANCHIN. Again, sir, I know being new, and again, I say this; I appreciate you being here. If I could get more direct answers, if you could look back into that and get me more direct answers, how The Joint Commission—when Mr. Missal went through, I found out more in the seven days they were there than I found out through the whole time of the investigations.

Dr. PERLIN. Right. Well, the Inspector General, of course, did a very focused "for cause" review, and I will find out what we had.

[The Joint Commission response to Senator Manchin appears on page 77 of the Appendix.]

That said, let me just make two points. First, you know, we get our driver's license, and that is a demonstration of basic competencies and safety if you abide by the rules of the road. This was a malevolent individual with intent to harm. I wish I could sit here and tell you that would never happen again. It is not possible.

Senator MANCHIN. Yes.

Dr. PERLIN. What I can tell you is that in contrast to the other accrediting bodies The Joint Commission has a broad range of standards that go far deeper into both the culture of safety and the mechanisms of safety and into accountability than the others.

Senator MANCHIN. Sir, I am sorry to cut you off. I just want to ask Mr. Missal one question because I have got to go vote.

Mr. Missal, understanding that every incident is different, what are the standards the OIG uses when assessing and investigating VA facilities both before and after the OIG has made findings and issue recommendations? What is your follow-up procedures before and after?

Mr. MISSAL. Well, the standards we follow are VHA policies and procedures and determine whether or not the facility is complying with those policies and procedures. We will, on occasion, make comments if we do not believe the policy or procedure is adequate.

We do follow up on at least a quarterly basis. We will look at any open recommendations and work with the facility to try to close those, but again, they have to be to our satisfaction, that we believe they have met the objective and it is sustainable.

Senator MANCHIN. Let me just say this. Every member we have that serves on this Committee is here for a—we have chosen to be on this Committee because of the veterans, because of people in our families, our communities, and what they have served and sacrificed for all of us. So we care deeply, and when something happens this tragic—and there is more than seven that we know of. That is all she admitted to. We know there is more.

You can only imagine looking at these families saying, "My dad was okay. He was okay two days ago. What happened?" And there were no answers given. That is the reason that we are in this the way we are.

I appreciate all of you. I do not want this to happen in New Hampshire or in Alabama. It should not happen anywhere and to go through this. So how do we prevent it? How do you hire? What is the vetting process? Locking things down. Making sure. That should be recognized beforehand.

I am so sorry. They are going to cut me off here anyway, but if you want to answer very quickly, please do.

Mr. PERLIN. On the hiring, I think that is so critically important. There are things I learned in private sector that I wish I had known when I had the privilege of leading VA.

You indicated a tension right now between the shortages in workforce and the whole vetting of an individual.

Senator MANCHIN. Yes.

Mr. PERLIN. Here is an approach which is a stoplight report. Green: good credentials, clean background. Yellow: maybe some problems in competencies, maybe some problems in background, needs a VISN approval. Red: absolute dead stop and that can only be approved in the Under Secretary's Office or the Office of the Secretary.

Senator MANCHIN. Thank you.

Thank you, Mr. Chairman. I am sorry for taking a little bit privilege there.

Senator MORAN. An important topic. Terrible tragedy in West Virginia.

Senator Tuberville.

Senator TUBERVILLE. Thank you, Mr. Chairman.

Thank you for being here today. That was interesting. We all find that sad things happen.

Inspector General, I want to ask you about issues related to coordination of medical care between the VHA and community providers. I believe your office has identified multiple examples of providers in the community not reviewing documentation from VA providers and vice versa when providing care to veterans, which slows down the delivery of effective treatment and diagnoses for veterans. Does your office provide recommendations on how to address these situations, and those recommendations, are they acknowledged and resolved by either the VA or the community provider?

Mr. MISSAL. Our recommendations will be to VA, not to the community providers, and we do look at community care. We have issued a number of reports already. We have others in progress.

We recognize the importance of community care. And we have, as you pointed out, recognized issues with documentation, where if a veteran goes out in the community sometimes the documentation does not come back to VA. And to have care coordination, you need to have a complete record, and we sometimes do not see that, so we have made recommendations to ensure that those records are back.

And I will turn it over to Dr. Kroviak if she has any other thoughts on that.

Dr. KROVIAK. I would just add and actually endorse what Mr. Missal just described. That information sharing is critical. And we repeatedly find shortcomings, and we have addressed it at the facility level, where we find those issues, where communication was not consistent, where records were not returned to the facility on time.

And unfortunately, what typically happens is the providers on the VA side are going out of their way to find out what type of care the veteran received in the community, and that is an inefficient use of their expertise. That should be spent taking care of the patient, not doing paperwork.

Senator TUBERVILLE. What kind of feedback do we normally get, you know, on this? Do we get—either one of you—you know, the feedback that you provided through these recommendations?

Dr. KROVIAK. From the facility or from VA?

Senator TUBERVILLE. Yes.

Dr. KROVIAK. So classically, the conversations are productive, and we reach an agreement and a consensus that they agree with our findings. And they put forward an action plan that we can accept, and we will ultimately wait to see what kind of evidence they provide throughout that process to close the recommendation.

But as Dr. Clancy suggested, our standards are quite high, to see not only the evidence is valid and shows that it met the intent of the recommendation but that they are sustaining that improvement through the action plan. So it is not easy for them to get closure of our recommendations.

Mr. MISSAL. And I would just add that both of our goals, the OIG and VHA, is to help improve services for veterans. So we have that same objective, and that is why when we have discussions we are all trying to reach the same point.

We typically get involved when we may have identified an issue. We believe we understand what the root cause is because whenever we do a report we look at root causes because if you do not understand why something happened it is hard to fix it. We are the ones

who decide what we think is the most appropriate manner in which to address it. We will talk to VA to make sure we have not missed anything, but at the end of the day, we are the ones who issue the recommendations.

Senator TUBERVILLE. Thank you. In the case of Tuscaloosa VA Medical Center, where your staff confirmed, you know, numerous visits—after numerous visits, recommendations over a three-year period, that the facility continues to fail VHA mandated standards for patient safety. What is the responsibility of the IG here?

Veterans are being seen there continuously, still every day. And what avenues can the IG leverage besides confirming that there are failed standards? I mean, what can we do? I mean, we have got an ongoing process here. All three of you, if you can answer, that would be great.

Mr. MISSAL. Our responsibility is to conduct oversight and identify issues. Tuscaloosa is yet another example where we came in, we found issues with the patient safety program, came back about a year later, they still had not fixed what we thought they were going to fix. So when we see facilities which have continuous problems or more serious leadership issues, then we are going to watch it that much more closely, and Tuscaloosa is a good example of a facility where we are watching closely and we have other active projects in that area.

It is up to VA to fix it. We can identify the problem, make recommendations, but it is up to VA——

Senator TUBERVILLE. Is it usually personnel, or is it usually just restrictions or guidelines that they do not follow?

Mr. MISSAL. It is really a host of different things it could be. They have different policies that they have in place. They are required to follow it by their own policies. So we will identify it, but if there are other issues that we identify which impact patient safety or just the efficiency of health care, we will raise those as well.

Senator TUBERVILLE. Anybody else got a comment on that?

Dr. KROVIAK. If I could just add, it is often leadership. VA has a plethora of policies specific to patient safety, but if the leaders are not promoting the staff repeatedly carrying out those policies to actually feel responsible and empowered to carry out those policies, we will always have these repeated findings.

Senator TUBERVILLE. It always starts with leadership.

Dr. KROVIAK. Absolutely.

Senator TUBERVILLE. We all know that. And does anybody ever lose their job over this? Do you know? Is there any examples of people?

Mr. MISSAL. I can give you one example. The example I brought up with the Washington, DC inventory system, where we found significant issues, I personally briefed the then Secretary on that issue, and he told me he was making a change in leadership that day, and he did so. And I am sure there are other examples that we could think of as well.

Senator TUBERVILLE. Thank you. Thank you very much.

Chairman TESTER [presiding]. Senator Hassan.

SENATOR MARGARET WOOD HASSAN

Senator HASSAN. Well, thank you, Mr. Chair, and I want to thank you and the Ranking Member for holding this hearing. And to our witnesses, thank you so much for being here.

Mr. Missal, the VA has routinely dismissed whistleblower claims, including whistleblowers at VA facilities that Granite State veterans rely on for their care. Last year, the Office of Special Counsel published a really troubling report that reinforces that the VA failed to take seriously whistleblower complaints, this time regarding allegations at the White River Junction Medical Center, right over the river from New Hampshire in Vermont.

This case is just one example where the VA failed to treat allegations seriously and failed to safeguard whistleblowers, which impacts patient safety, quality of care, and the VHA workforce. How can the VA address the culture of silence and whistleblower retaliation at VHA facilities in its strategy to address patient safety?

Mr. MISSAL. I will keep repeating that it really comes back to the leadership. When you have a culture like that, the tone is set at the top, and leaders really have to say that when there is an issue, you should raise it. You need to have a climate where staff, whistleblowers, and others who raise complaints, feel comfortable coming forward, and we hear time and time again that people are not comfortable in doing so. That is why we appreciate the training bill that you introduced because I think the more the VA staff understands the OIG and other outlets they may have and that they can make their complaints anonymously, that they will be protected, et cetera, I think that will have a good effect and hopefully change the culture.

Senator HASSAN. Well, thank you.

Dr. MEYER. Senator, may I comment on that question?

Senator HASSAN. Yes, sure.

Dr. MEYER. I do think there is a clear way to do that, that we actually know that we can actually measure among our staff their psychological safety and their safety culture. And I do believe holding leaders accountable for their safety culture results as part of their performance, just like you hold them accountable for financial performance, you hold them accountable for quality performance, you hold them accountable for safety performance, holding them accountable for culture performance is a mechanism to achieve exactly that.

Senator HASSAN. Well, I appreciate that, and let me just follow up then a little bit on what you just said, Mr. Missal. Your testimony noted that the common contributing factors to Veterans Health Administration failings "are poor, inconsistent, or ineffective leadership that cultivate complacent and disengaged medical facility culture in which the VHA goal of zero patient harm is improbable, if not impossible."

So we have talked a little bit about the whistleblower issue and that the importance of culture and leadership there. But from the many incidents specific in Veterans Health Administration's systemwide reports that the Office of the Inspector General produces, what are some of the other challenges VHA faces?

Mr. MISSAL. Ensuring people are held accountable because if there are issues and that people are not accountable, then that

again corrodes the culture that they have. There also has to be a recognition that mistakes are going to be made. And a real key is not so much the mistake, you get into the root cause, but what happens afterward.

Senator HASSAN. Right.

Mr. MISSAL. You want to make sure that they raise it and that it is dealt with appropriately.

Senator HASSAN. Right. Thank you. And you mentioned that the bill that I have in bipartisan legislation with Senator Boozman. I just want to let my colleagues know I am grateful for your support of it.

The VA currently offers an optional 45-minute whistleblower training to employees, but what we find now is many VA employees have opted out of the training and they often therefore lack the skills to spot the early indicators of fraud, potential crimes, or deficiencies in patient care. I am pleased that this Administration supported a directive that now makes this training mandatory, but I do believe we need to make that directive permanent and in statute.

So I am grateful to Senator Boozman for the work, and if there is anything else you would like to add about the importance of that legislation, please feel free now before I run out of my time.

Mr. MISSAL. No, we agree it is critically important. Even though there is a directive in place, a future Secretary could take that directive away. We have been asking previous Secretaries for that same training. Secretary McDonough is the first one to agree to do it, and so legislating the requirement of the training, I think, would be critically important going forward.

Senator HASSAN. Well, thank you. I appreciate that, and thanks, Mr. Chair.

Chairman TESTER. Senator Cassidy.

SENATOR BILL CASSIDY

Senator CASSIDY. Thank you all. Mr. Missal, you had mentioned at the Washington—there was a change in leadership in the inventory system, but you did not specifically say the person accountable was fired. You just said there was a change in leadership. To your knowledge, was the person responsible for this fired?

Mr. MISSAL. I do not recall all the personnel actions. I know there were a number of changes made at the facility, but that would be VA who does those. We do not get involved in personnel actions.

Senator CASSIDY. There is a woman behind you shaking her head "yes," and so either she approves of the question or she knows the answer.

Dr. CLANCY. Yes, that person was fired.

Senator CASSIDY. Yes. Thank you. I appreciate that.

Now you mentioned that there are—I forget your nomenclature, but that there are a group of low-performing hospitals that are characterized by constant turnover in leadership. Now what percent of VA facilities are low performing with the criteria that you specified?

Mr. MISSAL. The report that is mentioned in the testimony, we looked at one particular VISN and looked at medical centers within

that VISN. One was higher performing; one was lower-performing. You have the same VISN leadership. You would think they would be pretty similar. So the question was: Why is one higher-performing and one is lower-performing?

And one of the things that really stuck out to us after doing the inspection was that the higher-performing facility had more stable leadership.

Senator CASSIDY. I get that; I get that.

Mr. MISSAL. Okay. But we did not look beyond that. That report was just for those two facilities, our——

Senator CASSIDY. Let me ask then. I am a little—and I am sorry I have not read your report. I have read your testimony. But you talk about episodes across the Nation that—you know, the people in Arizona, the people in Clarksburg, the people in Arkansas and Alabama. So it sounds like you did some work outside of one particular VISN, or were those just anecdotes that you were investigating?

Mr. MISSAL. No, in every project, we do look at leadership. Leadership is so important.

Senator CASSIDY. But my point—I guess what I am after, we need some sort of statistical evaluation as to what percent of these hospitals are miserable because they have leadership which is constantly overturning and someone like Dr. Levy is allowed to do these terrible things which, as a physician, just outrages me.

Now if all we can do is just do a sample and only from that sample know the results of that particular sample as opposed to extrapolation, I am not sure that is as helpful as to say that these are the characteristics of a poorly functioning facility and therefore require more attention just because they have these characteristics. Now did you do any of that, or would it just be a matter of extrapolating your findings for someone else like the VA to go do that?

Mr. MISSAL. No. We did it in this particular report. We looked at what are the characteristics of leadership at a well performing facility——

Senator CASSIDY. But did you extrapolate those results to see if they apply to other facilities?

Mr. MISSAL. We did not specifically extrapolate, but we look at dozens and dozens of facilities a year. We do look at leadership and assess how they are doing and the impact that they are having.

Senator CASSIDY. And, sir, knowing that they have done this work and knowing that you all reviewed this, do you take the criteria of this kind of tumultuous leadership, constantly changing, et cetera, as a means to more closely scrutinize some facilities as opposed to others?

Dr. PERLIN. One of the most important sections of The Joint Commission's standards is the chapter on leadership, and leadership turnover is a sign——

Senator CASSIDY. But that is not my question. But if there is tumultuous turnover, do you therefore focus more intently upon that facility?

Dr. PERLIN. That would be a clue to the surveyors that, yes, they would increase their level of scrutiny.

Senator CASSIDY. Gotcha. Thank you. I do not mean to be rude.

Dr. PERLIN. No, no, no, sir.

Senator CASSIDY. Dr. Meyer?

Mr. MISSAL. But if I could say——

Senator CASSIDY. Yes, sir.

Mr. MISSAL. One thing we do when we inspect we do look at tenure of all the leaders there, and one thing we found that was disturbing is at about half the facilities their director, the leader of that facility, had been in place two years or less.

Senator CASSIDY. Is that half of the facilities VA-wide or just those at which you looked?

Mr. MISSAL. That we looked at, but we look at about a third of the facilities every year. We are at about a three year cycle. So it is a pretty significant percentage.

Senator CASSIDY. Dr. Meyer, I think you are somewhere out there on Zoom. I think we heard that a third of the facilities have turnover in their leadership, which is associated with poor outcomes. You reviewed the literature. I gather that you have written some of the literature which you review, which finds a similarity and even indeed, at times, an increase or better care among VA facilities versus the community.

But if we hear that a third of them have this kind of turnover in leadership, which is a hallmark of not doing well, is it just that we are burying our mistakes in the mean, or if we looked at a distribution of results, will we see that there is a subset of VA hospitals which underperform?

Dr. MEYER. There is always going to be a subset which underperform, and I think that is one of the points I tried to make in my earlier testimony. And that is that although it can be comforting that in the aggregate the VA does well, there is wide variation, and it is really focusing in on that variation that is so important. One of the factors, obviously, is stability of leadership, but there are others that really create those outliers where attention should be directed.

Senator CASSIDY. So, Dr. Meyer, do we know that the VA is taking that subset of hospitals, which apparently you and the Inspector General can look at and The Joint Commission can look at and say they are at risk? Do we know that the VA is looking at that subset and doing a deep dive so that if there is a pathologist who is falsifying results that that pathologist is discovered? Is that a "yes" or a "no"? Do you know? Do we know if they are doing that?

Dr. MEYER. I do not know if they are doing that.

Senator CASSIDY. Gotcha. Dr. Meyer, I am almost out of time, but—well, I am out of time, but I am the last one here, so why not. Can I go a little bit further?

Chairman TESTER. [Inaudible.]

Senator CASSIDY. You mentioned the greater efficiency of the VA facilities versus the private sector. A concern of mine, though, has been—at least, maybe this has changed, but the lack of effective utilization review for those veterans who go out of the VA system to get their care. I did not completely review the NBER study that you reference that referenced the increased efficiency. But if there is a VA hospital in which, because of the lack of UR, the veteran is going to a private facility and getting a complete workup, sometimes maybe duplicative of that which has already been done, is

that being counted toward the efficiency of the VA, or is that not being included? I do not know that; I am asking.

Dr. MEYER. Yes, that study by the NBER, that that would be considered to be civilian care, and so they would not be included with the VA——

Senator CASSIDY. Even though the VA was paying that bill?

Dr. MEYER. Even though the VA was paying for that because what they do is they tracked veterans who were eligible for Medicare and VA care, and what they did is they looked to see of all them going to an emergency room how many of them end up getting their care on the civilian side versus the VA side. They tag the VA with a——

[Simultaneous discussion.]

Senator CASSIDY. But I guess what I am asking——

Dr. MEYER [continuing]. The civilian side with civilian side.

Senator CASSIDY. So if it is only restricted to those who are on Medicare as opposed to the younger veteran for whom the VA would be paying for that service provided by the private sector, then that study is flawed because the VA is not getting dinged for perhaps excessive services occurring in the private sector that are only occurring because there is inadequate utilization review. Is that a fair critique?

Dr. MEYER. That is a fair critique. However, I would say that in general, when you look across very, very broadly, across the costs per veteran of health care and compare that with the costs per civilian in health care, the VA is generally lower. It could be an issue.

Senator CASSIDY. In that NBER study that I read, it looked like some of that was driven by end-of-life care where the VA was more efficient with end-of-life care, and that is very expensive. And so if you take out end-of-life and you look at the other health care, I would be interested in knowing—and again, you would not know. It would be the authors of the study. As to—because I am concerned that people are going to—that the lack of utilization review by the VA is resulting in people going to private clinics and getting excessive testing.

Anecdotally, I have seen evidence of that, but it is all anecdote, does not mean it is data, but it seems if you are ignoring that. And again, if you take out the end-of-life care, which would, of course, help the Veterans Administration look lower per patient—I think I have developed my point. I am worried about the validity of that study.

Dr. MEYER. I would say I think the study is valid for looking at segments of the VA population. I think your concern about lack of UR is an important consideration and something that needs to be addressed.

I would also note, in addition to improved end-of-life care, I think that the VA offers three things that are special compared with civilian care that I think do allow it to be more efficient. The first is continuity of care, that veterans tend to be loyal to the system. The second is their electronic health records that allow them to follow patients over time and space. And the third one is veteran's care is integrated much more so than the care afforded in most civilian facilities. So there are several other factors that I think

make the VA different, and all would lean toward them being more efficient.

Senator CASSIDY. Thank you. I thank you all for coming here, and I yield.

Chairman TESTER. Thank you, Dr. Cassidy, and I think it is important that when studies are done we are comparing apples with apples. And I would also say we had a panel that Dr. Clancy was on that may be able to answer your question about whether they are doing in-depth reviews on underperforming clinics.

Senator CASSIDY. We will do that as a QR.

Chairman TESTER. You bet. Absolutely.

Do you have anything, Senator Moran, before I close this out?

Senator MORAN. I do not, Mr. Chairman.

Chairman TESTER. Okay. So I just want to thank everybody for being here today, thank all our witnesses. I look forward to continuing to work to ensure that we are providing veterans with the highest quality care possible.

The record will be kept open for a week, and this hearing is adjourned.

[Whereupon, at 4:43 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statements

STATEMENT OF
CAROLYN CLANCY, MD
ASSISTANT UNDER SECRETARY FOR HEALTH FOR DISCOVERY, EDUCATION, AND AFFILIATE NETWORKS
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

May 11, 2022

Good morning, Chairman Tester, Ranking Member Moran, and Members of the Committee. I appreciate the opportunity to discuss VHA's efforts in ensuring Veterans receive quality healthcare. I am accompanied today by Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services, and Kristine Groves, Executive Director, Office of Quality Management.

VHA's approximately 380,000 employees come to work every day to serve Veterans, their families, and caregivers. All of us at VHA know the importance of patient safety as evidenced by the incredible work VHA has done during the pandemic. When personal protective equipment (PPE) was running low for health care professionals at the beginning of the pandemic, VHA created reusable, 3D-printed PPE and dispatched it directly to the front lines. When it was not safe for some Veterans to come to the hospital, VHA cared for them remotely by rapidly ramping up telehealth to unprecedented levels. When local community hospitals became overwhelmed, VHA provided beds and cared for hundreds of non-Veterans as part of VA's fourth mission. When vaccines became available, VHA vaccinated millions of Americans. VHA employees have spent the pandemic doing what many employees have done for 75 years: delivering the care that Veterans, their families, and caregivers expect and have earned.

Despite the challenges associated with the global pandemic, VHA remained 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. All 50 states, the District of Columbia, Puerto Rico, and several Tribal Nations sought assistance from us during the pandemic, also demonstrating the trust in VA's world-class workforce. In addition, expansion of telehealth during the pandemic allowed the VHA to deliver timely and safe care to our Veterans.

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 our Nation's Veterans. This is demonstrated through favorable measures in Outcomes,

Timely and Effective Care, Patient Experience, and Patient Safety. VA compiles these metrics on a regular basis, provides the information to clinicians and leadership, and collaborates with our colleagues in the field to implement improvement strategies and share successful approaches across VHA.

To compare quality with the community at the enterprise, regional and local levels, VA publishes benchmarks available from the Centers for Medicare & Medicaid Services (CMS) and the major accreditor for health plans, the National Committee for Quality Assurance (NCQA). Both CMS and NCQA use clinical measures of quality and patient safety derived from scientific evidence, along with standardized measures of patients' experiences of care.

Comparisons of VHA hospital performance with private hospitals are tracked at www.medicare.gov/care-compare.

Peer-reviewed studies, conducted in response to statutory directives for independent assessments (CHOICE) have consistently shown that VHA outperforms most private sector hospitals in many core measures of inpatient quality of care, achieves lower overall inpatient mortality, and achieves superior levels for important in patient safety measures (e.g., surgical complications) compared with the private sector. 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 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 non-VA hospitals or non-VA outpatient centers.[1] A study 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 three 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 regions.[2]

In this 2018 study, comparisons were made between VHA-affiliated hospitals and hospitals that were not part of the VHA healthcare system, and for outpatient measures, VA outpatient facilities were compared to non-VHA outpatient facilities. Non-VA facilities/sites included sites within commercial HMOs or PPOs, as well as publicly-funded (Medicare and Medicaid) HMOs. Quality measures that were compared included inpatient care, notably that VA performed better on patient safety, inpatient mortality, and inpatient effectiveness, but worse on some readmission and patient experience measures. For outpatient care, VA performed better than non-VA sites in preventive care (cancer screenings) as well as diabetes, cardiovascular disease, and depression management.

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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).

A 2019 study published by Medical Care focused on the quality of VHA 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 as Veterans on inpatient mental health units in VHA hospitals.[1] Another important study published just last month showed that Veterans requiring emergency care who were transported to VA hospitals had a substantially lower risk of death within one month than those transported to non-VA hospitals, corresponding to a 20% lower mortality rate among Veterans taken to VA hospitals.[2] The advantage was particularly large for Hispanic and Black patients, older patients, and patients who arrived with relatively low mortality risk. An ancillary paper on Veteran care in emergency care settings also showed costs of care were less at VA hospitals compared to non-VA hospitals.

Although adverse patient events occur in every hospital and every large health system, studies like these and others show that at multiple points in time VHA's overall quality of care compares favorably to the rest of American health care delivery. Our commitment to Veterans demands that we review our performance frequently to identify and address improvement opportunities rapidly.

VHA is committed to transparency and fostering a culture that reports and evaluates errors and near misses to better understand and improve systemwide vulnerabilities. When an adverse event occurs, VHA facilities conduct a prompt review to understand why the adverse event occurred so that system improvements can be made. 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 VHA medical facilities. Direct communication along service lines from VHA Central Office to Veterans Integrated Service Networks (VISN) and facilities is encouraged.

This system of transparency and cross-disciplinary coordination also supports VHA on its journey to becoming a High Reliability and learning organization and works to ensure delivery of the highest level of service to Veterans, their families, and caregivers.

High-Reliability Organization (HRO)

VHA has also used 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 before the pandemic. When the 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

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[1] Comparing Rates of Adverse Events and Medical Errors on Inpatient Psychiatric Units at Veterans Health Administration and Community-based General Hospitals - PubMed (nih.gov)

[2] Mortality among US Veterans After Emergency Visits to Veterans Affairs and Other Hospitals: Retrospective Cohort Study. *The British Medical Journal*. February 16, 2022.

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.

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; 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, nearly 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, 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.

Addressing Findings from External Reviews

VHA is grateful for independent investigations that improve patient safety, and it looks for opportunities to apply lessons learned across the enterprise. Transparency and accountability are key principles at VHA, and they guide our efforts in this regard.

VHA's efforts are significantly augmented by reviews from the Government Accountability Office, the Office of the Inspector General, the Office of the Medical Inspector, the Office of Special Counsel, and multiple industry accreditation organizations, including The Joint Commission and CARF International. These oversight efforts are important and are taken seriously. VHA reviews and responds to findings from external reviews, including those from the Office of the Inspector General (OIG), and determines the corrective actions needed to address identified deficiencies and to improve quality and safety outcomes. These reviews inform improvement activities across the entire VHA system. In response to external oversight reports and recommendations, key VA stakeholders and subject matter experts develop evidence-based action plans to resolve any deficiencies identified in the reports. VA's action plans are published in oversight reports. VA, in collaboration with the oversight body, follows up regularly with stakeholders until actions are complete and the oversight body agrees its recommendations have been resolved. In this way, the Department knows that it has achieved the improvements in care that our external oversight bodies are seeking.

Conclusion

Patient safety characterizes the culture at VHA and permeates the organization. This results in quality care for Veterans, their families, and caregivers. VHA has made substantial strides in ensuring Veterans, their families, and caregivers receive quality

care even during this challenging time of the pandemic. VA is committed to ensuring that it provides the most accessible, convenient, and high-quality care possible through the VHA system, as well as through community providers, and that we do so in a transparent, Veteran-centric, way.

DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS, U.S. SENATE
HEARING ON
QUALITY OF VA'S HEALTH CARE
MAY 11, 2022

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

[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.

The Joint Commission

Statement of

Jonathan Perlin, M.D., Ph. D, M.S.H.A
President and Chief Executive Officer
The Joint Commission

Before the

Senate Committee on Veterans' Affairs
May 11, 2022

INTRODUCTION

Good afternoon, Chairman Tester, Ranking Member Moran, and distinguished members of the Committee. Thank you for the opportunity to speak to you about The Joint Commission's accreditation program for Veterans' hospitals. I am Dr. Jonathan Perlin, President and CEO of The Joint Commission.

I am testifying not just as the new head of The Joint Commission, but as a person who has devoted a significant portion of my life to Veterans' care. Many of you know that I have a long-standing affiliation with the Department of Veterans Affairs, and the mission of service to those who have served is a labor of love for me. My career started in academia and eventually gave me the privilege of leading clinical operations, a one of the largest health systems in the private sector and, of course, the tremendous privilege of serving as VA's Under Secretary for Health. This set of experiences and my work in health IT, data science, and clinical performance improvement allowed me to hit the ground running at The Joint Commission on a wide range of quality issues. But this unique expertise also means that I can look with fresh eyes at The Joint Commission's accreditation work with Veterans' care. While I may not know all the answers, I do know the right questions to ask to improve care for Veterans.

Veterans using the VA for care tend to have greater health needs than the population at large. They frequently have unique healthcare challenges from serving in one of the highest-risk occupations – military service – and those unique occupational risks needs are driving the use of the healthcare services they require.

We applaud the Department of Veterans Affairs' focus on continually trying to meet the needs of Veterans wherever that care is delivered, in VA settings or in the community, to ensure that Veterans receive the timeliest, highest quality and safest care possible. But we need to appreciate that the Veterans Health Administration (VHA) faces the same challenges in delivering care that are confronting private sector health care systems -- maintaining an adequate workforce, coordinating care, and keeping pace with new delivery methods such as telehealth--and facing some of its own challenges, such as implementing a new health information system that can capture and transmit timely, accurate and useful data to coordinate an understanding of care needs over the life of the Veteran, from military service to present, and across all of the settings in which services may be provided.

THE JOINT COMMISSION

Founded in 1951, The Joint Commission is the nation's oldest and largest standard-setting and accrediting body for health care. We are an independent, not-for-profit organization with significant global reach. Although well-known as accrediting the majority of our nation's hospitals, including those of the Departments of Veterans Affairs and Defense, The Joint Commission accredits across the continuum of care. More than a dozen of our programs are relied upon by the Federal government, and every state depends upon our reviews for either a portion or all their hospital licensure requirements.

As part of our mission to continuously improve the quality of care provided to patients across every healthcare setting, we are deeply committed to the care Veterans receive. To accomplish our mission, we evaluate health care organizations through accreditation surveys and specialty program review. The Joint Commission couples the rigorous accreditation process with a breadth of services to assist hospitals in their journey toward excellence and to keep pace with developments in quality and safety.

Moreover, just as we expect our healthcare organizations to continuously assess the outcomes they obtain and improve what they do, we expect the same of ourselves. We are serious about our obligation to be a learning organization. In recent years we have incorporated into our oversight programs, meaningful enhancements to their effectiveness. The added rigor combined with machine learning algorithms allows us to make more in-depth and consistent judgments about compliance across thousands of hospitals, while more clearly informing hospital leaders about their relative safety risks. And please be assured that I am introducing several initiatives to further strengthen The Joint Commission's capacity to evaluate healthcare organizations and foster improvement.

Accreditation is an essential part of the evaluation armamentarium that complex systems should have to understand how well they are managing multifaceted and difficult issues in contemporary health care. Our accreditation is based on a set of Federal clinical, operational and leadership requirements that healthcare organizations must demonstrate to serve Medicare patients and enhanced by an even larger set of evidence-informed requirements that we add to foster safe and effective operation. There isn't any other organization with as much pragmatic knowledge about hospital assessment as the Joint Commission. With "boots on the ground", at one-third of our nation's hospitals annually, we see what works and what doesn't. We can observe both good practices and identify which system failures lead to poor outcomes. Importantly, this information is not only

translated into our standards and survey process but used to provide feedback to the organizations we survey.

Let me provide a brief overview of The Joint Commission's accreditation program as it relates to evaluating hospitals.

SURVEY PROCESS AND ACCREDITATION STANDARDS

Our survey process depends upon the strength and interdependence of three domains that comprise an effective evaluation: first, the use of state-of-the-art standards; second, their application by expertly trained and experienced surveyors who can provide contemporaneous feedback about good practices during the onsite survey; and third, an assessment process that is discerning, systematic, risk-based, and engages hospital staff and patients.

Joint Commission accreditation standards set us apart among other hospital accreditors. We go beyond basic Federal requirements to address emerging, critical issues in health care, such as our recent standards on maternal morbidity and mortality, workplace violence, and suicide prevention. Our standards are evidence-based and developed in partnership with leading experts, reviewed by practicing clinicians, and honed through a public field review. Recently VA staff were invaluable to our technical expert panel on suicide prevention and contributed to changes to accreditation standards for all healthcare organizations, as well as to the creation of a related National Patient Safety Goal on suicide prevention.[1]

By keeping our standards up to date, our nation's Veterans benefit from the application of the latest knowledge about care delivery practices. Our standards set expectations for organizational performance that are reasonable, achievable, and surveyable. They also set a floor for expectations of competency for safe operations and assist a hospital in focusing on those important processes and organizational functions that are essential to providing safe, high-quality care. Furthermore, the standards seek to build organizational learning around these requirements and expectations.

The survey measures consistency with a robust set of standards by a highly trained survey team. Traditional, triennial surveys *are unannounced* and occur onsite at any time during an interval of 18-36 months from the previous survey. The goal of periodic but

[1] https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf.

unannounced surveys is that hospitals don't just study for an exam but, learn – and own – the material. We also conduct "for cause" surveys under circumstances that arise from a precipitating event, such as a serious complaint submitted by Veterans, families, health care providers; through state and Federal agency reports; or through information taken from the media. Such "for cause" surveys are an in-depth look into a specific concern and provide an extensive, deep view on a specific issue in a manner that cannot be accomplished during the triennial survey. If the triennial survey is like a general physical exam to assure basic health, a "for cause" survey is like a specialist visit for a suspected, life-threatening problem, such as heart disease.

The survey process is fundamental to ascertaining whether a hospital has the necessary structures and processes in place to undergird the provision of quality care. This includes sampling records and reviewing policy and process to assess among other things, whether the hospital has a properly credentialed workforce, a safe physical environment, and the systems in place to address healthcare-associated risks such as infection prevention. Surveys and any follow-up activities are intended to encourage organizations to embed accreditation expectations into routine operations with the goal of continuously maintaining clinical and operational excellence.

Starting with a common framework, the standard elements are matched to the services offered by a particular organization. Notably, a portion of the survey will determine whether the organization is delivering services as intended by its own policies. There are numerous components to a survey, but some salient features are that surveyors:

- trace the full experience of selected Veterans during their hospital stay,
- focus on evaluating the underlying systems of care delivery,
- observe the performance of medical and surgical procedures,
- interview staff and patients,
- evaluates standards of safety related to the facility's physical environment, and
- engage in daily communication with the hospital leadership on what is being found during the survey.

The survey team's composition is driven by the size and complexity of the organization and the scope of services provided. All hospital surveys include clinical and non-clinical staff, including but not limited to physicians, masters or doctoral-level nurses, and pharmacists. Non-clinical survey team members are individuals with expertise in facilities management, engineering, and fire protection. Surveyors receive annual education and training specific to the operations of VA hospitals.

Tracer Methodology and the SAFER® Matrix Tool

I would like to highlight two cornerstones of our survey process. The first is our ***tracer methodology***. Tracers assess standards compliance by following all the care and services a patient encountered during a hospital stay -- from admission to discharge, including expectations for follow-up services. Such patient-specific tracers provide a critical view into an organization's ability to achieve patient-centered and high-quality care. And, technically, they trace whether a patient's experience was consistent with the standards for care quality that are part of all standard surveys, as well as assessing whether a patient's care was consistent with the hospitals own policies.

During our survey, these individual patient tracers are complemented by system tracers, which assess how successful the underlying functions of a hospital are at supporting the entire organization's service delivery. For example, a system tracer may evaluate how the organization manages its data privacy, maintains infection prevention, or utilizes HR policy.

A second cornerstone is our *SAFER® Matrix* tool, which plots the likelihood of a violated standard causing harm to a patient, staff member or visitor against the scope of risk, from isolated to widespread. The introduction of this tool changed survey results from amplifying numerous negligible risks to placing focus on the most severe risks: those with high likelihood of harm, especially if widespread. The SAFER matrix allows for synthesizing views of common risks, especially among hospitals or in a system.

Survey Deficiencies: Requirements for Improvement:

Deficiencies identified during the survey result in *Requirements for Improvement* (RFIs) that represent breaches in standards. These RFIs are provided to the hospital leadership on the last day of a survey and are a compilation of the survey team's findings. We require plans of correction for each formal requirement with specified time frames for completion. The proposed corrective actions are reviewed in our central office for completeness and their likelihood to resolve the deficiencies. Some issues may require additional onsite visits or other touchpoints with the organization. However, evidence must be provided to The Joint Commission demonstrating that the plans of correction have resulted in compliance before the hospital receives an unrestricted accreditation decision.

Despite our sign off on a hospital's plan of correction, it is up to the facility to be accountable for change. We expect organizations to react to our findings in a positive and decisive manner, implementing new policies and practices to achieve the needed

changes to hospital operations. The most effective hospital systems have system-level control processes to assure timely, effective remediation of our Requirements for Improvement.

In those instances where we find that the organization has failed to institute change, despite our survey requirements, the organization is likely to be placed in a provisional status. Provisionally accredited organizations are displayed on our website with the reasons for not attaining full accreditation.

VHA Enterprise Summation

Each year, we conduct a summary review for VHA that provides an analysis of system-wide survey findings across the hospitals surveyed that year, as well as context from all surveys conducted by The Joint Commission. These summations have a wide attendance, including both system-level leadership, VISN leadership, as well as other quality and safety leaders.

Specifically, the summation offers: 1) an objective assessment of overall strengths and weaknesses found in the hospitals surveyed that year; 2) a summary of general accreditation findings across the surveyed organizations; and 3) benchmarking against both an internal and several external comparison groups. In reviewing the *internal* benchmarking data, we have seen that the overall number of requirements made for improvement have remained consistent over the last 5 years. However, the specific opportunities for improvements in meeting accreditation standards as well as the demonstrated strengths in delivering care will vary year to year. For example, mental health and suicide prevention programs, staffing issues, and infection control are currently at the forefront.

We believe that the information that we provide in these summations is valuable to the VA as an enterprise, and we hope that it results in additional sharing among all facilities and internal stakeholders with an expectation for appropriate actions. A notable best practice across all health systems is the sharing of issues, so that a risk found at one facility is presumed present elsewhere and is remediated at all sites of care operating within the system.

LIMITATIONS OF ACCREDITATION

In good conscience, I cannot tell you that accreditation can guarantee that bad things can never happen in an organization. Accreditation can, however, significantly help with risk reduction. The result of being awarded accreditation after a survey is analogous to getting a driver's license from the Motor Vehicle Administration. It is an assurance of safety if the rules-of-the-road are followed. Likewise, accreditation represents compliance with expectations for how the hospital will operate but cannot prevent all system failures or willful misconduct.

Another limitation of accreditation -- a limitation shared with all other evaluators -- is measuring the intangible, or unstructured aspects of care delivery and operations, such as effective communication or a culture that is conducive to safety and reliability. Like others who oversee quality and safety, we have more work to do in these areas if we are to effectively pick up signals that an organization is in trouble.

OBSERVATIONS ABOUT QUALITY AND SAFETY CHALLENGES

The pandemic has brought excruciating clarity to the difficulties in care delivery that face hospitals nationwide. The pandemic has critically exacerbated existing challenges such as workforce shortages, the need to improve the well-being of hospital staff, and the fragility of our supply chains. At the same time, hospitals are grappling with expansions in the use of virtual care, learning how to provide continuity for patients among care providers in multiple settings (including virtual), and seeking to measure performance and deliver increasingly higher-value healthcare. VA is not isolated from any of these challenges, and as care is more frequently provided to Veterans in community settings, coordination of information and care continuity is even more complex.

From my observations, and from looking at the peer reviewed, scientific literature, there are arenas where the VHA outperforms the private sector and areas where there is not sufficient information to make comparisons, because the metrics either do not exist or they are not systematically tracked. While there is no single metric that we can point to for making overarching comparisons, some peer reviewed studies in selected clinical areas have pointed to where the VHA has excelled over the private sector – such as in decreased mortality rates when critically ill patients are taken by ambulance to VHA hospitals, wound healing, and the rates of certain preventive health screenings. And many additional studies have shown the VA care to be on a par with the private sector, such as mortality after cardiac rehabilitation.

Next, I have observed that most VA staff are very dedicated to serving patients. Many staff and, indeed, leaders are themselves Veterans. VA leadership seeks to be responsive when quality issues arise, but as a system, VA is challenged with leadership turnover and stability. This is especially problematic, as whenever there are voids in leadership, additional, not fewer, competencies are needed to accomplish mission. While most bedside caregivers will still provide care, serve patients, and act with best intentions, they may not have the benefit of sophisticated guidance at every level of the organization that can quickly differentiate between expedient adaptations and bona fide best practice.

Lastly, the importance of proactively accounting for safety is more consequential than ever. Solutions do not include asking staff to try harder. Effective safety involves ensuring fidelity to well-designed processes that mitigate harm and that can keep mistakes from reaching patients by accounting for the inevitability of human factures and frailties. The Joint Commission and VHA have a shared responsibility to continuously examine where workarounds can create vulnerabilities in high-risk activities and where safety culture may be failing. It has been said that high-reliability organizations have a healthy paranoia about system risks and failure modes and an equally aggressive commitment to control systems and robust defenses against human error.

By control systems, I am referring to ongoing and internal audit processes to "check the math." Examples would be avid chart abstractions, proactive risk assessments, evaluations of internal metrics, large scale and even automated data review, and robust peer review systems. Furthermore, any identified risks should serve as signals to be actively shared among other VA facilities, because similar risks will assuredly confront other hospitals.

MOVING FORWARD

The issue at hand is how we create a better health care system. Working in tandem, I believe we can make more progress. Let me mention three of the more salient ways.

First, we stand ready to offer more support through The Joint Commission's Office of Quality and Patient Safety which helps hospitals conduct credible and unrelentingly thorough root cause analyses of serious patient safety events. This unique resource engages highly trained and experienced clinical staff in assisting a hospital in uncovering the system issues leading to an unexpected occurrence of a death or serious harm – what we call a Sentinel Event. The causes leading up to such serious adverse events almost always involve human factors interacting with multiple system failures. Our experts can

help a hospital understand where systems redesign and process improvement are needed to mitigate a similar occurrence in the future

Many hospitals voluntarily report Sentinel Events to us. Others go further: the Department of Defense has a regulation requiring such reporting.

Regardless of reporting, The Joint Commission requires that all hospitals experiencing a Sentinel Event immediately conduct a root cause type of investigation and develop a comprehensive response that includes a pathway to making the necessary preventative system changes. Nonetheless, we appreciate hospitals voluntarily reporting to us their Sentinel Events even if they do not wish assistance with root cause analysis. Such reporting informs The Joint Commission about the scope and frequency of safety events which then improves our accreditation programs and resources for all hospitals.

We appreciate that hospitals may have reticence to report, as it may trigger a "for-cause" survey. However, learning about Sentinel Events through other means may also do so in a less favorable context, as a working assumption is that the organization is not committed to transparency in addressing and remediating failure modes. Importantly, a for-cause survey is not meant to be punitive, but rather it is to provide assistance in remediating issues underlying a Sentinel Event. Voluntary reporting has informed our highly influential National Patient Safety Goals in areas such as infection control and wrong site surgery and has contributed to our issuing Safety Alerts, based on the unfortunate, if not tragic, learnings elsewhere. Cross-industry sharing of such information is critical in other fields that required high reliability, such as aviation and nuclear engineering.

Second, The Joint Commission can prepare customized reports for VHA's central office leadership on certain high-profile areas of interest. We have done this in the past when VHA asked that we conduct focused surveys in a short period of time so that leadership could get a more contemporaneous view of performance across all hospitals on selected quality issues.

Third, as I prepared for this testimony, I learned that The Joint Commission has had the opportunity to occasionally work with the VA's Office of the Inspector General, such as in a case where we shared information about problem spots in a particular facility. In that instance, parallel "for cause" investigations revealed similar concerns and deepened the understanding of failure modes, a key to implementing the effective remediation of critical issues. There is more potential here for collaboration with all elements of VA while assiduously guarding our respective obligations to provide VHA and Veterans with independent, reliable surveys and forthright findings.

CONCLUSION

In conclusion, The Joint Commission welcomes all opportunities to strengthen its partnership with the Federal government, and I believe there is additional ground to explore. We stand with you in commitment to building a safer system, and commit to being responsive to the Committee and to VA. As I noted earlier, I may not have all the answers, but I do know the right questions to ask to ascertain what needs remediation. I look forward to working with you in any manner that is constructive to our shared goals.

Thank you for inviting The Joint Commission to be here today.

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STATEMENT OF
GREGG S. MEYER, MD, MSc
BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS

11 MAY 2022

Thank you for the opportunity to submit this statement about the quality of healthcare provided to our nation's veterans. I have been asked to address several questions posed by the committee and will do so in turn. My responses reflect my perspective as a physician and proud U.S. Air Force veteran who has dedicated much of my career to improving the quality and safety of healthcare.

For this testimony, I use the most widely accepted definition of quality, which was articulated by a Committee on Medicare of the Institute of Medicine (IOM) in 1990. That definition, that "quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge," [1] has now been widely adopted in the quality measurement community. The recognition that a thorough assessment of quality demands attention to both individuals and populations was a significant broadening of the previous quality lens, which focused only on one patient at a time. The definition also acknowledges that even with the best possible processes for care delivery, we cannot guarantee a good outcome for all patients due to the inherent complexity of the human condition. The emphasis on "increasing the likelihood" of good outcomes rather than simply stating that quality equals good outcomes suggests that a unilateral focus on outcomes may not capture the true quality of care being delivered. The use of the term "desired" is also important since it requires consideration of the patient perspective (for example, will a patient be able to return to work?) rather than just the biomedical perspective (did the hospital avoid an infection?). Finally, the statement on consistency with "current medical knowledge" supports the notion that the definition of quality, and thus the measures to characterize it, are not static and should be expected to change over time. The evolution of our understanding of healthcare quality includes the further refinement of a nationally accepted framework for quality measurement and improvement articulated in the IOM's (now the National Academy of Medicine) 2001 landmark report *Crossing the Quality*

[1] Lohr, K., & Committee to Design a Strategy for Quality Review and Assurance in Medicare (Eds.). *Medicare: A Strategy for Quality Assurance*, Vol. 1. Washington, DC: IOM, National Academy Press, 1990.

Chasm.[2] That framework, now in wide use in civilian as well as VA care systems concluded that healthcare should be:

- *Safe*—avoiding injuries to patients from the care that is intended to help them.
- *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- *Patient-centered (or, in the case of the VA, Veteran-centered)*—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficient*—avoiding waste, including waste of equipment, supplies, ideas, and energy.
- *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

A fulsome assessment of quality needs to account for performance in all 6 domains.

How does the quality of health care provided to veterans in Department of Veterans Affairs' (VA) facilities and in civilian facilities compare?

The VA has a noble mission in fulfilling President Lincoln's promise to care for those who have borne the battle, for their families, and their caregivers. Providing healthcare consistent with the highest standards of quality is essential to meeting that mission. Although there have been times where the VA has clearly fallen short, for example the access crisis leading to the passage of the Veterans Access, Choice, and Accountability Act of 2014 and more recently the horrific tragedy at the Clarksburg the VA, it is important to not lose sight of the VA's leadership in healthcare quality. A 2003 report of the Institute of Medicine (IOM) entitled *Leadership by Example* recommended that federal direct care programs, include the Veterans Health Administration and the Military Health System, be used to evaluate policy options for improving quality and value. [3] In fact, the VA had already been a quality improvement leader prior to that publication. The VA's Surgical

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[2] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: The National Academies Press, 2001.

[3] Institute of Medicine. 2003. *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality.* Washington, DC: The National Academies Press. https://doi.org/10.17226/10537

Quality Improvement Program[4] created a national model for outcomes improvement in surgical care which was later adopted by the American College of Surgeons as the National Surgical Quality Improvement Program. The VA has also been an early leader in the collection of rigorous clinical data based on actual care rather than billing records and pioneered the application of systems engineering to quality improvement and safety. In addition, the VA was an early developer and adopter of quality enhancing technologies including electronic health records and telehealth. Given this history and the debt we owe to our nation's veterans it is safe to conclude that the VA has an obligation to lead in quality and safety.

With the availability of civilian or "privatized" options for federal direct care programs there have been a number of comparisons of the quality of care between these options asking the question - is direct care good value for the veteran and taxpayer? But comparability between study populations (veterans getting care within the VA compared with those who get civilian care, for example) is always challenging. Patient preferences, geography, availability of services, and prior experience with the VA or civilian care, along with other factors, can bias comparisons and lead to erroneous conclusions. This is equally true for comparisons among civilian institutions making over-interpretations of "differences" or what may be better or worse problematic. The findings are more directional than dispositive.

With that caveat in mind, a review of VA versus civilian care in all six domains of quality reveals a relative consistent direction. In terms of the *safety* and *effectiveness* quality domains these comparisons suggest that direct care in the VA has comparable, and in many cases, superior quality of ambulatory and inpatient care, compared with privatized civilian alternatives. These include numerous studies of specific medical conditions and therapeutic procedures which have made comparisons between the care received by veterans in the VA system with veterans who receive private care as well as comparisons

[4] Young GJ, Charns MP, Barbour GL. Quality Improvement in the US Veterans Health Administration, *International Journal for Quality in Health Care*, Volume 9, Issue 3, 1997, Pages 183–188.

of VA care to the general civilian population.[5] [6] [7] [8] Over half of those studies suggest care within the VA has superior quality and most of the others suggest VA care is on par with that delivered through the civilian healthcare system. Studies looking more generally at VA versus private care which are focused on populations rather than specific conditions or procedures, such as reviews of mortality[9] (some of which found a 20% reduction for those receiving care in VA versus civilian facilities), have come to similar conclusions. Over a range of commonly used metrics of inpatient and outpatient quality and safety, care within the VA system was better or similar to that in the civilian system and in most cases the VA was more transparent in its reporting of those metrics.[10] [11] Studies focused specifically on safety indicators have similar findings. [12]

In terms of *veteran-centered care* studies have generally found that VA facilities again matched or outperformed their civilian counterparts.[13] [14] [15] This is not surprising because throughout healthcare there is a growing trend toward tailoring healthcare services to

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[5] Kesseli SJ, Samoylova ML, Moris D, et al. Outcomes in kidney transplantation between Veterans Affairs and civilian hospitals: Considerations in the context of the MISSION Act. *Annals of Surgery.* 2020;272(3):506-510..

[6] Mody L, Greene MT, Saint S, et al. Comparing catheter-associated urinary tract infection prevention programs between Veterans Affairs nursing homes and non-Veterans Affairs nursing homes. *Infection Control & Hospital Epidemiology.* 2017;38(3):287-293.

[7] Dizon MP, Linos E, Arron ST, Hills NK, Chren MM. Comparing the quality of ambulatory surgical care for skin cancer in a Veterans Affairs clinic and a fee-for-service practice using clinical and patient-reported measures. *PLoS ONE [Electronic Resource].* 2017;12(1):e0171253. https://pubmed.ncbi.nlm.nih.gov/28141817/

[8] Nuti SV, Qin L, Rumsfeld JS, et al. Association of admission to Veterans Affairs hospitals vs non-Veterans Affairs hospitals with mortality and readmission rates among older men hospitalized with acute myocardial infarction, heart failure, or pneumonia. *JAMA.* 2016;315(6):582-592.

[9] Chan DC, Danesh K, Costantini S, Card D, Taylor L, Studdert DM. Mortality among US veterans after emergency visits to Veterans Affairs and other hospitals: retrospective cohort study. BMJ. 2022 Feb 16;376:e068099.

[10] Anhang Price R, Sloss EM, Cefalu M, Farmer CM, Hussey PS. Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings. J Gen Intern Med. 2018 Oct;33(10):1631-1638.

[11] Langhoff E, Siu A, Boockvar K, Bund L, Connell J, Hung W. The VA and non-VA experience of tracking good care. *Population Health Management.*

[12] Cullen SW, Xie M, Vermeulen JM, Marcus SC. Comparing rates of adverse events and medical errors on inpatient psychiatric units at Veterans Health Administration and community-based general hospitals. *Medical Care.* 2019;57(11):913-920.

[13] Eid MA, Barnes JA, Trooboff SW, Goodney PP, Wong SL. A comparison of surgical quality and patient satisfaction indicators between VA hospitals and hospitals near VA hospitals. *Journal of Surgical Research.* 2020;255:339-345

[14] Heidenreich PA, Zapata A, Shieh L, Oliva N, Sahay A. Patient ratings of Veterans Affairs and affiliated hospitals. *American Journal of Managed Care.* 2017;23(6):382-384.

[15] Stroupe KT, Hynes DM, Giobbie-Hurder A, Oddone EZ, Weinberger M, Reda DJ, Henderson WG. Patient satisfaction and use of Veterans Affairs versus non-Veterans Affairs healthcare services by veterans. Med Care. 2005 May;43(5):453-60.

particular market segments. Witness the growth of models such as OneMedical tailored to a younger employed population, Iora Health focusing on Medicare beneficiaries, and Oak Street Health servicing disadvantaged Medicaid/Medicare dual eligibles in the civilian healthcare marketplace. It is therefore not surprising veterans have a preference for their segmented healthcare offering, VA-based care.

Studies of *efficiency* in the VA generally demonstrate good value in terms of expenditures versus outcomes. One widely cited study by the National Bureau of Economic Research found that veterans cared for in VA hospitals had lower mortality rates and 21% lower spending relative to civilian healthcare.[16] The authors suggest that some of those benefits accrued from the continuity of care, advanced electronic health records, and integrated care offered within the VA. The VA has also demonstrated its capability in appropriately limiting utilization of costly services[17] and providing end of life care.[18]

The two quality domains where the VA faces the greatest challenge in comparisons with civilian care are *equity* and *timeliness*. Like the civilian healthcare system, the VA system continues to struggle with issues around equity, despite the absence of financial barriers to care.[19] Nevertheless the VA has again taken a leadership role. For example, in 2012 the VA, when confronted with evidence that there were disparities in care of veterans, established an Office of Health Equity.[20] That response pre-dated most of civilian healthcare by half a decade or more. Timeliness remains a persistent challenge but the most recent assessments of wait times suggest things are improving.[21] The evolving impact of the Veterans Choice Act on timeliness measures is an area where Congress should focus attention over time.

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[16] Chan DC, Card D, Taylor L. Is There a VA Advantage? Evidence from Dually Eligible Veterans. National Bureau of Economic Research Working Paper Series No. 29765, February 2022, http://www.nber.org/papers/w29765.

[17] Axon RN, Gebregziabher M, Everett CJ, Heidenreich P, Hunt KJ. Dual healthcare system use during episodes of acute care heart failure associated with higher healthcare utilization and mortality risk. *Journal of the American Heart Association.* 2018;7(15):e009054.

[18] Gidwani-Marszowski R, Needleman J, Mor V, et al. Quality of end-of-life care is higher in the VA compared to care paid for by traditional Medicare. *Health Affairs.* 2018;37(1):95-103.

[19] Saha S, Freeman M, Toure J, Tippens KM, Weeks C. Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review [Internet]. Washington (DC): Department of Veterans Affairs (US); 2007 Jun. PMID: 21155211.

[20] Atkins D, Kilbourne A, Lipson L. Health equity research in the Veterans Health Administration: we've come far but aren't there yet. *Am J Public Health*. 2014;104 Suppl 4(Suppl 4): S525-S526.

[21] Penn M, Bhatnagar S, Kuy S, et al. Comparison of wait times for new patients between the private sector and United States Department of Veterans Affairs medical centers. *JAMA Network Open.* 2019;2(1):e187096.

What measures should be used to compare VA versus civilian care?

Despite a legitimate desire for clarity and simplicity there is no single measure or "thermometer" which can capture all the domains of quality which must be assessed to ensure veterans are receiving the high-quality care they deserve from both VA and civilian facilities. Responsibility for the care of veterans cannot be simply "outsourced" without oversight. As a result, Congress should continue to be provided with information covering all six domains of quality. But oversight would be enhanced by ensuring that information is focused on the issues that matter most to veterans. Although benefits have accrued from the expansion of quality metrics the VA follows, the number of measures threatens to shift resources from improving quality in areas of greatest need to cover a plethora of quality-performance metrics that may have a limited impact on the things that really matter to veterans. Working with the VA, Congress should work towards policy which is balanced to meet the need of end users to judge quality and cost performance and the need of providers to continuously improve the quality, outcomes and costs of their services; and parsimonious to measure quality, outcomes and costs with appropriate metrics that are selected based on end-user needs.[22] This will require focusing on fewer metrics, avoiding over-emphasis on any particular domain (e.g. timeliness) at the expense of others, and ensuring that potentially perverse impacts from a focus on specific metrics are mitigated. An example of the latter would be increased readmissions as a result of a focus on decreasing inpatient length of stay. "Balancing measures," where significant areas of measurement are accompanied by tracking their potential downside impacts is one mechanism to help address this issue. As with previous work on quality, a collaboration between those providing Congressional oversight and VA leadership in defining a more focused framework could provide a national model for the civilian healthcare system.

In addition to the aforementioned issues with comparability, it is likely that ongoing oversight of VA versus civilian care of veterans will be challenged by data issues. Availability of data in community care, especially rural areas with less data infrastructure, will remain a challenge. Compared with most rural civilian facilities the VA has an electronic health record, data warehouses, and sophisticated analytic capabilities. In assessing VA versus civilian care Congress should be aware of this limitation and to the extent possible provide both the resources and requirement for quality reporting on metrics of interest as part of its expectations of civilian facilities caring for veterans.

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[22] Meyer GS, Nelson EC, Pryor DB, James B, Swensen SJ, Kaplan GS, Weissberg JI, Bisognano M, Yates GR, Hunt GC. More quality measures versus measuring what matters: a call for balance and parsimony. BMJ Qual Saf. 2012 Nov;21(11):964-8.

It is also essential that Congress avoid the temptation of extrapolating isolated failures to be universally indicative of widespread problems. In this regard the recent tragedy at the Clarksburg VA is neither a distraction nor is it indicative of failures of care with the VA overall. My own system, like all those engaged in the complex endeavor of delivering healthcare with a high reliance on both systems and humans, has faced similar challenges in the past. The key focus should be to understand what happened, why it happened, and what can be done to prevent it from happening again. Unfortunately, when events comparable to those at Clarksburg happen in civilian organizations there is often an effort to address the issue out of public view. The ongoing demand for transparency, focus on systems, and addressing issues across the system to ensure learning from failures are appropriate expectations we should have of the VA but perfection is not.

How can the quality of care provided in VA facilities be improved?

While comforting in terms of aggregate quality in general, the majority of studies comparing VA with civilian healthcare share another feature indicating that there is still significant opportunity for improvement. That is that within the VA system itself there is often wide variation across facilities. Such inter-facility and regional variation are a common feature of civilian healthcare as well. For example, my own system, Mass General Brigham, which has a national reputation for excellence, remains challenged by such variation.

Addressing variation in quality within the VA is essential and there are several elements required. The first is attention to the variation so improvement can be prioritized. This is a place where Congressional oversight is essential. The second is robust measurement covering all six domains in quality with meaningful benchmarks for each. A review of the QPS Enterprise Level Measure Set used by the VA for this purpose demonstrates that it is on par with or better than civilian dashboards for quality measurement and improvement. It includes information on mortality, avoidable adverse events, care transitions, patient experience, access to care, mental health, disease prevention and treatment, patient safety, and medication metrics, all benchmarked to performance within the VA system. The VA is large enough to be its own benchmark but additional benchmarking with civilian national and community performance would enhance the dashboard. When I compare it with the measurement dashboards used within my own system the two areas where additional metrics should be considered are those related to equity and workforce safety. In addition, measurements of employee engagement and safety culture, both of which are currently tracked by the VA, should be incorporated into these dashboards given their importance to quality and safety improvement.

The third is a robust methodology for improvement. Here the VA has been a national leader in embracing the tenets of High Reliability Organizations and the supporting Strategic Analytics for Improvement and Learning Value (SAIL) Model to measure, evaluate and benchmark quality and efficiency at medical centers which provide a national model for these activities. Daily safety huddles, regular metrics reviews, and creating leadership accountability are all important features of those methodologies. The final required element is appropriate resourcing and support for these activities -another area for Congressional attention. It is important to note that over the years investments in quality improvement in the VA have not only benefitted veterans but have also often served as prototypes which are scaled over the civilian healthcare sector. One example of that is the VA's creation of a National Center for Patient Safety which developed tools such as root cause analysis which are now used in healthcare organizations across the country.

The VA also has a rich history of leadership in research in quality which could help inform future quality improvement efforts. Studies using clinical data from electronic health records, prospective design, and carefully tailored comparable study populations to examine the quality and costs of VA as compared with civilian care should be encouraged. They will provide guidance on how to improve service delivery, efficiency, and benefit design to ensure that veterans receive the best care possible.

What are the future best practices for collecting and analyzing quality in the VA?

Over the last two decades, a variety of publicly available data sources have emerged that purport to provide patients with information about hospital quality and safety through "report cards" and "league tables" of performance. These ratings are published by CMS (e.g., Hospital Compare Star Ratings), U.S. News & World Report (e.g., Best Hospitals), Consumer Reports, the Healthgrades website, Leapfrog Group, and others and are based on compilations of quality indicators and measures, and in some cases are supplemented with survey data. The data sources used for creating indicators and less robust measures of quality can be problematic. Some of the data that is captured, for example, diagnostic codes using the ICD-10 classification system, has been shown to be unreliable for quality assessment purposes.[23] Exclusive reliance on quality and patient safety indicators and

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[23] Institute of Medicine. *Reliability of National Hospital Discharge Survey Data.* National Academy of Sciences, Washington DC, 1980. See also Institute of Medicine. *Reliability of Medicare Hospital Discharge Records.* National Academy of Sciences, Washington, D.C., 1977; Institute of Medicine. *Reliability of Hospital Discharge Abstracts.* National Academy of Sciences, Washington, D.C., 1977; Hsia DC, et al. "Accuracy of Diagnostic Coding for Medicare Patients Under the Prospective Payment System." *N Engl J Med* 1988;318:352-55; Fisher ES, et al. "The Accuracy of Medicare's Hospital Claims Data: Progress Has Been Made, But Problems Remain." *AJPH* 1992;82:243-48.

quality measures generated from administrative data (data derived from billing records) does not allow for a comprehensive quality analysis because these indicators are not direct measures of quality; rather they are approximate markers that indicate potential problem areas that need further review and investigation.

This is one area where the VA can once again take a lead in quality. The VA should leverage its capabilities in data science, the availability of clinical data from electronic health records, and its close relationships with veterans to move beyond the current set of metrics it, and the majority of civilian health facilities employ, to a new more meaningful generation of quality metrics. Those metrics should go beyond administrative data and indicators to include analyses of clinical data, produced in the process of care and abstracted directly from electronic health records. The generation of electronic Clinical Quality Measures (eCQMs) is a ripe area for continued VA leadership. In addition, given the loyalty of its patient population to VA care, the VA could become a leader in the collection of Patient Report Outcome Measures (PROMs). PROMs go beyond traditional metrics (did the surgery result in an infection or require a readmission?) to things that matter to veterans and families such as how well was my pain controlled, how quickly could I return to work, and was I able to perform activities of daily living that are important to me?[24] Future assessments of VA quality and its improvement should define the next generation of quality measurement, just as the VA provided early leadership in electronic health records, patient safety, and applying engineering approaches to the improvement of care.

Conclusion

The American public should be both reassured yet unsatisfied with the quality of care provided to its veterans. Reassured that the care provided by the VA direct care system is comparable to, and oftentimes better than, that available through civilian facilities in most of the domains of quality. Yet unsatisfied that we can do better for our veterans by continuing to improve care, learning from failures, and working to ensure that veterans will receive high quality care regardless of where they access the system. Finally, a fulsome assessment of the value of VA based care compared with that available in the civilian sector for veterans should incorporate an assessment of the full range of benefits and learnings the VA system affords. This includes not only the direct impact of that care on veterans and their families, but also an appreciation of the potential leadership role of the

[24] Basch E. Patient-reported outcomes—harnessing patients' voices to improve clinical care. *N Engl J Med.* 2017;376(2):105-108.

VA in defining and delivering care that our veterans deserve which can help the VA meet its ongoing responsibility to serve as a national model.

Questions for the Record

The Joint Commission

May 18, 2022

The Honorable Jon Tester
Chairman
Committee on Veterans' Affairs
U.S. Senate
311 Hart Office Building
Washington, D.C. 20510

The Honorable Jerry Moran
Ranking Member
Committee on Veterans' Affairs
U.S. Senate
521 Dirksen Office Building
Washington, D.C. 20510

[Re: *Examining Quality of Care in VA and the Private Sector* May 11, 2022, Hearing]

Dear Chairman Tester and Ranking Member Moran:

The Joint Commission appreciates the opportunity to submit for the record responses to questions asked during the May 2022 hearing on *Examining Quality of Care in VA and the Private Sector*.

1. Has The Joint Commission ever performed a "for cause" survey at a VA hospital as a result of a VA Office of Inspector General (OIG) findings / report? And, has a VA hospital ever lost accreditation based on findings of that survey?

From January 1, 2017, to May 11, 2022, The Joint Commission conducted 14 "for-cause" surveys because of findings in a VA OIG report. As noted in my witness statement, a "for cause" survey is an in-depth look into a specific concern and provides an extensive, deep view on a specific issue in a manner that cannot be accomplished during the triennial survey.

The Joint Commission has never denied accreditation based on the findings of a "for-cause" survey initiated because of an OIG report. It is important to note that OIG reports generally contain findings at a VA hospital that occur months and sometimes years prior to the report becoming publicly available. By the time the OIG report is available for The Joint Commission to review, the VA and the hospital usually have taken corrective actions to address the issues identified in the OIG report. Nonetheless, The Joint Commission will evaluate the issues identified in the OIG report and ensure that the hospital has taken appropriate corrective actions.

2. Has The Joint Commission ever revoked accreditation status of a VA hospital?

The Joint Commission has never revoked an accreditation status of a VA hospital. However, The Joint Commission has given a VA hospital an Accreditation with Follow-up Survey and Preliminary Denial of Accreditation decision. These are restricted accreditation decisions accompanied by significant requirements for improvement.

The Joint Commission
Washington, DC Office
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202 783 6655

3. Did The Joint Commission require Clarksburg VA to take corrective actions (follow-up) after the incident at the Clarksburg VA?

The Joint Commission learned of the events at Clarksburg VA about a year and half after the events and then The Joint Commission conducted an onsite "for-cause" survey. At the end of the survey, a Requirement for Improvement (RFI) was provided to hospital leadership. The Joint Commission required a plan of correction for the RFI with specified time frame for completion. The proposed corrective action was reviewed by Joint Commission's central office for completeness and its likelihood to resolve the deficiency. The hospital then submitted evidence to The Joint Commission demonstrating that the plan of correction resulted in compliance with Joint Commission standards.

If you have any questions regarding my responses, please do not hesitate to contact me or Margaret VanAmringe, Executive Vice President for Public Policy and Government Relations. She can be reached at 202-783-6655 or at mvanamringe@jointcommission.org. Also, The Joint Commission is readily available to meet with Committee staff to discuss any additional questions.

Sincerely,

Jonathan B. Perlin, M.D., Ph.D.
President and Chief Executive Officer

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans Affairs
United States Senate
Quality of Care Hearing
Examining Quality of Care in VA and the Private Sector

May 11, 2022

Questions for the Record from Ranking Member Jerry Moran

Question 1: The MISSION Act required VA to establish quality standards for VA direct care. If VA finds a medical service line is deficient, the Secretary is supposed to remediate the service line and report to Congress. In the three years since the publication of the quality standards, VA has yet to report a deficient service line to Congress. Can you explain what benchmark the Department uses to determine whether a medical service line is deficient?

VA Response: VA uses publicly reported quality measures that are widely used across U.S. health care as the benchmark to determine whether a medical service line is deficient. Our specific core measures (see the following table) align with the standards that Medicare and other payors use for Accountable Care Organizations. We note that these standards for quality, with associated measures, were proposed in a report submitted to Congress in March 2019 and were established in a Federal Register (FR) notice published on October 3, 2019 (84 FR 52932). In November 2021, additional public comment was sought on the standards for quality to ensure they were up-to-date and addressed Veteran priorities (86 FR 60969, dated November 4, 2021).

The process to designate VA medical service lines, which began in September 2019, is ongoing, with routine monitoring of relevant data throughout the year and an intensive annual review at the end of the year in alignment with key community benchmark data updates. The initial data surveillance for the standards for quality is followed by a detailed data evaluation by a national Technical Advisory Group for consideration of additional factors identified in VA regulations.

Over the past several years, VA's review process and deliberations took into consideration many challenging contextual factors affecting the U.S. health care sector, including the following: (a) impacts of the ongoing Coronavirus Disease 2019 (COVID-19) pandemic on healthcare operations, (b) community care delays (that may result in worse outcomes for Veterans), (c) staff shortages and recruitment challenges affecting the whole health care sector and (d) data limitations and cautions (internal VA and external health care industry data sources were significantly impacted by the COVID-19 pandemic which makes it difficult in many cases to accurately compare VA's performance to community benchmarks).

VHA Standards	Initial Measures
Timely Care: Provided without inappropriate or harmful delays	Patient-reported measures on getting timely appointments, care, and information Wait times for outpatient care
Effective Care: Based on scientific knowledge of what is likely to provide benefit to Veterans	Smoking and Tobacco Use Cessation Immunization for Influenza
	Breast and Cervical Cancer Screening
	Mortality Rates - Risk Adjusted Controlling high blood pressure Beta-blocker treatment after heart attack
	Comprehensive Diabetes Care – Blood Pressure and Glucose control
	Improvement in function (short-stay nursing home patients) Newly received antipsychotic medications (short-stay nursing home patients)
Safe Care: Avoids harm from care that is intended to help Veterans	Catheter and central line associated infection rates C. difficile infection rate
	Death rate among surgical patients with serious treatable complications
	Nursing home safety measures
Veteran-Centered Care: Anticipates and responds to Veterans specific needs	Patient's overall rating of the Provider Patient's rating of Coordination of Care
	HCAHPS Overall Rating of Hospital HCAHPS Care Transition Measure

Question 2: When comparing MISSION Quality Standards to SAIL, the two share several quality measures. However, unlike MISSION's Quality Standards, VA heavily uses SAIL to measure quality at VHA facilities. If a facility fails to meet SAIL's internal benchmarks, VA adds the facility to a list ranked by intervention engagement needs. This list includes several facilities and is updated quarterly with some facilities remaining on the list for multiple quarters or deteriorating. With so many shared measures, can you explain how a facility can appear on SAIL's intervention list for multiple quarters but somehow its service lines do not trigger remediation under the Quality Standards?

VA Response: VA's Strategic Analytics for Improvement and Learning (SAIL) is used for internal comparisons of the performance of VA medical centers (VAMC) to each other across multiple dimensions, not just quality of care, whereas the standards for quality established pursuant to 38 U.S.C. § 1703C are used to compare the quality of medical service lines at VAMCs to corresponding services available in the local community. A facility may appear on SAIL's list for support due to a decline compared to other VA facilities or a decline within the individual VAMC, but still exceed the quality of care available at local community facilities. Alternatively, local community facilities may not report two or more distinct and appropriate quality measures at the medical service line level, which is necessary for VA to exercise this authority pursuant to 38 U.S.C. § 1703(e)(1)(B)(ii).

Question 3: The Department's testimony touched on VA's expansion of the use of telehealth and other virtual care services during the COVID-19 pandemic. Can you share with the Committee how the quality of VA virtual care compares with the private sector?

VA Response: To demonstrate VA's comprehensive approach to Veteran experience and satisfaction, VA has implemented Office of Management and Budget (OMB)-approved telehealth surveys that were designed through extensive input from Veterans

and VA subject matter experts. The satisfaction surveys use the domains of Trust, Ease, Efficiency/Speed, Effectiveness and Emotion and are administered by email each week to a set of randomly selected Veterans who received telehealth outpatient services during the previous week. The telehealth surveys aim to capture data from approximately 5,000 respondents each month.

With the onset of the COVID-19 pandemic, the health care industry moved toward a more virtual health care model. However, the ability for VA to compare its quality indicators for virtual care to those of private sector is limited to mainly technology audio/visual aspects, thus limiting the ability to comprehensively compare virtual care metrics. Although developed specifically for VA, three questions on two of VA's telehealth surveys closely align with three telehealth questions that are included in a nationally recognized patient satisfaction survey administered by Press Ganey. Tables 1 through 4 that follow show that VA virtual care performs very similarly to the private sector.

Table 1. VA Telehealth at Home or Mobile Appointment Survey (March 1, 2020, to June 5, 2022).

VA: Telehealth at Home or Mobile Appointment Survey	VA Virtual Care	VA # of Responses
During my appointment, my provider made me feel at ease by explaining every step they took in a way that was easy to understand.	90.1	140,875
I was able to see the provider clearly by video.	86.3	140,875
I was able to hear the provider clearly by video.	86.0	140,875

Table 2: Private Sector Survey (March 1, 2020. to June 5, 2022).

Private Sector Telehealth Survey Questions	Private Sector	Private Sector # of Responses
Ease of talking with the care provider over the video connection.	91.52	442,741
How well the video connection worked during your video visit.	89.14	392,020
How well the audio connection worked during your video visit.	90.14	438,327

Important Notes:

- There are differences between the wording of the Press-Ganey survey questions in comparison to VA survey questions that may impact interpretation and response (e.g., VA's survey asks, "I was able to hear the provider clearly by video" vs. Press- Ganey asking "How well the audio connection worked during your video visit."

- VA scores for video-to-home experiences have improved steadily in 2022 as reflected in the following table (Table 3). This improvement likely can be attributed to concerted national efforts to improve the Veteran experience for video-to-home.

Table 3. VA Telehealth at Home or Mobile Appointment Survey (July 1, 2022, to September 28, 2022).

VA: Telehealth at Home or Mobile Appointment Survey	VA Virtual Care (7/1/2022 – 9/28/2022)	VA # of Responses
During my appointment, my provider made me feel at ease by explaining every step they took in a way that was easy to understand.	91.1	14,856
I was able to see the provider clearly by video.	88.8	14,856
I was able to hear the provider clearly by video.	88.9	14,856

- Differences may exist between VA facilities and Veterans compared with non-VA healthcare organizations and patients that also could explain differences in observed responses, for example:
  - Rurality: ~30% of Veterans live in rural areas where connectivity challenges may be more prevalent.
  - Medical/social complexity: published literature suggests that Veterans are more medically and socially complex than their non-Veteran counterparts, potentially influencing survey responses.

Table 4. Comparison of VA Telehealth at the Clinic Appointment Survey to Private Sector Survey (March 1, 2020, to June 5, 2022.)

VA: Telehealth at the Clinic Appointment Survey	Private Sector Telehealth Survey Questions	VA Virtual Care	Private Sector	VA # of Responses	Private Sector # of Responses
During my appointment, my provider made me feel at ease by explaining every step they took in a way that was easy to understand.	Ease of talking with the care provider over the video connection.	91.8	91.52	10,439	442,741
I was able to see the provider clearly by video.	How well the video connection worked during your video visit.	94.2	89.14	10,439	392,020
I was able to hear the provider clearly by video.	How well the audio connection worked during your video visit.	92.6	90.14	10,439	438,327

A review of literature related to patient satisfaction with virtual care in the private sector provided the following findings compared to VA telehealth survey data:

- Provider Perceptions of providing Quality Care during Telehealth Visit.[1] In a study conducted by the American Medical Association (AMA; COVID-19 Healthcare Coalition Physician Survey) that examined the use of telehealth and whether telehealth met the needs of patients during the COVID-19 pandemic, 59.6% providers "Agreed" or "Strongly Agreed" that "Telehealth has allowed our practice to provide more comprehensive quality care for patients." The Veterans Health Administration (VHA) also surveys health care providers and has a similar question. In VA, 91.9% of providers experienced with telehealth and 70.9% of providers that recently adopted telehealth into their clinical practice agreed or strongly agreed with the statement "I can provide comprehensive and quality care for select telehealth video visits."
- Preference for Telehealth.[2] In a study published in December 2021, by the Journal of the American Medical Association (JAMA), the authors sought to determine patient preference between telehealth and in-person care. In this study, approximately 21% of those surveyed preferred video visits compared to 53% who preferred in-person care. Comparing VHA data (during a similar survey time period), approximately 38% of Veterans who previously had a video visit preferred video visits compared to 43% who preferred in-person care.

Question 4: The Office of Connected Care has established specific quality standards for telehealth programming formalized under the Conditions of Participation, which includes 44 measures to evaluate performance and compliance. However, the Office of Connected Care has not yet provided staff with the outcomes data illustrating these high-quality care goals are being met, nor have we received any veteran satisfaction scores. Is it possible to receive this data?

VA Response: The Office of Connected Care (OCC) Virtual Care Scorecard and Dashboard provide quarterly and monthly updates on 44 quality and performance measures at the national, Veterans Integrated Service Network (VISN) and facility level. These updates include 11 Veteran satisfaction measures, which are evaluated against established benchmarks. These benchmarks and pertinent performance quality monitors are used to create an environment of high performance and are established based on national averages and strategic goals/targets that are agreed and approved annually in collaboration with key VA stakeholders, VA field-based staff, the Virtual Care Scorecard User Acceptance Review Group and OCC leadership. The Virtual Care Scorecard and Virtual Care Dashboard have been available starting in fiscal year (FY) 2022 and previous versions of these data reports have been available to VA staff since FY 2019. National outreach within VA for education and use of the Virtual Care Scorecard (and their previous versions) have been consistently offered since October 2018 to enable VA staff to track their progress. Data on Veteran satisfaction with and preferences for telehealth are routinely available to VA staff through a web-based

[1] 2021 Telehealth Survey Report | AMA (ama-assn.org).
[2] Assessment of Patient Preferences for Telehealth in Post–COVID-19 Pandemic Health Care | Health Care Delivery Models | JAMA Network Open | JAMA Network.

platform and have been shared on VA field-facing calls as well as with senior VA leadership and in previous Congressional responses.

- OCC has established specific quality standards for telehealth programs that are formalized under Conditions of Participation (COP), a model of continuous quality improvement that supports the implementation and sustainment of telehealth and connected care programs nationally. In combination with the COP standards and the Virtual Care Scorecard, the OCC Quality Management Program conducts evaluations of VISN program performance improvement plans, and provides national, regional and VAMC-based telehealth and connected care program evaluations of compliance with COP quality standards. The OCC Quality Management Program evaluates and monitors performance data, benchmarks and outcomes; critically reviews program implementation and operations; and identifies and encourages the implementation of strong or leading practices nationwide. COP standards are assessed quarterly by OCC using the Virtual Care Scorecard performance results, conference calls with VISN Telehealth Program Managers and the VISN's completed COP Standards and Self-Assessment Electronic Tool. Furthermore, the Peer Review Panel (PRP) is briefed on VISN performance and may make recommendations to support performance improvement and address any issues. These recommendations include VISN submittals of additional information, formal Performance Improvement plans and/or site visits by the OCC Quality Program Team.

- The National Association of Healthcare Quality (NAHQ) invited VA to present an overview of how VA measures and manages virtual care quality in 2021. The NAHQ indicated that the VA quality program for virtual care was an outstanding example of a comprehensive quality management process that was truly reflective of the NAHQ core framework.

- OCC made a snapshot of its scorecard information available in response to this request (see Attachment 1).

TAB 1B 8155182
Attach 1 Virtual Care

- In addition, VA provided information showing key Veteran experience scores for video care in the home, which is the most commonly used telehealth application (see Attachment 2).

TAB 1C 8155182
Attach 2 Veteran Exp

Patient safety relies on providers following best practices. More than 300 VA anesthesiologists have repeatedly written to leadership with concerns about the possibility VHA will move away from a physician-led anesthesia care model to allow nurses to provide anesthesia care independently. They cite concerns this will diminish the quality of care veterans receive and note physician-led care is a best practice employed by top healthcare systems across the country.

Question 5a: If VHA is striving to be a High-Reliability Organization, how do you incorporate such a widely held concern into VHA policy?

VA Response: As a High Reliability Organization (HRO), VA continuously monitors the quality and safety of care delivered to Veterans and works to ensure excellence for each Veteran in our care. Among the HRO principles we strive to uphold is Deference to Expertise, which recognizes that leaders must know and acknowledge those within the organization who possess specialized knowledge. VA takes the concerns of our employees seriously and listens to their input, always holding ourselves and our organization to the highest possible standard. It is important to note that the standards of practice referenced in previous letters are still in a developmental stage and there have been no changes to VA's model of care.

VA is developing national standards of practice to ensure safe, high-quality care for the Nation's Veterans and to ensure that VA health care professionals can meet the needs of Veterans wherever they are located. Importantly, the development of national standards of practice will not undo the longstanding team-based model of care already established within VA and delineated in VHA Directive 1123, National Anesthesia Service. Rather, national standards of practice are intended to strengthen team-based care and thereby generate the best possible access and outcomes for Veterans. VA has not yet finalized national standards of practice for any of our 49 health care professions, to include the Anesthesia Service.

As part of the process to develop the national standards, a draft of the standard will be sent to each State licensing board, will be available in the Federal Register for public comment and also will be posted on an internal VA mechanism for comment from all VA employees and our labor partners. We will review feedback from State licensing boards, professional associations, unions, VA employees and any other person or organization who informally provides comments. VA welcomes comments from the public and from VA employees and will make any changes as appropriate in response to the feedback received to help VA meet its mission and goals, and that are better for Veterans or VA health care professionals. VA continuously monitors the quality and safety of care delivered to Veterans and is committed to excellence for the Veterans we serve. We are committed to the provision of excellence in clinical care by using our highly skilled workforce in a manner commensurate with their training and expertise.

Question 5b: Has VA sent a response to these VHA anesthesiologists about their concerns?

VA Response: VA is aware of the "Stop the Line" letter sent by members of the Association of VA Anesthesiologists (AVAA) on January 19, 2022, and VHA responded on behalf of VA on May 5, 2022. In addition, VA leadership met with members of the AVAA to address their concerns on March 25, 2022. We treat responses to letters received from VA stakeholders very seriously. VA will continue to engage internal and external stakeholders regarding VA's national standards of practice. It is important to note that no decisions on any national standards have been made and these will be designed through extensive internal and external expert consultation with a focus on increasing Veterans' access to health care and improving health outcomes. We will publish every draft national standard in the Federal Register for public comment. In addition, VA will send every State Board a letter with information on the impact of the proposed national standard of practice on the specific State, with an opportunity for the State Board to respond. We also will ensure that VHA employees will have the ability to review and comment on any proposed standards before they are finalized.

Question 5c: If VA chooses to allow nurses to provide anesthesia care independently, how will VA monitor patient safety and health outcomes from anesthesia care?

VA Response: As previously mentioned in the response to Question 5b, no decisions on any national standards have been made and these will be designed through extensive internal and external expert consultation with a focus on increasing Veterans' access to health care and improving health outcomes. We will publish every draft national standard in the Federal Register for public comment. In addition, VA will send every State Board a letter with information on the impact of the proposed national standard of practice on the specific State, with an opportunity for the State Board to respond. We also will ensure that our VHA employees will have the ability to review and comment on any proposed standards before they are finalized.

Question 5d: How will VA change its standards of practice for nurse anesthetists if independent practice is associated with higher rates of negative patient outcomes in the future?

VA Response: As previously mentioned in the response to Questions 5b and 5c, no decisions on any national standards have been made and these will be designed through extensive internal and external expert consultation with a focus on increasing Veterans' access to health care and improving health outcomes. We will publish every draft national standard in the Federal Register for public comment. In addition, VA will send every State Board a letter with information on the impact of the proposed national standard of practice on the specific State, with an opportunity for the State Board to respond. We also will ensure that VHA employees will have the ability to review and comment on any proposed standards before they are finalized.

In their testimony, VA Inspector General Missal and other witnesses discussed the importance of having strong leadership in place to ensure VHA policies on quality and safety are being closely followed. They also discussed the need for higher-level review, such as from the VISN, when certain problems are identified with an employee or candidate. One current VHA surgeon is now in an acting supervisor role, yet VA previously had to pay four tort claims for this provider for negligence, performing the wrong procedure, causing major injury, and leaving foreign bodies in the patient. This employee was subject to review by the VISN Chief Medical Officer and was still permitted to perform surgeries, and even serve in a supervisory role.

Question 6a: Please explain why a provider can have this many documented cases of failing to meet the standard of care and still be able to perform surgeries on veterans at VHA.

VA Response: The general process for granting surgical privileges within VHA is in accordance with The Joint Commission standards and VHA policy. Privileging authority is solely with the Medical Center Director (MCD) based upon the unique evidence and totality of information provided for each provider. The information provided to the MCD upon which to base privileging decisions includes but is not limited to:

- Information gathered during credentialing including training, malpractice history, National Practitioner Data Bank (NPDB) review, licensure status, peer references, training and work history;
- Recommendation from provider's respective clinical service chief based upon specialty specific review of clinical history;
- Recommendation from the Executive Committee of the Medical Staff based upon clinical leadership's review of the provider's credentials, clinical history and service chief review; and recommendation from the VISN Chief Medical Officer (CMO), if applicable, for providers meeting the threshold for review based upon malpractice history.

While the MCD's privileging decisions are not delegable, national policy is in place to assess clinical performance on an ongoing basis including Focused Professional Practice (FPPE) evaluation for those with new privileges, Ongoing Professional Practice Evaluation (OPPE) for those who have passed their initial FPPE period and Continuous Query of the NPDB where monitoring for new reports is completed on an ongoing basis for all appropriate providers through an electronic interface between VHA's credentialing system, VetPro and the NPDB system.

Question 6b: What factors must a VISN CMO consider when reviewing providers for privileging or credentialing decisions when malpractice, tort claims, or other standard of care issues are present? Please provide any written policies.

VA Response: In accordance with VHA policy, VISN CMOs must review the malpractice case history of providers who meet one of the following:

- Three or more medical malpractice payments in payment history.
- A single medical malpractice payment of $550,000 or more.
- Two medical malpractice payments totaling $1,000,000 or more.

The VISN CMO provides a recommendation and summary of their review of the cases to the facility. MCSs are the only individuals who have privileging authority, which is at the facility level in accordance with facility Medical Staff Bylaws. The VISN CMO review is considered by the facility's Executive Committee of the Medical Staff, who in turn make a recommendation to the Director as to whether a privileging action is clinically warranted. The Director ultimately considers the recommendation, all facts related to the malpractice case and the review completed by the VISN CMO to make a final decision. See p. 8 of VHA Directive 1100.20 Credentialing of Health Care Providers (Attachment 3).

TAB 1D 8155182
Attach 3 VHA Directi

Question 6c: What factors must a medical center director or chief of staff consider for such a situation? Please provide any written policies.

VA Response: Factors for facility-level consideration related to a settled malpractice case would include but are not limited to the provider's practice history, complexity of the case, known complication rates, system issues, involvement of other providers and reviews from external peers. See VHA Directive 1100.20 Credentialing of Health Care Providers (Attachment 3).

TAB 1D 8155182
Attach 3 VHA Directi

Question 6d: What responsibility does a VISN or VACO have in monitoring privileging decisions at the facility and VISN level to ensure CMOs and local officials are using good judgement in decisions about providers with quality of care concerns?

VA Response: It is estimated that over 50,000 privileging decisions are made throughout VHA on an annual basis. These privileging decisions include routine granting of privileges or adverse actions including denial, reduction or revocations, which may only be made by MCDs as the Governing Body of the VAMC in accordance with The Joint Commission standards and VHA policy, respectively. MCDs make decisions based upon collaboration and recommendation from their respective Executive Clinical Medical Boards and consultation as needed from the Office of General Counsel, Workforce Management and Consultation, VHA Program Offices and their respective VISN Chief Medical Officer. The final decisions of the MCDs are not delegable, and accountability resides at that level of the agency.

If clinical competence concerns are triggered, defined processes for review are in place to complete focused clinical care reviews and to remove privileged providers from patient care during investigation for patient safety. Deviations from process become apparent through trends identified through many different methods including external audits and robust quality assurance reviews.

Question 7: I am concerned that VA has failed to fully integrate quality data to truly benefit veterans. In your testimony you note that veterans can compare VHA hospital performance with private hospitals on a Medicare compare website which includes a 1 to 5 star rating system. However, a cross check on VA's community provider website shows that 1 and 2 star hospitals are a part of the Community Care Network. Can you explain why information found in the hospital compare tool is not used to screen low ranking hospitals out of the Community Care Network?

VA Response: Although Optum is not contractually required to evaluate a facility's Centers for Medicare & Medicaid Services (CMS) star rating for participation in the VA Community Care Network (CCN), Optum does ensure all facilities are qualified and competent to render services to Veterans. Each facility must be successfully credentialed as part of their VA CCN onboarding. Every facility contracted for VA CCN participation must maintain the proper required licensure, accreditation (if applicable), malpractice insurance and must not have any sanctions from the Office of Inspector General, General Services Administration, appear on the CMS preclusion list, or have received any other disciplinary action by any Federal or State entity. In addition, all participating facilities are recredentialed at a minimum of every 36 months.

Optum also evaluates each VA CCN participating facility based on prescribed metrics outlined in the contract, which mirror the criteria found within the CMS Hospital Compare Tool. The measurements listed in the following table are used to determine if a given facility qualifies for the designation of Center of Excellence (COE), which is reported to VA on a quarterly basis. In the event a particular facility does not have sufficient data for statistical analysis, they are assigned a COE designation of "unknown" which should not be interpreted as an endorsement of the facility's quality of performance.

Measure Name	Measure Description
Patient Given Discharge Information	Patients who reported that YES, they were given information about what to do during their recovery at home
Patient Not Given Discharge Information	Patients who reported that NO, they were not given information about what to do during their recovery at home
Care Transition (Composite measure)	Patients who "Strongly Agree" they understood their care when they left the hospital
Care Transition (Composite measure)	Patients who "Agree" they understood their care when they left the hospital

Measure Name	Measure Description
Care Transition (Composite measure)	Patients who “Disagree” or “Strongly Disagree” they understood their care when they left the hospital
9-10 Overall Rating	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
7-8 Overall Rating	Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)
0-6 Overall Rating	Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)
Definitely Recommend the Hospital	Patients who reported YES, they would definitely recommend the hospital
Probably Recommend the Hospital	Patients who reported YES, they would probably recommend the hospital
Not Recommend the Hospital	Patients who reported NO, they would not recommend the hospital
Follow-up after hospitalization for mental illness	Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 7 days of discharge
Early management bundle, severe sepsis/septic shock	Percentage of patients who received appropriate care for severe sepsis and septic shock
MRI Lumbar Spine for Low Back Pain	Outpatients with low-back pain who had an MRI without trying recommended treatments (like physical therapy) first
AMI-Fibrinolytic in 30 min of ED arrival	Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival
AMI-Median time to transfer	Average number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital
Pressure sores (alternate Measure ID: PSI_3_Ulcer) Deaths among patients with serious treatable complications after surgery	Pressure Ulcer Rate
Deaths among patients with serious treatable complications after surgery (alternate Measure ID: PSI-4-SURG-COMP)	Inpatient Surgical Deaths
Collapsed lung due to medical treatment (alternate Measure ID: PSI-6-IAT-PTX)	Collapsed lung due to medical treatment
Broken hip from a fall after surgery (alternate Measure ID: PSI_8_POST_HIP)	Postoperative Hip Fracture
Bleeding or bruising during surgery (alternate Measure ID: PSI_9_POST_HEM)	Perioperative Bleeding/Bruise

Measure Name	Measure Description
Kidney and diabetic complications after surgery (alternate Measure ID: PSI_10_POST_KIDNEY)	Postoperative Kidney & Diabetic Complications
Respiratory failure after surgery (alternate Measure ID: PSI_11_POST_RESP)	Postoperative Respiratory Failure
Serious blood clots after surgery (alternate Measure ID: PSI-12-POSTOP-PULMEMB-DVT)	Perioperative Blood Clot/Embolism
Blood stream infection after surgery (alternate Measure ID: PSI_13_POST_SEPSIS)	Postoperative Sepsis
A wound that splits open after surgery on the abdomen or pelvis (alternate Measure ID: PSI-14-POSTOP-DEHIS)	A wound that splits open after surgery on the abdomen or pelvis
Accidental cuts and tears from medical treatment (alternate Measure ID: PSI-15-ACC-LAC)	Accidental cuts and tears from medical treatment
	Central line-associated bloodstream infections (CLABSI) in ICUs and select wards
	Catheter-associated urinary tract infections (CAUTI) in ICUs and select wards
	Surgical site infections (SSI) from colon surgery
	Surgical site infections (SSI) from abdominal hysterectomy
	Methicillin-resistant Staphylococcus Aureus (MRSA) blood infections
	Clostridium difficile (C.diff.) intestinal infections

Furthermore, participating VA CCN providers are continuously monitored through concurrent processes conducted by Optum's Clinical Quality and Program Integrity Departments. As the PQI CCN contract states in section 14.2, Clinical Quality and Patient Safety Issues: 14.2 Clinical Quality and Patient Safety Issues Identification, "The Contractor must identify, track, trend, and report interventions to resolve any Potential Quality Issues (PQI), Potential Safety Issues (PSI), Identified Quality Issues (IQI), or Identified Safety Issues (ISI) using performance metrics such as the National Quality Forum (Serious Reportable Events, CMS Hospital Acquired Conditions, and Agency for Healthcare Research and Quality Patient Safety Indicators)." The Contractor shall adhere to processes identified in VA Guidance (e.g., VHA OCC Patient Safety Guidebook, VHA Patient Safety Handbook 1050.01).

As to Fraud, Waste and Abuse (FWA), in the contract, section 12.9, Claims Auditing, VA requires the contractor to always ensure that fraud, waste and abuse (FWA) detection analytics are inherent in its claims processing system. The Contractor must always share information when FWA is substantiated for any payments for which they were reimbursed by VA. The Contractor must always make every reasonable attempt to

recover all improper payments for services rendered to Veterans or for persons who were not eligible to receive a benefit. Optum's Clinical Quality Department reviews each Potential Quality Issue (PQI), which may be reported at any time by anyone. Similarly, Optum's Program Integrity Department performs routine claims analysis and reviews all reports of suspected FWA.

Questions for the Record from Senator Blackburn

In your testimony, you also mentioned that VHA undertook an enterprise-wide initiative, the High-Reliability Organization (HRO) Journey to Zero Harm, to enhance the overall culture of safety and decrease patient harm events across the organization. "Stop the Line" is an essential component of patient safety and one of the principles stressed as part of VHA's Journey to becoming a High Reliability Organization (HRO). Also, in an HRO, all employees, regardless of rank or title, are empowered to speak up in the interest of patient safety.

Question 1: Are you aware that hundreds of VA anesthesiologists have formally invoked VA's "Stop the Line" patient safety whistleblower program in response to VA's possible shift from the Anesthesia Care Team model to a CRNA/nurse-only model?

VA Response: VA is aware of the "Stop the Line" letter sent by members of the Association of VA Anesthesiologists (AVAA) on January 19, 2022, and VHA responded on behalf of VA on May 5, 2022. In addition, VA leadership met with members of the AVAA to address their concerns on March 25, 2022. We treat responses to letters received from VA stakeholders very seriously. VA will continue to engage internal and external stakeholders regarding VA's national standards of practice. It is important to note that no decisions on any national standards have been made and these will be designed through extensive internal and external expert consultation with a focus on increasing Veterans' access to health care and improving health outcomes. We will publish every draft national standard in the Federal Register for public comment. In addition, VA will send every State Board a letter with information on the impact of the proposed national standard of practice on the specific State, with an opportunity for the State Board to respond. We also will ensure that VHA employees will have the ability to review and comment on any proposed standards before they are finalized.

Question 2: Are you aware that these individuals expressed concerns that if the VA moved forward with this change, it would jeopardize the quality of Veterans' health care and unnecessarily put Veterans' lives at risk?

VA Response: VA is aware of these concerns and is considering all feedback during the development process for the National Standards of Practice. As a High Reliability Organization (HRO), VA continuously monitors the quality and safety of care delivered to Veterans and works to ensure excellence for each veteran in our care. HROs are organizations that achieve safety, quality and efficiency goals by employing five central principles, including sensitivity to operations, reluctance to simplify, preoccupation with failure, deference to expertise and practicing resilience, and VA strives to continuously meet these goals, always holding ourselves and our organization to the highest possible standard. It is important to note that we have not made any changes to our current team-based model of care. More specifically, there have been no proposals made to eliminate valued physician anesthesiologists from the care of Veterans. We greatly

value the input of anesthesia providers in VA and appreciate and welcome their input throughout this process.

Question 3: Are you aware that these VA anesthesiologists have not received a response from the VA regarding their concerns?

VA Response: VA is aware of the "Stop the Line" letter sent by members of the Association of VA Anesthesiologists (AVAA) on January 19, 2022, and VHA responded on behalf of VA on May 5, 2022. In addition, VA leadership met with members of the AVAA to address their concerns on March 25, 2022. We treat responses to letters received from VA stakeholders very seriously. VA will continue to engage internal and external stakeholders regarding VA's national standards of practice. It is important to note that no decisions on any national standards have been made and these will be designed through extensive internal and external expert consultation with a focus on increasing Veterans' access to health care and improving health outcomes. We will publish every draft national standard in the Federal Register for public comment. In addition, VA will send every State Board a letter with information on the impact of the proposed national standard of practice on the specific State, with an opportunity for the State Board to respond. We also will ensure that VHA employees, will have the ability to review and comment on any proposed standards before they are finalized.

Question 4: How can VHA strive to be a High Reliability Organization if they continue to ignore these whistleblowers?

VA Response: As noted in an earlier response, VA received a "Stop the Line" letter from the Association of VA Anesthesiologists dated January 19, 2022. This was responded to on behalf of VA on May 5, 2022. VA welcomes the input of employees and takes all concerns regarding patient safety very seriously. As valued members of the VA anesthesia community, the expertise of anesthesia providers is essential to the excellence that VA care teams deliver for Veterans. The letters invoke "Stop the Line," which is a VA-wide initiative that empowers employees to speak up immediately if they identify a potential or actual risk to patients, encouraging employees to report behaviors, actions or inaction that could potentially result in errors or patient harm. As an HRO, VA continuously monitors the quality and safety of care delivered to Veterans and works to ensure excellence for each Veteran in our care. Among the HRO principles we strive to uphold is Deference to Expertise, which recognizes that leaders must know and acknowledge those within the organization who possess specialized knowledge. It is important to note that the standards of practice referenced in your letter are still in a developmental stage and there have been no changes to date in VA's model of care. VA is committed to delivering exceptional health care and services to the Nation's Veterans, and each anesthesia provider is a valued member of our world-class workforce. We appreciate their investment in ensuring VA continues to deliver safe, high quality anesthesia care to Veterans.

Question 5: When can we expect Secretary McDonough to meet with the VA anesthesiologists?

VA Response: Specialty Care Services leadership has been closely involved in the communications regarding the responses to VA anesthesiologists and participated in a group call with the Association of VA Anesthesiologists' leadership on March 25, 2022, to address their concerns. The newly appointed Undersecretary for Health has expressed his intention to meet with physician anesthesiologists and certified registered nurse anesthetist groups to understand the concerns of both groups of providers.

Questions for the Record from Senator Hirono

A recent OIG report found that 98 percent of VHA facilities identified at least one severe occupational staffing shortage. Inadequate staffing can be the root cause of negative patient care due to overworked staff or staff being stretched too thin, as well as increased wait times. On top of a large number of existing vacancies at some facilities, the OIG's testimony mentioned that 19 percent of staff reported burnout and 25 percent of staff experienced "high" or "extreme" stress levels associated with COVID-19. VA has struggled with staffing issues for a long time.

Question 1: How does the Department plan to handle these issues, especially considering potential increases in turnover related to burnout?

VA Response: As the operator of the largest integrated health care delivery system in America, VHA has workforce challenges that mirror those of the health care industry at large. Despite those challenges, VHA talent acquisition strategies have resulted in more than 87,500 new hires in FY 2020 and FY 2021 combined, and growth rates of 4.0% and 2.2%, respectively. Changes brought by the COVID-19 pandemic and other employment and economic realities, however, have resulted in significant changes in the landscape for VHA, including higher turnover rates and extremely low or no growth in critical occupations.

VA initiated a Reduce Employee Burnout and Optimize Organizational Thriving (REBOOT) task force to help alleviate burnout and promote employee well-being. VHA is addressing staffing challenges directly. One way is through a series of Nationwide Hiring and Onboarding Surge Events. These surge events promote VHA as the health care employer of choice and accelerate the onboarding experience for those currently in the hiring pipeline. So far, 45 VAMCs across every VISN have held a surge event, resulting in more than 2,500 potential new recruitments.

Question 2a: Further, every year since 2014, Nurse occupations were identified as severe shortages. The ongoing shortage, exacerbated by the COVID-19 public health emergency, puts the health of our nation's veterans at risk. Problems recruiting and retaining nurses are even more difficult in high cost of living states like Hawaii. The RAISE Act, which I cosponsored, will hopefully help when it comes to nursing shortages. How else does the Department plan to recruit and retain nurses?

VA Response: This year, VHA is rolling out a new product to put workforce data and top recruitment and retention strategies all in one place for critical shortage occupations. The first of these workforce blueprints was published for nursing occupations earlier this year.

The top 10 recruitment and retention strategies for immediate implementation are:

1. Use Education Debt Reduction Program (EDRP) to target hard-to-recruit and retain nurse specialties.
2. Use staffing methodologies, future forecasting and leverage VA-Trainee Recruitment Events to proactively identify the talent requirements for today and tomorrow to manage the talent pipeline.
3. Expand schedule flexibilities, such as part-time, intermittent and 72/80 work schedules.
4. Use recruitment, retention and relocation (3R) incentives for nurses.
5. Employ nurse recruiters at every facility and develop through Nurse Recruiter Orientation and Nurse Recruiter University.
6. Use online recruiting tools such as those available for the Hire Right Hire Fast model which uses a standardized and team-centric approach for developing candidate pipelines and hiring candidates more quickly and the Total Rewards Brochures that lay out the monetary and non-monetary value of a rewarding career in VA.
7. Implement an Employee Referral Awards Program.
8. Develop local marketing, recruitment, social media platforms and hiring processes to build recruitment pipelines.
9. Implement Stay in VA, an employee-centered strategy designed to improve retention by focusing on employee experience through regular engagement.
10. Use education and scholarship programs to develop highly qualified nursing professionals.

Question 2b: Does VHA recruit nurses from the Philippines to help alleviate these staff shortages?

VA Response: VHA routinely hires U.S. citizens or naturalized U.S. citizens with foreign nursing education from the Philippines who possess a current, full, active and unrestricted registration as a Nurse from a State's board of nursing. In the case of hiring non-citizens in Nurse roles, in addition to registration, there are three requirements:

1. Non-citizens may only be appointed when it is not possible to recruit qualified citizens and when they possess eligibility/status for employment. See 38 U.S.C. § 7407.
2. English Language Proficiency. In accordance with 38 U.S.C. 7402(d), no person shall serve in direct patient care positions unless they are proficient in basic written and spoken English.
3. Non-citizen hires must be graduates of a school of professional nursing approved by the appropriate State-accrediting agency and accredited by either the Accreditation Commission for Education in Nursing or the Commission on Collegiate Nursing Education at the time the program was completed by the applicant or meet the foreign nursing education requirement.

Question 2c: How do staffing shortages, especially shortages of nurses, impact the quality of care available at VA?

VA Response: Facilities engage in several strategies to ensure patient quality is not compromised, irrespective of the discipline within the health care team that is experiencing a shortage. VA is reviewing quality, safety and satisfaction across multiple indices and taking appropriate measures to provide resources and guidance. VA remains fully committed and capable of meeting its primary mission of providing timely, patient-centered and high-quality care to each Veteran.

Question 3: I have heard from constituents in Hawaii who do not live on Oahu that it can be difficult to access the most up-to-date maternal and fetal care. This is especially true for those in need of high-risk obstetric care, homeless veterans, and other groups with special needs. In states that have rural or remote women veterans, like Hawaii, how does VA ensure those veterans are able to access quality care?

VA Response: Across the country, millions of pregnant and postpartum people live in maternity care deserts (i.e., counties that lack hospitals with obstetric care, maternity specialists, birthing centers or individual obstetric providers).[3] VA recognizes the severity of this problem and the importance of ensuring all pregnant and postpartum Veterans using VA for maternity care, including those living in rural and remote areas, receive high-quality maternal care. VA has implemented a variety of unique solutions to address this critical issue and expand Veterans' access to care.

Although some maternity care services such as pregnancy-related services might be available at the Veteran's assigned VAMC (such as pregnancy-related education, e.g., breast-feeding and lactation classes, child-birth preparation classes, etc.), VA does not generally provide obstetric care in its facilities. Obstetric services are furnished by authorized community providers. VA established the Maternity Care Coordination program, which may be conducted entirely remotely. Maternity care coordinators (MCC) conduct regularly scheduled calls with Veterans throughout the pregnancy and postpartum period. During the Veteran's pregnancy, the MCC assists the Veteran in coordinating care with community maternity providers and VA health care providers and navigating VA maternity care benefits. Postpartum, the MCC ensures the Veteran is engaged with VA primary care and has access to appropriate resources and services. In addition, throughout the Veteran's pregnancy and postpartum period, the MCC screens for overall wellbeing and social determinants of health and provides resources and support, as needed.

[3] March of Dimes. (2020). Nowhere To Go: Maternity Care Deserts Across the U.S. (p. 5). Retrieved 5.26.2022. 2020-Maternity-Care-Report-eng.pdf (marchofdimes.org).

Veterans who use VA for maternity care may have a higher burden of mental health conditions compared to their civilian counterparts.[4] Pregnancy and the postpartum period is a time during which access to providers with mental health expertise is critically important. To address this need, the VA Office of Mental Health and Suicide Prevention has developed a national reproductive mental health consult service. This service is available to VA providers and staff across the health care system to provide expert recommendations tailored to the individual Veteran's needs.

To further reduce barriers to care, VA's Office of Connected Care and VA Homeless Programs provide eligible Veterans with smart devices such as smartphones with time-limited pre-paid data plans and tablets with pre-installed broadband connectivity. These devices ensure that all Veterans, regardless of their location or resources, have access to VA and community services, including but not limited to, maternity care.

VA recognizes that homeless Veterans, especially those who are pregnant, represent a vulnerable population, often with intersecting social and economic challenges. To address these multifaceted issues, VA's Homeless Programs Office provides wraparound support services, many of which can be provided remotely, to support homeless Veterans' health care, mental health, housing and employment needs. The smart devices discussed previously herein also can help ensure homeless Veterans remain connected to their care.

Finally, to the extent that maternity care services cannot be provided remotely, Veterans eligible for VA's Beneficiary Travel program can be reimbursed for mileage and other travel expenses to and from approved health care appointments. Through the programs and services previously mentioned herein, VA strives to provide all pregnant and postpartum Veterans, regardless of their location or other challenges, with high-quality coordinated maternity care.

Question 4: During the hearing, I asked about delays in prescription refills, including for my constituents in Hawaii. While I understand that VA doesn't have control over USPS, are there steps the Department can take to provide other refill options for veterans who may be experiencing delays?

VA Response: Yes, the VA Pacific Islands Health Care System has a contract in place so VA pharmacists or providers may authorize prescription fulfillment services at a retail pharmacy if Veterans experience a delay in their prescription delivery by mail. Veterans are encouraged to order their refills at least 10 days before their next prescription refill is needed. Prescriptions mailed by the VA Consolidated Mail Outpatient Pharmacy to Hawaii average 3.55 days for delivery.

[4] Combellick JL, Bastian LA, Altemus M, Womack JA, Brandt CA, Smith A, Haskell SG. Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans. J Womens Health (Larchmt). 2020 Apr;29(4):577-584. doi: 10.1089/jwh.2019.7948. Epub 2020 Jan 6. PMID: 31905319.

Questions for the Record from Senator Sinema

Question 1: What lessons and best practices has the VA learned from the pandemic that they can implement into their care of veterans located in inaccessible, rural areas or incapable of physically coming to the VA?

VA Response: Throughout the COVID-19 pandemic, the VHA Office of Rural Health (ORH) continued its active collaboration with clinical program offices to extend a wide variety of clinical services into the homes and communities of Veterans who live in rural and highly rural areas, or who may be incapable of physically traveling to a VA facility for their care. During the COVID-19 pandemic, VHA learned to apply existing technology and resources in new and different ways to ensure the continued delivery of care and services to rural Veterans. From across-the-board increases in the use of telehealth technology that extend care into Veterans' homes, to the rapid implementation of vehicle sterilization processes in the Veterans Transportation Program, VHA quickly adopted new ways of doing things that have proven to be best practices; for example, several ORH-funded enterprise-wide initiatives, including the Clinical Resource Hubs (CRH), Veterans Transportation Service (VTS) and Home-Based Primary Care (HBPC) programs, proved instrumental in the delivery of uninterrupted care to rural Veterans during the COVID-19 pandemic.

ORH, in collaboration with the Office of Connected Care, established CRHs within all 18 VISNs. The CRHs are dedicated to delivering primary care, mental health, medical specialty, surgery and rehabilitative services through virtual and in-person modalities to Veterans and facilities. The CRHs offer a nimble platform to shift clinical resources to the greatest area of need within each VISN. This arrangement was pivotal during the COVID-19 pandemic, with CRHs supporting numerous sites experiencing COVID-19 case surges. CRH services that peaked during the COVID-19 pandemic included: infectious disease, social work, palliative care, primary care, call centers and COVID-19 hotline support. Without the CRHs, Veterans may have experienced delayed care. VHA continues to expand CRH services and has identified more than 40 new and promising practices developed since inception of the CRH program in October 2019. VA has taken measures to disseminate and spread these practices across the enterprise to meet the needs of Veterans where they live.

VTS and ORH have a long-standing collaborative partnership focused on improving rural Veterans' access to care and expanding transportation resources to mitigate transportation barriers to Veterans.

During the COVID-19 pandemic, rural Veterans experienced transportation barriers that were exacerbated due to the reduction in the number of non-VA transportation options available. Rural ambulance programs were overwhelmed and had limited capacity to simultaneously transport multiple patients due to social distancing requirements, and some rural transportation services simply had to curtail services or close completely due to a lack of available back-up staff to continue operations. As a result, more rural Veterans missed appointments and did not receive needed care (or their care was

delayed). This transportation problem was especially acute for Veterans requiring transfer to higher level of care facilities.

To minimize the impact to Veterans and to continue to operate and provide safe transportation services during the COVID-19 pandemic, VTS initiated sophisticated vehicle disinfection practices and provided complete personal protective equipment (PPE) for transport drivers. These measures allowed rural VTS programs to continue throughout the pandemic.

The VHA HBPC program, a unique model of home care, was a valuable resource during the COVID-19 pandemic. The HBPC program targets Veterans with complex chronic diseases that worsen over time. HBPC provides interdisciplinary, cost-effective primary care, palliative care, rehabilitation, disease management and coordination of care in a Veteran's home. Currently, HBPC teams are active in all 50 States, as well as the District of Columbia, Puerto Rico and Guam. Prior to the COVID-19 pandemic, 46% of HBPC clinicians surveyed were using telehealth (telephone and video) care delivery options. This usage rose to 90% during the COVID-19 pandemic. In addition, in FY 2019 (pre-COVID-19 pandemic), only 5% of Veterans served by HBPC received a home video visit, but in FY 2022 the percentage of home video visits increased to 54%. HBPC clinicians learned from the COVID-19 pandemic they can provide stronger support for Veterans living at home when they incorporate telemedicine (phone and video) technology to supplement and support overall health and wellbeing.

During the COVID-19 pandemic VA reaffirmed that it is vital to be adaptive, agile and resourceful. Telehealth technology and in-place VTS allow VA to continue to provide care and services to Veterans where they live.

Question 2a: My team has heard about systematic barriers female veterans face when accessing healthcare and benefits. What processes have been put into place following the Deborah Sampson Act?

VA Response: Title V of Public Law 116-315, the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, also known as "the Deborah Sampson Act of 2020," was established to enhance and improve VA's women Veterans' health care programs and delivery of health care services for women Veterans as well as address issues such as health care access; harassment and sexual assault; military sexual trauma; and gender-specific prosthetics.

VA has enhanced provision of care to women Veterans by focusing on the goal of developing designated Women's Health Primary Care Providers (WH-PCP) at every site where women access VA. As of 2022, 85% of women overall were assigned to a specially trained or experienced designated WH-PCP, which has been shown to enhance satisfaction and quality of care. To ensure we meet the needs for the increasing numbers of women Veterans, VHA is rapidly increasing access to trained designated Women's Health Providers through large scale educational initiatives and has now trained over 5,840 primary care providers since 2008. Educational efforts

include hosting national mini-residency programs at training conferences each year, local mini-residency programs and the newest training at rural sites. In response to the Deborah Sampson Act of 2020, a third national mini-residency program was held in 2022.

VA now has at least two WH-PCPs at all of VA's health care systems and 93% of community-based outpatient clinics have a WH-PCP in place. VA is in the process of training additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a WH-PCP.

In 2021, VA launched the Women's Health Innovation and Staffing Enhancements (WHISE) program. WHISE provides an opportunity for sites to apply for specific purpose funding for women's health personnel including women's health primary care providers and nurses, or special programs such as pelvic floor physical therapy or breastfeeding support and lactation classes, to mitigate local gaps in availability of women's health personnel.

Between FY 2021 and FY 2022, $150 million was distributed to the field across all 18 VISNs in support of over 800 positions, programs and mammography and specialty equipment for women Veterans with limited mobility.

VA is ensuring that all sites have a full-time Women Veteran Program Manager (WVPM) without collateral duties. In 2021, 137 health care systems had a full or part time WVPM.

Question 2b: How has the implementation of dedicated primary care providers affected their access to care, and what are their wait times compared to the overall veteran population?

VA Response: As of FY 2021, men and women Veterans who were established patients seeking primary care and mental health appointments received equitable timeliness.

Question 3: Currently the VA is the only health system that does not use FDA-cleared reprocessed single-use devices. What are your thoughts on making the switch, and would it allow for a reduction in emissions, waste, or cost?

VA Response: At least three VHA national workgroups have convened over the last 13 years to determine whether VHA should use reprocessed single-use devices. Each time, and most recently in December 2021, VHA determined not to use reprocessed single-use devices .

Question 4a: The VA has been plagued with a history of long wait times for patients needing appointments. What procedures has the VA put into place to

reduce wait times, and how can congress support you if further implementation is needed?

VA Response: VA is strengthening its commitment to improving timely access to world-class care for Veterans. As an organization, we are incorporating best practices learned during the COVID-19 pandemic, building on existing initiatives and developing new ones to ensure the way we schedule Veteran appointments results in timely care and a better overall Veteran experience. We regularly review access to care across the agency to ensure care is available when it is clinically appropriate while identifying and resolving potential gaps or barriers.

Wait times are an important component of timely access. Veterans tell us that in addition to just being faster, timely care means getting care when it is clinically needed and when convenient for them. Veterans also cite coordination and continuity of care, quality, equity and trust in VA as being as, or even more, important to them.

Veteran experience continues to be at the core of VA's approach. VA recently brought together teams that manage policies and processes for Veteran care from VA and community providers. Aligning these teams and the work they do under one organization is going to make it easier for Veterans to get the care they need when and where they need it.

VA's FY 2023 budget request would support critical investments so VA can continue to provide the care and benefits America's Veterans, families, survivors and caregivers have earned and deserve. VA's total FY 2023 budget request is $301.4 billion, a 11.3% increase above the FY 2022 request. The FY 2023 request supports 435,926 full-time equivalent employees (FTEs), an increase of over 10,496 from the FY 2022 budget request level. The majority of the increase, 8,945 FTEs, is in medical care, which will allow VA to meet continued growth for VA provided health care services, particularly due to COVID-19-related deferred care returning in FY 2023.

Question 4b: Is the VA using reported wait times to task and resource your workforce? What additional authorities do you need to provide flexibility to meet this challenge?

VA Response: As referenced previously herein, VA uses reported average wait times as one of many measures to monitor access and address resources. Other metrics that are used to plan for resources include, but are not limited to vacancy rate, turnover and growth.

Question 5a: The VA Electronic Health Record Modernization (EHRM) Program continues to create challenges, from cost and schedule overruns to cybersecurity vulnerabilities. We recently heard a report that at a VA hospital in Washington,

the system has crashed more than 50 times. Do we need to be rethinking this process?

VA Response: From August 8, 2020, through May 23, 2022, there have been a total of 42 unplanned degradations and 9 unplanned outages, none of which prevented patient care. The majority of the events experienced by VA were not total outages, but rather latency issues, which resulted in the slowing of the system, but it was still functional, and patients were still seen and treated.

Despite these challenges, VA is confident in moving forward with its new Electronic Health Record (EHR) system. In fact, VA anticipated that there would be periodic outages and degradations, as with any system in commercial practice, and is working diligently to address them. We are using lessons learned from each of our initial operating capability sites to identify areas for changes and further hone our processes to benefit future site deployments. Based on these lessons learned, we are well positioned to alleviate any outage and degradation concerns going forward and are planning appropriately for the future, preventing any issues with limited capacity or access to service.

VA's enterprise-wide effort to modernize the EHR system is one of the most complex clinical and business transformation endeavors in the Department's history. It is an opportunity for VA to fundamentally change the delivery of health care through standardization of its operations to deliver consistent, high-quality care wherever Veterans seek it. For example, automated integrated functions in the new EHR system have already proven to help providers get their work done faster, as experienced in our laboratories where they are able to process more specimens than with the legacy system and with greater frequency. It has also improved the user experience by moving key functions from multiple applications to one. This automation and integration of capabilities represents a significant change from how VA is managing our health records in the legacy system.

Question 5b: What does an outage mean for the patient on the ground?

VA Response: With the proper protocols in place, an outage should have no noticeable effect on a patient's seamless access and provision of care. VA has protocols in place that allow providers to continue administering safe and effective care during downtime. For sites where the new EHR has been deployed, the facility and VHA have updated their standard operating procedures (SOP). These processes improve communication and ensure patient care continues in an environment focusing on patient safety that reflects the best practice guidelines established by VHA. These SOPs include local staff specific downtime processes for documentation, orders, results retrieval and charging associated with system downtime.

Question 5c: What sort of feedback are you getting from the medical professionals when they interact with this system and its unreliability?

VA Response: Staff affected by degraded service in the EHR are understandably frustrated. However, VA has protocols in place to enable staff to continue to deliver care in these situations. VA is working diligently with our vendor, Cerner, to prevent future outages. A capacity and performance engineering group has been established to evaluate each outage systematically and diligently to determine root cause and prevent reoccurrence.

Aside from frustrations with periodic outages and degradations, adoption of the new system among site personnel is trending positively. Based on objective measures and feedback from leadership, the recent deployment sites are effectively using the system and making improvements in their delivery of care. At Mann-Grandstaff VAMC in Spokane, Washington, the new system has improved laboratory efficiency and streamlined procedures as it is now capable of processing more lab samples than with the legacy system. At Jonathan M. Wainwright Memorial VAMC in Walla Walla, Washington, the new EHR has increased efficiency and radiology turnaround times and freed lab staff of roughly 3 hours a day of manually processing thousands of specimens. And at the VA Central Ohio Healthcare System in Columbus, Ohio, the surgery department is performing more surgeries than pre-deployment and there have been significant improvements in laboratory turn-around times compared to the legacy system.

Question for the Record from Senator Tillis

Question 1: Dr. Clancy, does the VHA see opportunities to collaborate with non-governmental entities via innovative, public-private partnerships to potentially reduce long-term costs and improve health outcomes in the Veterans' population, particularly in terms of chronic conditions such as cardiovascular disease and cancer?

VA Response: VHA engages in nonmonetary public-private partnerships with nongovernmental organizations to augment VHA services to eligible and enrolled Veterans and to extend these services to those who opt not or are not eligible to receive care through VA. These partnerships raise awareness about healthy living, alternative therapies for chronic conditions and VA resources, and include information about publicly available and free suicide prevention training. Each partnership leverages the expertise and resources of VHA and the community partner to engage Veterans where they are, offer support to families and caregivers and serve as force multipliers of VA services. Examples include VHA partnering with:

- American Lung Association to increase awareness of and access to Better Breathers Clubs and onsite resources for Veterans, their families, caregivers and clinicians.
- American Kidney Fund for kidney action days that include public screening for kidney disease risk factors and high blood pressure, online education resources and collaboration with subject matter experts.
- Arthritis Foundation for increased awareness of resources, including nonpharmacologic interventions for pain, webinars and patient education online.
- Crohn's and Colitis Foundation to increase awareness of the disease, projection and resources available to optimize health and wellness, targeting the public, Veterans and their families and caregivers.
- Lung Cancer Alliance (formerly GO2 Foundation) to increase awareness of the treatment trajectory, reduction of complications and peer support.
- Marcus Institute for Brain Health to facilitate care and case management of Veterans treated for traumatic brain injury who receive care through Marcus Institute.
- Microsoft Adaptive Controllers as part of gaming therapy for Veterans with upper limb loss or immobility to learn how to use existing capability and prosthetics to engage in socialization, mobility and enhance health and wellbeing.
- OnStar for Veterans with GM vehicles and enrolled in OnStar, provides direct link through OnStar to the Veterans Crisis Line, training for the operators at OnStar on suicide prevention, and increased awareness of mental health resources.
- Parkinson's Foundation working with the PADRECCs to increase awareness of the disease, VA resources and collaboration between subject matter experts.
- Pet Partners to increase availability of animal assisted therapy, virtually during the COVID-19 pandemic, and at VAMCs to improve the human-animal bond and health and wellbeing.

Questions for the Record from Senator Tuberville

Question 1: How does the VA measure success and failure for substance use disorder treatment programs?

VA Response: VA recognizes substance use disorder (SUD) as a chronic relapsing condition. In that regard, SUD is akin to other chronic relapsing conditions such as hypertension and diabetes in which the continuum of clinical outcomes ranges from remission (enduring absence of the signs and symptoms of the condition) to mortality. Therefore, the goal is to collaborate with Veterans to optimize their quality of life as defined by goals they set in consultation with their treatment providers. Furthermore, VA has embraced a Whole Health approach to health care, including but not limited to SUD care, that centers around *what matters to* each Veteran we serve, not *what is the matter* with each Veteran. Our treatment teams seek to know each Veteran as a person, before working to develop a personalized health plan based on the Veteran's values, needs and goals.

Treatment of substance use concerns within VA occurs along a continuum ranging from early identification and prevention efforts, engagement and treatment of substance use concerns outside of traditional SUD specialty care programs, to more traditional SUD specialty care provided in outpatient, residential and inpatient settings of care. The Office of Mental Health and Suicide Prevention has established a comprehensive approach for evaluating the treatment of SUDs within VA. Evaluation efforts emphasize factors such as access to care; receipt of SUD-specific clinical services and medications when clinically indicated; screening and brief intervention rates; and engagement in follow-up services. In addition, VA has established a framework for monitoring symptoms of substance use as assessed by the Brief Addiction Monitor (BAM). These data allow VA to better understand symptom reduction following treatment, further strengthening existing quality improvement efforts.

The current evaluation system allows local facilities to compare current performance to that of other facilities and programs. Where appropriate, VA also has established national benchmarks. This information is used to inform our understanding of high and low performing sites and to facilitate follow-up with sites focused on improved performance.

The majority of what is traditionally considered "inpatient" treatment for SUDs occurs in the Domiciliary SUD programs within VA. At the end of the second quarter of FY 2022, there were more than 70 Domiciliary SUD programs with over 1,800 official operational beds. Currently, VA monitors access to care including the number of Veterans pending admission, time waiting and actual wait time upon admission. Further, VA has established standards for collection of patient-reported outcome data using the BAM at admission and discharge to better inform an understanding at the Veteran- and program-level of treatment effectiveness. Finally, VA monitors post-discharge engagement and re-admission rates. Note that readmission is not necessarily an indicator of program failure. In fact, over the last several years, recognizing the clinical

course of SUD may include a return to use following a period of abstinence, VA has worked, consistent with the literature, to remove admission requirements that historically limited access to care based on time since last admission.

Increasingly, electronic tools are being developed to monitor the use of standardized instruments in the course of care in SUD treatment. A measurement-base care (MBC) dashboard has been developed that enables VA SUD monitoring nationwide of the frequency of administration of the BAM. The dashboard yields reports for monitoring over time BAM use by VA facility, inpatient, residential and outpatient SUD treatment programs, and by individual staff care providers. Tracking BAM administration trends across VA allows for detailed monitoring and the targeting of sites with lagging progress implementing symptom measurement and are in need of quality improvement intervention.

As part of ongoing VA mortality surveillance, VA conducts ongoing monitoring of Veteran drug overdose mortality. Each year, VA and the Department of Defense conduct joint national death certificate data searches of the Centers for Disease Control and Prevention's National Death Index. Findings are used by VA's Office of Mental Health and Suicide Prevention to evaluate overdose mortality of Veterans, including sub-analyses by drug type, year and for Veterans with versus without VHA health care encounters. The most recent data are through 2019 (Begley et al., 2022; https://www.sciencedirect.com/science/article/abs/pii/S0376871622000333). VA also tracks overdose mortality per VHA site reports.

VA also uses the Academic Detailing Opioid Use Disorder (OUD) Dashboard and Trends to monitor the number of providers with a DEA X-waiver to prescribe buprenorphine formulations for OUD, and how many of those X-waivered providers are currently prescribing buprenorphine in their practice. While these tools do not determine success or failure of SUD treatment programs directly, they can be used to assess capacity and access to medications for OUD (M-OUD) in a variety of VA practice settings.

The Academic Detailing OUD data suite features population health management and surveillance tools to complement team-based, collaborative SUD care. Reports that track and trend the number of X-waivered providers and how many of those X-waivered providers are currently prescribing buprenorphine in their practice allows facilities to assess capacity and access to M-OUD treatment in a variety of VA practice settings. The OUD patient report contains information related to M-OUD, naloxone distribution and SUD specialty treatment in patients diagnosed with OUD, which allows the care team to proactively identify upcoming appointments and engage in care. The buprenorphine patient report identifies patients with an active prescription for buprenorphine and those who have current or recent buprenorphine coverage based on recent fill history. This report includes date of recent urine drug screen, an assessment of adherence of medication, naloxone, pertinent labs, patient risk and upcoming appointment information, which allows the care team to avoid missed opportunities in treatment while promoting recovery.

The BAM data for Veterans enrolled in SUD specialty care are extracted quarterly at intake and 30- to 90-day follow-up. Data are used to assess the change in alcohol and drug abstinence from intake to follow-up. In addition, BAM summary scores are used to assess change in the use, risk and protective factors between intake and follow-up. Data are reported at a national level. These data allow for assessment of the effect of SUD specialty care on cessation, as well as harm reduction and quality of life outcomes.

On a quarterly basis, diagnostic and encounter level data are extracted to assess care receipt among Veterans with co-occurring posttraumatic stress disorder (PTSD) and SUD. The report assesses the location of care (SUD, PTSD or general mental health clinics), the number of patients receiving SUD/PTSD care and the number of visits received over time. Data are reported at the national and local level. These data allow for assessment of trends in recommended treatment delivery that focuses on SUD and PTSD.

Receipt of medications for alcohol use disorders (including acamprosate, oral and injectable naltrexone, disulfiram, topiramate) and M-OUD (including buprenorphine, injectable, extended-release naltrexone and methadone) by Veterans receiving care in SUD specialty care are updated on a quarterly basis. Data are reported at the national and local level. These data assess whether Veterans enrolled in SUD specialty care receive recommended evidence-based pharmacotherapy for alcohol and opioid use disorders.

Question 2: What kind of follow up, or monitoring, does the VA perform to identify what veterans are suffering from a relapse?

VA Response: VA policy stipulates that Veterans diagnosed with a SUD receive a multidimensional, bio-psychosocial assessment to guide Veteran-centered treatment planning for SUD and any co-occurring psychiatric, general medical conditions and psychosocial service needs. All Veterans receiving SUD treatment participate in collaborative, customized treatment planning informed by ongoing assessment of their condition. The treatment plan must include the patient's diagnosis or diagnoses and document consideration of each type of evidence-based intervention for each diagnosis. The treatment plan needs to include approaches to monitoring the outcomes (therapeutic benefits and adverse effects) of care and milestones for reevaluation of interventions and of the plan itself. As appropriate, the plan needs to consider interventions intended to reduce symptoms, improve functioning and prevent relapses or recurrences of episodes of illness. The plan needs to be recovery-oriented; attentive to the Veteran's values and preferences; and evidence-based regarding what constitutes effective and safe treatments. The treatment plan needs to be developed with input from the Veteran, and when the Veteran consents, appropriate family members. While treatment planning is inclusive of relapse prevention, VA recognizes the importance of continuity of care and retaining Veterans who are diagnosed with a SUD in care. Therefore, VA emphasizes a collaborative approach to treatment planning

that attends closely to each Veteran's preferences, leverages each Veteran's strengths and customizes services to address each Veteran's challenges.

Coordination and development of the Veteran's treatment plan proceeds following the Veteran's consent when the Veteran possesses adequate decision-making capacity or with the Veteran's surrogate decision-maker's consent (when the Veteran does not have adequate decision-making capacity). The treatment plan reflects the Veteran's goals and preferences for care. Implementation of the treatment plan is monitored and documented. This implementation must include tracking progress in the care delivered, the outcomes achieved and the goals attained. The treatment plan is revised in accord with changes in the Veteran's clinical status as informed by assessment data and the provider's and Veteran's perspective of the Veteran's clinical status. To inform adaptive, customized treatment planning, all Veterans in treatment for SUD have their condition monitored in an ongoing manner and treatment adjusted, as appropriate, in response to changes in their clinical status. Regular contact is maintained with the patient as clinically indicated as long as ongoing care is required.

The BAM is the requisite instrument in VA for informing individual measurement-based care and program evaluation in our SUD specialty care programs. Throughout the entire course of SUD specialty care, all patients are required by policy to receive repeated assessment ("collect") and timely feedback of assessment results ("share"), with such information used to inform collaborative treatment-planning, decision-making and treatment modifications ("act"). Assessment frequency is a function of clinical need and preference (patient and provider). Generally, higher frequency assessment is indicated and encouraged early in care and with higher acuity patients. Although assessment frequency may be stepped-down as clinical status stabilizes and consistent with provider and patient preferences, assessments at every transition in care must continue throughout the patient's course of treatment. To meet accreditation requirements established and monitored by The Joint Commission (TJC), the "share" and "act" aspects of measurement-based care must be evident in clinical documentation (e.g., treatment plan, progress notes, treatment plan updates, discharge plan). The BAM can be supplemented (but not substituted) with other measures as clinically indicated and consistent with provider and patient preferences.

All Veterans discharged from a Domiciliary SUD program are required to receive follow-up care with emphasis on the first month following discharge. This period of time is meant to emphasize engagement in care during this period of transition from inpatient/residential care to outpatient care.

Question 3: How does the VA improve upon its substance use disorder treatment programs?

VA Response: Performance and outcome monitoring of SUD programs is conducted by VA's Office of Mental Health and Suicide Prevention in cooperation with VA's Program Evaluation and Resource Center (PERC) at the Palo Alto VAMC, and VA's Centers of Excellence in Substance Addiction Treatment and Education at the

Philadelphia VAMC and the Seattle VAMC. Outcome monitoring includes both patient population outcome measures and program performance monitoring. Such measures assist in evaluating the quality and effectiveness of treatment.

VA has a variety of quality improvement systems and initiatives to optimize the quality of SUD care we provide to Veterans, which include:

- Sources of continuing education and educational materials for providers.
- Community of practice meetings during which providers can receive guidance on policy and practice as well as share lessons learned from the field.
- Recurring national conferences during which providers can establish consultation networks and receive guidance on implementation of novel practices to enhance the treatment services available to Veterans.
- Enterprise-wide training initiatives in evidence-based treatments for SUD initiatives to expand collaborative, team-based SUD care.
- Consultation services through which providers can access guidance from subject matter experts in various aspects of SUD care.
- Fellowships that provide training and mentorship to junior clinical staff commencing their careers in SUD treatment and research.

More focused support for enhancing the quality of SUD care in VA include the Stepped Care for Opioid Use Disorder (OUD) Train the Trainer initiative that focuses on implementing a stepped care model of medication treatment for OUD to provide treatment services around Veterans at their preferred points of care and the Psychotropic Drug Safety Initiative that provides guidance and monitoring of safer prescribing practices and provision of evidence-based treatments for SUD. To identify and rectify disparities in Veterans' access to evidence-based OUD care, VA has convened a workgroup of SUD subject matter experts to identify and explore means of maximizing Veterans' access and choice of care in an equitable manner. At the facility or program level, VA enhances the quality of SUD care by participating in surveys conducted by accrediting agencies such as TJC and the Commission on Accreditation of Rehabilitation Facilities. VA also supports facility and program-level efforts at continuous quality improvement of SUD treatment services by assisting those facilities with routine outcomes analyses of aggregated, Veteran-reported outcome data, (i.e., the BAM). Those analyses inform program evaluation and management efforts. At the individual provider level, quality of care is monitored and enhanced via mid-year and annual staff performance evaluations. VA also supports the continuing education of its treatment providers by offering financial and leave support so they can attend national conferences related to their professional discipline and subject matter interests.

Department of Veterans Affairs

November 2022

Senator Cassidy
Questions for the Record
Senate Veterans' Affairs Committee
VA Quality of Care
05/11/22

Questions for Michael J. Missal:

1) Can we extrapolate data from quality care characteristics of a subset of low-performing VA hospitals and infer the highest/lowest-performing characteristics of said hospitals to all the VA facilities across the country for a utilization review? Extrapolation of these subsets of hospitals may account for overlooked hospitals when aggregated at the mean with the performance of other VA hospitals measured by similar quality care characteristics.

OIG Response: Metrics can and do support our quality of care reviews; but when used in isolation, such data can be misleading to veterans and other stakeholders and can lead to oversimplifying complex clinical care delivery. The VA OIG relies on quality of care and patient safety data in all our healthcare inspections but contextualizes and supplements the data review with medical record reviews, staff and patient interviews, exploration of industry standards, and current evidence-based clinical practices. However, we do not believe that an extrapolation of quality data sets from one facility or region has wholesale application to inform and improve performance at another facility or region, given that local facility and community attributes vary widely.

We aggregate data from our annual Comprehensive Healthcare Inspection Program (CHIP) reviews so that we can see our findings at a national level. Our CHIP reviews are designed so that results are generalizable to the VHA population, and as such, these reports can be helpful in identifying problem areas for all facilities. They also reveal some key contributors to success (such as stable and effective leadership). In sum, we share your interest in using data for improvement efforts. Quality data is only a piece of the complexity involved in assessing and formulating approaches to providing quality healthcare to millions of veterans.

2) Can Dr. Meyer, the Joint Commission, and you, the Inspector General, conduct a review on low-performing subsets of VA hospitals to discover which physicians and clinicians at such hospitals may be falsifying quality care results?

OIG Response: Our experience in reviewing quality of care at VHA supports that the clinical staff routinely acts with integrity when caring for our nation's veterans.

We have not received complaints or detected that low-performance generally has correlated with falsified quality care results. When allegations related to physicians or clinicians are brought forward that suggest performance is inconsistent with reported quality data or falsified results, the OIG has conducted reviews to understand the perceived or actual discrepancies.

One of the most egregious examples of quality data manipulation occurred under the leadership of Dr. Robert Levy at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas. Recommendations in our report regarding his actions were designed to help ensure that clinicians would not be reporting on and overseeing their own clinical practice. We have encouraged VHA and other facilities to follow these recommendations. Another example involved physicians falsifying blood pressure readings to document them at a level just below that required for additional follow-up work. We issued reports and recommendations on these matters. These types of reviews often lead to recommendations that affect VA policy, controls, or oversight beyond the targeted personnel or facility.

Sen. Hirono
Questions for the Record
Senate Veterans' Affairs Committee
Quality of Care
5/11/22

Questions for Michael J. Missal, Inspector General, Department of Veterans Affairs

1. As you know, veterans who live further from VA medical facilities, especially those in rural and remote areas of the country—like in many parts of Hawaii—often depend on mail-order prescriptions. Access to prescriptions is often life or death for many veterans. They depend on their medication for pain, depression, post-traumatic stress disorder and other serious physical and mental health concerns. VA's website states that prescriptions "usually arrive within three to five days" of being ordered or even an average of "60 hours from filling to delivery." But, recent reporting – and communication from my constituents – has indicated significant delays in prescription refills – sometimes taking up to 4 weeks. This is about quality of care. Missing antidepressants, maintenance medications for blood pressure, or anticoagulants can be catastrophic. We are not fulfilling our promise to our veterans if they cannot receive critical medication in a timely fashion.
    a. As you've been analyzing the process of delivering care at VA, to what extent has your office looked into prescription refill delays.
        i. Are certain more remote geographical areas more susceptible to these delays?
    b. What immediate and long-term steps can VA take to alleviate these delays and prevent against future delays?

OIG Response: OIG personnel are monitoring VHA's Consolidated Outpatient Pharmacy Program (CMOP) for a possible review. We have determined that some issues facing CMOPs relate to delays due the U.S. Postal Service, which is not within our jurisdiction. Another issue of concern is the time that must pass between refilling prescriptions, which is set by VA policy. OIG staff did review the CMOP program in November 2016, and published the report *Audit of VHA's Consolidated Mail Outpatient Pharmacy Program*. OIG staff also monitor allegations to our hotline from Hawaii and across the nation for any complaints that appear related to VA breakdowns in policy and practice affecting veterans' medical needs, with special sensitivity to issues specific to rural areas, and stand ready to take action as appropriate.

2. Inadequate staffing can be the root cause of negative patient care due to overworked staff or staff being stretched too thin, as well as increasing wait times. On top of a large number of existing vacancies at some facilities, your testimony mentioned that 19 percent of staff reported burnout and 25 percent of staff experienced "high" or "extreme" stress levels associated with COVID-19.
    a. VA has struggled with staffing issues for a long time – from your differing perspectives, what is the most important change the Department needs to make in order to resolve these issues?
    b. How do staffing shortages, especially shortages of nurses and specialists, impact the quality of care available at VA?

OIG Response: VA faces many challenges in staffing their facilities and managing personnel's stress. The national shortages of some occupations, the competition for services in urban areas, and the locations in some rural areas make it difficult for VA to adequately recruit, onboard, and retain clinicians and support staff. Without adequate staffing, delivering quality care stresses the current staff as well as the systems that they use to deliver care.

The VA Choice and Quality Employment Act of 2017 requires the VA OIG to determine on an annual basis, a minimum of five clinical and five nonclinical Veterans Health Administration occupations with the largest staffing shortages within each VHA medical center. The OIG is required to publish annually a report including that information. The eighth such review has been completed to identify those severe staffing shortages by occupation and will be published shortly. It compares the most recent numbers to the previous three years' reports to assess changes. In September 2021, the OIG released the fourth in the series that identified severe occupational staffing shortages *at the facility level*. VHA-identified points of contact in each facility provided the requested information, which OIG staff do not independently verify.

Every year since 2014, the medical officer and nurse occupations have been identified as severe shortages in OIG's annual report. The 2021 report revealed about 90 percent of facilities had severe shortages for medical officers and 73 percent of facilities had severe shortages for nurses, two positions that are fundamental to the delivery of health care. VHA is able to noncompetitively appoint individuals to both of these Title 38 occupations in accordance with VA guidance. The OIG cannot propose a single most-important solution, as strategies need to be tailored to local needs. For example, the availability of specialists, both within VA facilities and within a particular community, is very area-specific. For some positions or areas of practice, the OIG has recommended the use of more effective staffing models, some of which still need to be implemented to help better understand specific needs and allocate resources effectively. It should be noted that the problems VA has experienced are not unique and there is still significant competition with the private sector.

Senator Cassidy
Questions for the Record
Senate Veterans' Affairs Committee
VA Quality of Care
05/11/22

Questions for Dr. Gregg S. Meyer:

1) Is the VA's lack of a utilization review resulting in patients going to private clinics and receiving excessive testing resulting in biased quality performance results across VA hospitals?

The lack of utilization review is a clear gap in the management of veterans' care when they chose to, or due to specific needs or geography, have to, get care in civilian facilities. A program of utilization review is essential to ensuring that one of the three key aspects of quality, avoiding overuse, is being achieved. Utilization review is a common feature of civilian care and the lack of it for VA sponsored civilian care is a deficiency which should be addressed.

2) In successive utilization reviews of the VA, will younger veterans not on Medicare coverage, having the VA paying services provided by the private sector be included in the study, thereby accounting for VA utilization of excessive services occurring in the private sector for this age group?

As noted during the hearing, the focus of the NBER study on dual eligibles (veterans eligible for both VA care and Medicare) provided a means of making meaningful comparisons between civilian and VA care. The elegance of that study, however, also produced its greatest limitation in that its findings may not be applicable to younger veterans. To the extent that younger veterans may be using more services in the civilian sector, the concern that there may be over-utilization missed by the NBER study is a legitimate one. This could not be explored with the NBER's study methodology so future studies should focus on this important question.

As noted in the testimony, this will require more robust data collection from civilian facilities – many of which do not have data infrastructure comparable to that of the VA. Congress should commission a study with appropriate support for data collection by civilian providers as a means of exploring this issue. In the absence of such a study, however, we should not wait on implementing utilization review for veterans' care in the civilian sector.

Sen. Hirono
Questions for the Record
Senate Veterans' Affairs Committee
Quality of Care
5/11/22

Questions for Gregg S. Meyer, MD, MSc, President of the Community Division and Executive Vice President of Value Based Care, Professor of Medicine, Massachusetts General Hospital and Harvard Medical School

1. Inadequate staffing can be the root cause of negative patient care due to overworked staff or staff being stretched too thin, as well as increasing wait times. On top of a large number of existing vacancies at some facilities, Inspector General Missal's testimony mentioned that 19 percent of staff reported burnout and 25 percent of staff experienced "high" or "extreme" stress levels associated with COVID-19. These issues are not limited to medical professionals within VA.
    a. VA has struggled with staffing issues for a long time – from your differing perspectives, what is the most important change the Department needs to make in order to resolve these issues?

    There is no single simple solution to the workforce burnout challenge. To start it is important to note that this is not unique to the VA and in fact is one of the greatest challenges being confronted in civilian healthcare as well. A comprehensive approach to burnout needs to focus on improving working conditions as well as shoring up resiliency. In the civilian sector many healthcare organizations, including my own, Mass General Brigham, are developing comprehensive programs based on work at the Mayo Clinic.[1] I would suggest that the VA use that roadmap to craft its response to the burnout challenge. One particular timely issue for the VA to address is the potentially pernicious impact of its implementation of a new electronic medical record on provider burnout. Again, there are lessons from the civilian sector which can provide guidance to avoid those impacts.[2]

    b. Are there lessons from the way the private sector is currently handling staffing shortages that VA could use to better inform their own actions?

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[1]Swensen, Shanafelt. Mayo Clinic Strategies to Reduce Burnout: 12 Actions to Create the Ideal Workplace. Oxford University Press. 2020

[2] Meyer GS, Britton O, Gross D. Seven Challenges and Seven Solutions for Large-Scale EHR Implementations. NEJM Catalyst. 2018: https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0073 .

Staff shortages in the civilian and VA sectors are the single greatest challenge to the delivery of safe high-quality care at this moment in time. It is notable that just as COVID laid bare longstanding issues with healthcare disparities and inequities which preceded the pandemic, it has also exposed longstanding challenges with workforce adequacy whose origins (including inadequate training pools of nurses, medical technicians, and allied healthcare professionals) go back for decades. The VA needs to work on longer term solutions, including increasing collaborations with Community and health professional colleges to build the workforce of the future. But there are also a number of shorter-term actions the VA should take. These include attention to the 6 Rs. The first is Retention – specifically working on the strategies to address burnout noted above as well as an increased focus on leadership assessments that include safety culture and staff engagement as noted during my testimony. The second is Recruitment – using all the tools available to human resources including referral bonuses, leveraging social media, and ensuring that wages are at the regional median. The third is Re-engineering – systematically looking at work-flows (aka "value streams") to see how they can be streamlined to lower the burden on staff and reduce the number or workers required to perform a task while getting all staff to practice at the top of their license. The fourth is Replacement – using tools like robotic process automation to remove repetitive and replicable tasks from the demands on staff. The final one which is where Congress has a special role, is Regulation – this includes but is not limited to steps to limit price gouging and provide oversight for the contract labor industry.

c. How do staffing shortages, especially shortages of nurses and specialists, impact the quality of care at medical facilities?

The link of staffing levels to quality and safety of care is clear in the literature. A recent review by the American Association of Colleges of Nursing provides a useful overview of those findings.[3]

2. I have heard from constituents in Hawaii who do not live on Oahu that it can be difficult to access the most up-to-date maternal and fetal care. This is especially true for those in need of high-risk obstetric care, homeless veterans, and other groups with special needs.
   a. While your state doesn't have the same kinds of geographic constraints Hawaii has, would you say that women veterans – especially those in rural areas – are able to access quality maternal care?

   There are three elements to ensure access to high quality and safety maternal care. The first is assessment as early as possible and then throughout the pregnancy as to whether the care needs can be met locally or if referral to a regional center with

[3] https://www.aacnnursing.org/News-Information/Nursing-Shortage-Resources/Impact

more advance maternal-fetal health and neonatal care capabilities is required. The second is a capability for rapid transfer to a higher level of care when needed. The final one is the availability of virtual consultation using telehealth to more advanced services and opinions.

b. Would you recommend any changes to the way VA has historically approached maternal and fetal care, especially for those with special needs?

I am not familiar with the VA's historical approach and do not feel qualified to comment further.

Submissions for the Record

Attachment 1

Telehealth Quality and Performance Measures

VA Office of Connected Care

Virtual Care Scorecard

VA | U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Connected Care

Background – Conditions of Participation

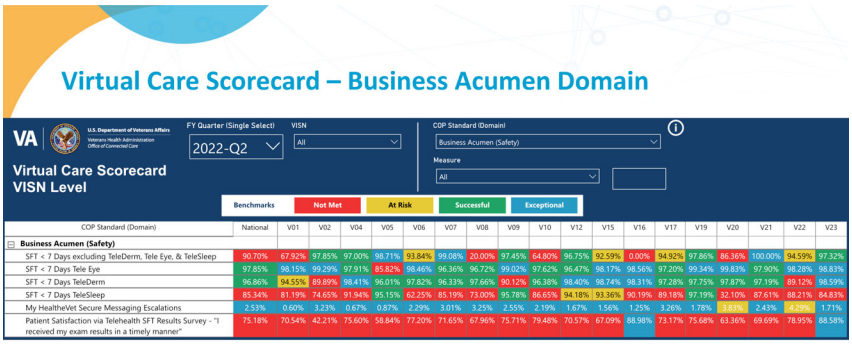
- The Conditions of Participation is the comprehensive quality management program in VA for virtual care that:
  - Establishes the foundational standards, criteria and evidence for all Connected Care/Telehealth program operations
  - Evaluates and monitors process and performance data
  - Sets and utilizes benchmarks and analyzes data
  - Critically reviews program implementation planning strategies
  - Standardizes foundational operations
  - Identifies and encourages the application of robust and leading practices nationwide

Background – Virtual Care Scorecard

- The Virtual Care Scorecard informs and supports the Conditions of Participation, VA's comprehensive quality management program for virtual care.
- The Virtual Care Scorecard (formerly known as the National Data Quality Scorecard) was first disseminated to Telehealth leaders and field staff in the first quarter of FY19.
- The Virtual Care Scorecard is a data strategy tool for performance management, monitoring and oversight of OCC programs.
- It is a structured data snapshot used nationally by Quality Managers, VISN Telehealth Program Managers and staff to plan, monitor and manage telehealth and virtual care program operations and performance.

Virtual Care Scorecard

- Users can filter by: Date (fiscal year and quarter), VISN, Conditions of Participation Standard and/or Individual Quality and Performance Measures
- Benchmarks:
  - Blue – VISN met or exceeded the target and are considered exceptional
  - Green – VISN is close to meeting the target and are considered successful
  - Yellow – VISN is close to not meeting the target and is considered at risk
  - Red – VISN did not meet target
- The measures that are not color coded are either:
  - Cumulative measures and 'scored' at the end of the fiscal year
  - Non scored elements



COP Standard (Domain)	National	V01	V02	V04	V05	V06	V07	V08	V09	V10	V12	V15	V16	V17	V19	V20	V21	V22	V23
Business Acumen (Safety)																			
SFT < 7 Days excluding TeleDerm, Tele Eye, & TeleSleep	90.70%	67.92%	97.85%	97.00%	98.71%	93.84%	99.08%	20.00%	97.45%	64.80%	96.75%	92.59%	0.00%	94.92%	97.86%	86.36%	100.00%	94.59%	97.32%
SFT < 7 Days Tele Eye	97.85%	98.15%	99.29%	97.91%	85.82%	98.46%	96.36%	96.72%	99.02%	97.62%	96.47%	98.17%	98.56%	97.20%	99.34%	99.83%	97.90%	98.28%	98.83%
SFT < 7 Days TeleDerm	96.86%	94.55%	89.89%	98.41%	96.01%	97.82%	96.33%	97.66%	90.12%	96.38%	98.40%	98.74%	98.31%	97.28%	97.75%	97.87%	97.19%	89.12%	98.59%
SFT < 7 Days TeleSleep	85.34%	81.19%	74.65%	91.94%	95.15%	62.25%	85.19%	73.00%	95.78%	86.65%	94.18%	93.36%	90.19%	89.18%	97.19%	32.10%	87.61%	88.21%	84.83%
My HealtheVet Secure Messaging Escalations	2.53%	0.60%	3.23%	0.67%	0.87%	2.29%	3.01%	3.25%	2.55%	2.19%	1.67%	1.56%	1.25%	3.26%	1.78%	3.83%	2.43%	4.29%	1.71%
Patient Satisfaction via Telehealth SFT Results Survey - "I received my exam results in a timely manner"	75.18%	70.54%	42.21%	75.60%	58.84%	77.20%	71.65%	67.96%	75.71%	79.48%	70.57%	67.09%	88.98%	73.17%	75.68%	63.36%	69.69%	78.95%	88.58%

Virtual Care Scorecard – Leadership Domain

Benchmarks	Not Met	At Risk	Successful	Exceptional

COP Standard (Domain)	National	V01	V02	V04	V05	V06	V07	V08	V09	V10	V12	V15	V16	V17	V19	V20	V21	V22	V23
Leadership (Access)																			
Telehealth Use (Tele1) *	26.68%	21.49%	27.65%	25.97%	21.24%	26.22%	31.17%	29.56%	23.37%	26.42%	21.46%	21.43%	23.40%	29.12%	23.27%	25.75%	30.47%	28.29%	18.75%
Remote Patient Monitoring-Home Telehealth Use (Tele2) *	1.61%	1.47%	2.48%	1.83%	1.80%	1.30%	1.81%	1.05%	1.69%	1.80%	1.51%	1.73%	1.71%	1.39%	1.36%	0.81%	1.58%	1.33%	1.54%
Clinical Video Telehealth Use (Tele3) *	22.76%	18.72%	25.29%	21.15%	18.22%	22.91%	27.45%	26.90%	17.89%	21.98%	18.41%	17.16%	19.24%	25.92%	18.71%	19.31%	22.19%	24.62%	14.98%
Store and Forward Telehealth Use (Tele4) *	3.87%	2.30%	1.93%	5.44%	2.86%	3.71%	4.32%	3.14%	5.76%	4.79%	2.86%	4.02%	3.98%	3.36%	4.79%	4.82%	3.25%	4.18%	3.70%
Video Telehealth to Off Site Patients Use (Tele9) *	20.79%	17.57%	23.70%	18.04%	15.98%	21.15%	25.52%	26.05%	16.14%	20.13%	14.18%	14.76%	17.07%	23.96%	15.57%	19.35%	20.34%	23.75%	10.43%
RPM-HT NIC Enrollment (Tele10)	65.30%	56.70%	61.70%	68.30%	58.90%	60.20%	56.10%	59.90%	69.70%	70.20%	72.60%	68.60%	69.60%	58.80%	71.60%	70.90%	72.70%	64.80%	70.90%
Specialty Care Telehealth Penetration - Eyecare (%) *	72.60%	36.21%	77.63%	89.47%	76.92%	74.51%	76.71%	61.36%	85.71%	77.17%	88.00%	79.10%	79.71%	67.19%	68.89%	64.15%	65.15%	74.07%	70.00%
Specialty Care Telehealth Penetration - Eyecare (#)	884	21	59	51	30	38	56	54	54	71	44	53	55	43	62	34	43	60	56
Specialty Care Telehealth Penetration - Dermatology (%) *	67.10%	77.59%	64.47%	84.21%	64.10%	76.47%	63.01%	56.82%	66.67%	77.17%	88.00%	71.64%	50.72%	46.88%	63.33%	64.15%	74.24%	58.02%	71.25%
Specialty Care Telehealth Penetration - Dermatology (#)	816	45	49	48	25	39	46	50	42	71	44	48	35	30	57	34	49	47	57
Tele Mental Health - # of Encounters	1,586,598	79,000	89,227	63,815	58,632	104,666	142,236	137,868	56,153	116,200	60,842	45,340	91,122	115,586	66,384	69,306	95,980	145,721	48,520
My HealtheVet Premium Authenticated Patients - FYTD Growth *	4.06%	3.66%	2.03%	3.20%	4.79%	5.00%	4.33%	3.86%	4.00%	3.01%	3.80%	4.52%	5.53%	5.42%	6.70%	3.58%	3.01%	4.01%	4.09%
My HealtheVet Active Unique Patient Senders - FYTD Growth *	7.34%	5.68%	6.42%	7.33%	8.88%	7.56%	8.76%	6.78%	6.16%	5.95%	7.68%	6.55%	7.74%	10.27%	10.93%	7.86%	5.99%	7.04%	6.03%
Annie Protocols in Use		119	74	94	85	109	79	142	71	93	84	60	93	89	82	84	100	96	132
Annie App Active Users/Participants		1,565	1,379	2,428	3,216	2,839	3,278	3,871	1,268	2,636	1,969	978	3,885	2,759	1,848	1,914	2,097	3,098	4,503
Annie App Authorizers of Protocols		15	32	54	31	44	30	29	17	38	34	18	50	35	53	23	28	30	210
Annie App Assignors of Protocols		53	50	83	54	75	40	78	29	71	60	24	84	59	81	36	56	53	257

Virtual Care Scorecard – Staff & Technology Domains

Benchmarks	Not Met	At Risk	Successful	Exceptional

COP Standard (Domain)	National	V01	V02	V04	V05	V06	V07	V08	V09	V10	V12	V15	V16	V17	V19	V20	V21	V22	V23
Staff (Resources)																			
# of Veterans per Care Coordinator	53.6	50.82	72.33	57.06	49.7	60.61	64.79	62.26	59.94	57.76	42.73	49.15	58.33	49.49	52.68	27.19	63.01	54.14	34.5
% VVC Providers with Required Course Completions (Tele17)	95.49%	93.24%	96.28%	97.53%	98.83%	97.42%	94.51%	95.66%	97.25%	95.21%	94.17%	96.36%	95.97%	93.09%	97.53%	92.78%	95.31%	95.41%	95.36%

Benchmarks	Not Met	At Risk	Successful	Exceptional

COP Standard (Domain)	National	V01	V02	V04	V05	V06	V07	V08	V09	V10	V12	V15	V16	V17	V19	V20	V21	V22	V23
Technology (Utilization)																			
% of iPads distributed with no future VVC appointment	68.37%	71.08%	69.86%	73.61%	72.88%	61.14%	62.46%	64.49%	74.18%	70.68%	70.42%	68.64%	67.90%	64.98%	73.23%	70.47%	67.12%	71.04%	66.73%
Devices Ordered w/ Digital Divide Completed	84.57%	81.61%	74.01%	80.59%	87.51%	92.15%	83.66%	92.90%	86.93%	89.49%	93.92%	90.72%	83.26%	94.49%	82.73%	30.88%	80.09%	93.64%	91.26%

NOTE: Data for the Technology Domain represents FY 2022 Quarter 1

Virtual Care Scorecard – Veteran Centric Care Domain

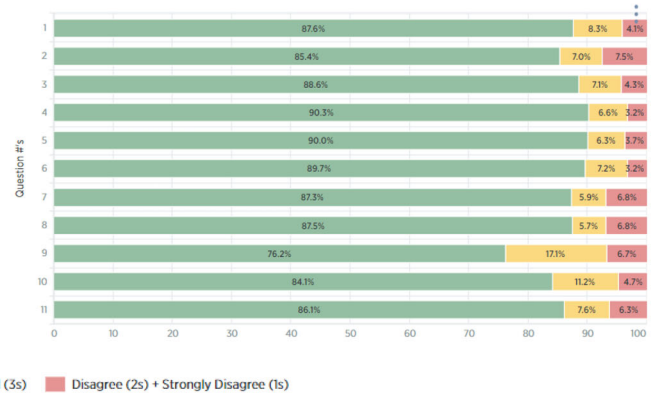
Benchmarks	Not Met	At Risk	Successful	Exceptional

COP Standard (Domain)	National	V01	V02	V04	V05	V06	V07	V08	V09	V10	V12	V15	V16	V17	V19	V20	V21	V22	V23
Veteran Centric Care (Satisfaction/Quality)																			
SFT Unreadable rates - TeleDerm	0.89%	1.66%	2.70%	0.19%	0.62%	1.30%	0.80%	0.16%	1.56%	0.69%	0.39%	0.22%	1.36%	0.36%	2.01%	0.31%	0.64%	0.37%	0.63%
SFT Unreadable rates - Tele Eye	11.55%	18.10%	13.41%	4.57%	6.01%	8.24%	4.94%	6.25%	3.57%	4.47%	6.69%	4.87%	3.63%	4.70%	3.41%	2.21%	9.18%	7.62%	3.27%
HEDIS retinal exam timeliness (DMG31h)	81.28%	80.60%	80.80%	83.48%	78.08%	80.29%	78.43%	80.00%	86.08%	85.36%	81.12%	77.61%	81.32%	83.76%	83.46%	76.51%	79.55%	82.58%	81.58%
RPM-HT Clinical Outcome Data (HbA1c)	73.84%	80.11%	74.12%	77.70%	75.57%	67.74%	76.06%	76.13%	83.06%	62.09%	68.13%	76.22%	74.72%	70.59%	59.00%	81.08%	73.78%	69.34%	77.02%
Patient Satisfaction via Telehealth at the Clinic Appointment Survey - Satisfaction Domain	90.25%	87.50%	96.08%	97.61%	81.25%	89.24%	83.33%	85.68%	94.73%	88.81%	94.35%	95.78%	86.76%	80.93%	89.24%	92.56%	87.96%	89.13%	95.33%
Patient Satisfaction via Telehealth at Home or Mobile Appointment Survey - Employee Helpfulness Domain	90.75%	91.94%	91.27%	92.52%	86.59%	89.81%	89.23%	90.92%	92.33%	91.25%	94.06%	91.66%	88.49%	92.26%	92.04%	91.03%	90.83%	88.36%	94.86%
Patient Satisfaction via Telehealth at Home or Mobile Appointment Survey - Satisfaction Domain	88.59%	89.61%	87.93%	91.96%	87.59%	87.63%	86.31%	88.35%	91.25%	90.43%	89.59%	91.89%	87.69%	88.01%	89.39%	89.34%	88.20%	86.29%	92.28%
Patient Satisfaction via Telehealth SFT at the Clinic Appointment Survey - Employee Helpfulness Domain	87.08%	89.79%	94.44%	84.49%	89.23%	95.83%	87.93%	90.83%	77.55%	84.56%	89.77%	100.00%	88.35%	86.13%	92.13%	89.38%	64.63%	87.07%	81.45%
Patient Satisfaction via Telehealth SFT at the Clinic Appointment Survey - Quality Domain	84.58%	94.12%	92.57%	81.78%	77.90%	91.79%	83.17%	85.14%	74.43%	80.97%	89.27%	90.87%	85.46%	86.34%	91.13%	84.97%	64.63%	88.39%	86.46%
Patient Satisfaction via RPM-HT Continuing Patient Survey - Quality Domain	92.81%	95.03%	92.21%	92.12%	93.40%	91.14%	93.02%	94.55%	91.76%	93.61%	93.32%	92.54%	92.26%	92.61%	87.46%	93.10%	91.52%	93.67%	96.14%
Patient Satisfaction via RPM-HT Continuing Patient Survey - Confidence/Trust Domain	92.81%	91.05%	94.22%	90.32%	94.95%	93.27%	92.63%	89.47%	93.51%	92.80%	94.85%	96.05%	92.79%	93.49%	88.98%	90.95%	93.22%	92.57%	96.15%
Provider Satisfaction via Continued Telehealth Exposure in CVT Survey - Confidence/Trust Domain	65.57%	83.33%	53.85%	76.92%	66.67%	72.22%	61.29%	82.14%	66.67%	48.28%	61.11%	63.64%	68.42%	83.33%	46.15%	75.00%	53.33%	62.07%	66.67%
Provider Satisfaction via Continued Telehealth Exposure in RPM-HT Survey - Confidence/Trust Domain	50.00%					100.00%				0.00%		0.00%				0.00%	100.00%	100.00%	
Provider Satisfaction via Continued Telehealth Exposure in SFT Survey - Confidence/Trust Domain	55.88%	50.00%	100.00%	66.67%			75.00%	20.00%	0.00%	100.00%	75.00%	0.00%	66.67%	50.00%	100.00%	100.00%	0.00%	100.00%	50.00%
Patient Satisfaction via Telehealth Appointment Scheduling Survey - "I felt prepared for my Telehealth video visit after I scheduled my appointment." *	83.83%	87.12%	85.12%	82.90%	84.63%	84.18%	82.37%	84.16%	85.57%	86.56%	86.07%	80.38%	84.54%	81.64%	80.85%	82.58%	84.05%	80.95%	88.66%
Patient Satisfaction via Telehealth at Home or Mobile Appointment Survey - "I trust Telehealth as part of my overall VA healthcare." *	88.00%	89.41%	89.31%	90.54%	88.59%	85.74%	85.08%	87.27%	89.52%	90.01%	91.98%	87.64%	87.89%	88.84%	89.84%	87.94%	89.26%	84.64%	90.96%
Patient Satisfaction via Telehealth at Home or Mobile Appointment Survey - "I felt prepared with using the technology when connecting to my appointment." *	89.00%	90.52%	89.16%	87.67%	89.27%	87.25%	87.75%	88.13%	90.63%	90.21%	90.25%	90.83%	88.10%	89.71%	91.04%	90.89%	88.18%	87.76%	90.85%

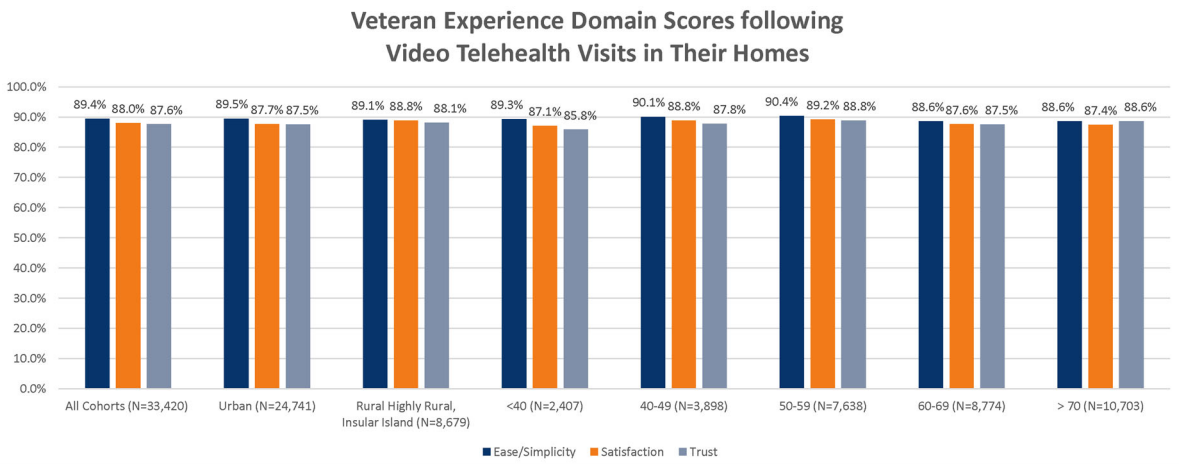
Attachment 2

FY22 Q1-Q2: Veteran Experience Scores for Video to Home Visits

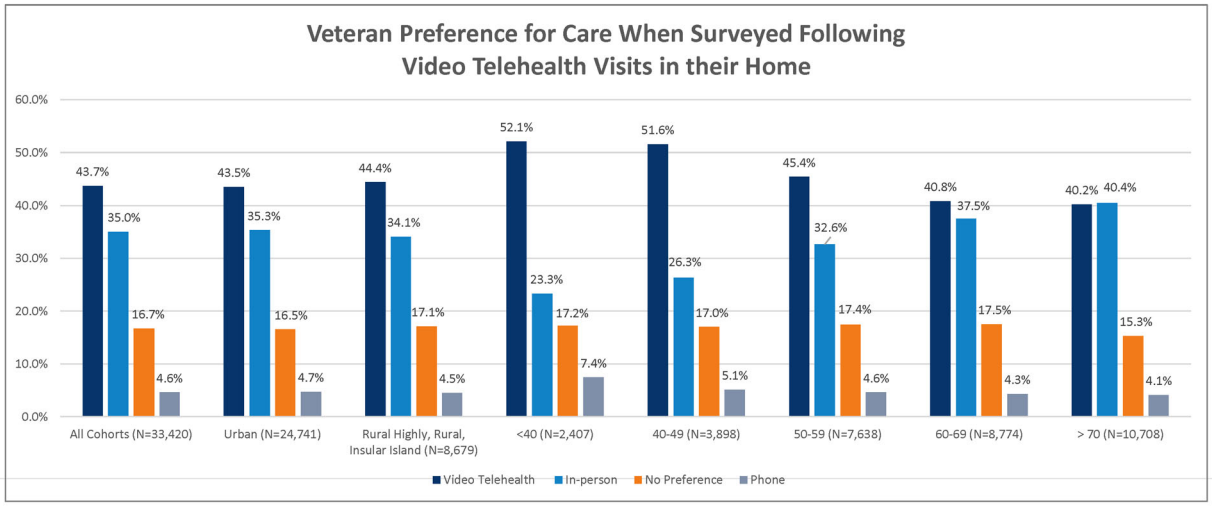
	Score %		
	%4-5	%3	%1-2
1. I trust Telehealth as part of my overall VA healthcare.	87.6%	8.3%	4.1%
2. Connecting to my Telehealth video appointment was easy.	85.4%	7.0%	7.5%
3. I felt prepared with using the technology when connecting to my appointment.	88.6%	7.1%	4.3%
4. During my appointment, my provider made me feel at ease by explaining every step they took in a way that was easy to understand.	90.3%	6.6%	3.2%
5. After my appointment, I was clear on what my next steps were.	90.0%	6.3%	3.7%
6. Telehealth reduces the need to travel long distances in order to meet with my provider.	89.7%	7.2%	3.2%
7. I was able to see the provider clearly by video.	87.3%	5.9%	6.8%
8. I was able to hear the provider clearly by video.	87.5%	5.7%	6.8%
9. At the beginning of the Telehealth video visit, the provider addressed privacy concerns.	76.2%	17.1%	6.7%
10. I would recommend Telehealth to other Veterans.	84.1%	11.2%	4.7%
11. Overall, I am satisfied with the Telehealth video visit.	86.1%	7.6%	6.3%



FY22 Q1-Q2: Veteran Experience with Video to Home Visit Across Cohorts



FY22 Q1-Q2: Veteran Preferences for Care Across Cohorts after Experiencing Video to Home Visit



Attachment 3

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1100.20
Transmittal Sheet
September 15, 2021

CREDENTIALING OF HEALTH CARE PROVIDERS

1. REASON FOR ISSUE. This Veterans Health Administration (VHA) directive establishes policy regarding credentialing of health care providers appointed within VHA in occupations requiring maintenance of licensure, certification, or registration. This requirement is mandated by occupation-specific qualification standards. Health care providers must be fully credentialed prior to onboarding and providing patient care.

2. SUMMARY OF CONTENTS.

a. This directive defines national standards and responsibilities for the credentialing of health care providers appointed within VHA in health care occupations requiring maintenance of licensure, certification, or registration.

b. This directive realigns the VA medical facility Credentialing and Privileging program under the VA medical facility Chief of Staff (COS).

c. This directive supersedes the Credentialing portion of VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012, but does not impact the Privileging portion of Handbook 1100.19, Credentialing and Privileging.

3. RELATED ISSUES. VHA Directive 1100.18, Reporting and Responding to State Licensing Boards, dated January 28, 2021; VHA Directive 1914, Telehealth Clinical Resource Sharing Between VA Facilities and Telehealth from Approved Alternative Worksites, dated April 27, 2020; VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009; VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.

4. RESPONSIBLE OFFICE. The Office of Quality and Patient Safety is responsible for the contents of this VHA Directive. Questions may be addressed to the Office of Medical Staff Affairs at VHA17QM6MedStaffAffairsAction@va.gov.

5. RESCISSIONS. VHA Directive 2012-030, Credentialing of Health Care Professionals, dated October 11, 2012; Operational Memo 2019-12-11, Requirement to Enroll All Licensed Providers Into National Practitioner Data Bank Continuous Query Program; Operational Memo 2019-12-11, Tracking Provider Reporting to National Practitioner Data Bank and State Licensing Board; Operational Memo 2019-12-11, Mandatory Annual Credentialing and Privileging Self-Assessment; Operational Memo 2018-08-11, Electronic Signature in the Credentialing and Privileging Process; Operational Memo 2011-03-04, Health Care Provider Credentialing and Privileging Records; and Operational Memo 2007-04-01, Credentialing of Non-VA Providers Delivering Care Off-Station are rescinded.

6. RECERTIFICATION. This VHA directive is scheduled for recertification on or before September 30, 2026. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

BY DIRECTION OF THE UNDER SECRETARY FOR HEALTH:

/s/ Gerard R. Cox, MD, MHA
Assistant Under Secretary for Health for Quality and Patient Safety

DISTRIBUTION: Emailed to the VHA Publications Distribution List on September 20, 2021.

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

CONTENTS

CREDENTIALING OF HEALTH CARE PROVIDERS

CREDENTIALING OF HEALTH CARE PROVIDERS

1. PURPOSE

This Veterans Health Administration (VHA) directive establishes VHA policy regarding credentialing of health care providers requiring maintenance of licensure, registration, or certification and monitoring of time-limited credentials. This directive specifies mandatory credentialing processes which are to be implemented consistently across the VA health care system. ***NOTE:*** *This VHA directive does not apply to health care providers furnishing health care to Veterans in the community through the Veterans Community Care Program (VCCP).* **AUTHORITY:** Title 38 United States Code (U.S.C.) §§ 7301(b), 7402, 7405, 7409.

2. BACKGROUND

a. The credentialing process is the first step in patient safety and ensures health care providers meet the clinical qualifications required to provide quality care.

b. This directive applies to all health care providers in occupations that require maintenance of a license, registration, or certification, as required by their occupation specific qualification standard, in any VHA entity, including VA medical facilities, VHA Central Office, Veterans Integrated System Network (VISN) offices, and other organizational components that would require credentialing unless otherwise cited in this policy.

c. This directive applies to all health care providers in occupations requiring maintenance of license, registration, or certification (i.e., applies to all licensed independent practitioners as well as those occupations which do not practice independently such as registered nurses and technologists).

d. Additionally, these procedures apply to:

(1) Without Compensation (volunteer);

(2) Contractor providers; and

(3) In limited circumstances, health care providers who have not yet obtained the license, certification, or registration required for their occupation, such as an unlicensed social worker or unlicensed psychologist who has just completed training and has a period of time to obtain the credential required to practice without oversight of another licensed provider. ***NOTE****: This directive does not apply to health care provider trainees.*

e. Additional information related to the credentialing process, including standard operating procedures (SOPs), checklists, flowcharts, VetPro User Guides, and auditing tools are located on the VHA Medical Staff Affairs intranet site: http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crVetProRef.aspx. ***NOTE:*** *These are internal VA websites that are not available to the public.*

3. DEFINITIONS

a. **Applicant.** An applicant is a health care provider who is applying to be credentialed and privileged at a VA medical facility for the first time.

b. **Appointment.** For the purposes of this directive, appointment means a medical staff appointment to the VA medical facility medical staff as a licensed independent provider (LIP) or date of onboarding or contractual start-date for non-LIPs. It does not refer to appointment as a VA employee (unless clearly specified). Medical Staff Appointment dates for LIPs correspond with the dates of the Active Privileges granted by the VA medical facility Director and are recorded in VetPro on the Appointment Screen. The appointment start date is defined as the date the Director signs the privileging form to officially grant the privileges. Both VA employees and contractors may receive appointments to the medical staff. For non-LIPs, the appointment date is the date they are onboarded by Human Resources (HR) or their contract start date.

c. **Certification.** Certification is a credential issued by a professional organization that a health care provider has met the standards or skills to practice their profession. For purposes of this directive, certification requirements generally pertain to requirements outlined within the qualification standards for the occupation in which the health care provider is being appointed. Examples include but are not limited to certification requirements outlined in qualification standards for advance practice nurses.

d. **Clean Application.** A clean application does not have any outstanding issues (commonly referred to as red flags) including, but not limited to, current or previously successful challenges to licensure, registration, or certification; no history of involuntary termination of medical staff at another organization; no history of pending or previous privileging actions; and no final judgement adverse to the applicant in a professional liability action.

e. **Competency.** For purposes of this directive, competency is a documented demonstration that an individual has sufficient knowledge or skill necessary to perform to a defined standard.

f. **Credentialing.** Credentialing is the process of obtaining, verifying, and assessing the qualifications of a health care provider to provide care or services in or for the VA health care system. Credentials are documented evidence of licensure, education, training, experience, or other qualifications.

g. **Current.** The term current applies to the timeliness of the verification and use for the credentialing process. A credential is considered current if verification was obtained after the health care provider submits their electronic credentialing application in VetPro and provides a signed Release of Information to obtain required documentation to be utilized for credentialing purposes. ***NOTE:*** *Credentials are considered current if verified within a two-year period with exception of time limited credentials, such as State licensure, which have an expiration date assigned by the State agency. For additional*

information visit http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx. This is an internal VA website that is not available to the public.

h. **The Federation of State Medical Boards.** The Federation of State Medical Boards (FSMB), since its inception in 1912, has grown to represent the current 71 state medical and osteopathic regulatory boards, commonly referred to as state medical boards within the United States, its territories and the District of Columbia. It supports its member boards as they fulfill their mandate of protecting the public's health, safety and welfare through the proper licensing, disciplining, and regulation of physicians and, in most jurisdictions, other health care professionals.

i. **Good Faith Effort.** Good faith effort is the reasonable attempt to obtain primary source documentation. A minimum of two efforts to obtain primary source documentation must be made with supporting written documentation. These efforts can be documented in the form of a report of contact, in lieu of the document sought. If a Good Faith Effort has been made and documented, but no primary source documents can be obtained, the VA medical facility Credentialing Specialist must then obtain verification through a secondary source. ***NOTE:*** *Good Faith Efforts may never be used for verification of licensure, registration, or certification obtained within the United States, including Puerto Rico. Verifications of these credentials may only be from the primary source.*

j. **Health Care Provider**. Health care providers are individuals in occupations which have qualification standards which require licensure, certification, or registration in order to provide direct patient care. Examples include, but are not limited to physicians, dentists, registered nurses, social workers, and dieticians. ***NOTE****: This does not include occupations which may have qualification standards requiring license, certification, or registration but do not provide direct patient care that is documented in a patient record for example, medical record technicians, chaplains, or medical supply technicians.*

k. **Licensed Independent Practitioner.** A licensed independent practitioner (LIP) is an individual permitted by law and the VA medical facility through its medical staff bylaws to provide patient care services independently, without supervision or direction, within the scope of the individual's license and in accordance with privileges granted by the VA medical facility. ***NOTE:*** *LIPs are required to be recredentialed every two years. Clinical Pharmacy Specialists, Physician Assistants, and Certified Registered Nurse Anesthetists (who are not privileged) are required to be credentialed and recredentialed in the same manner of as LIPs even though they are not LIPs.*

l. **Licensure.** Licensure is a legal right that is granted by a government agency in compliance with a statutory or regulatory authority governing an occupation (such as medicine, nursing, psychiatry, psychology, clinical counseling, or clinical social work) or the operation of an activity in a health care center (for example, skilled nursing facility, residential treatment center, hospital). ***NOTE:*** *Additional information related to verification of licensure and required licensure review of licensure actions is available at: http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/msaLanding.aspx*. ***NOTE:*** *This*

is an internal VA website that is not available to the public.

m. **Medical Staff Bylaws.** Medical Staff Bylaws are a governance framework that establishes the roles and responsibilities of a body and its members. The organized medical staff at a VA medical facility creates a written set of documents that describes its organizational structure and the rules for its self-governance. These documents are called medical staff bylaws, rules and regulations, and policies. These documents create a system of rights, responsibilities, and accountabilities between the organized medical staff and the VA medical facility Director as the governing body, and between the organized medical staff and its members. ***NOTE:*** *The Bylaws Template published by VA Central Office must be utilized by VA medical facilities utilizing all mandatory content. This template is located at http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/msp/mspLanding.aspx. This is an internal VA website that is not available to the public.*

n. **National Practitioner Data Bank.** The National Practitioner Data Bank (NPDB) is a web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. The NPDB is maintained and managed by the U.S. Department of Health and Human Services. Federal regulations authorize eligible entities to report to and query the NPDB. ***NOTE:*** *Individuals and organizations who are subjects of these reports have access to their own information. The reports are confidential, and not available to the public.*

o. **National Practitioner Data Bank Continuous Query Program.** The National Practitioner Date Bank (NPDB) Continuous Query (CQ) is a program in which enrolled practitioners are monitored on an ongoing basis. If an enrolled practitioner is reported to the NPDB by any entity, an email notification is sent to the facility which enrolled the practitioner to alert them about the report received by NPDB. The alerts are received within twenty-four hours of the report being made. ***NOTE:*** *For more information on the NPDB, see VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009.*

p. **Non-Licensed Independent Practitioner.** A non-licensed independent practitioner (Non-LIP) is a health care provider who works autonomously to the full extent of their license, registration, or certification but is not permitted by their license, registration, certification, or Medical Staff Bylaws to practice independently (and be privileged). Non-LIPs generally provide care through treatment plans developed by LIPs, orders, or under the oversight or direction of Licensed Independent Practitioners. ***NOTE:*** *Examples of Non-LIPs include but are not limited to registered nurses, licensed practical nurses, dieticians, radiology technologists, laboratory technologists.*

q. **Primary Source.** The original source or an approved agent of that source of a specific credential that can verify the accuracy of a qualification reported by an individual practitioner. Examples include, but are not limited to, medical schools, nursing schools, graduate education, state medical boards, federal and state licensing boards, universities, colleges, and community colleges. ***NOTE****: When primary source*

verifications cannot be obtained after good faith efforts, secondary source verification must be utilized. For more information on secondary source verification, see paragraph 3.s.

r. **Registration.** Registration is the official confirmation by a professional organization that one has fulfilled the requirements or met a standard or skill to practice the profession and may be required to qualify for appointment within a specific occupation within VA.

s. **Report of Contact.** Report of Contact is the written documentation in VetPro of a primary or secondary source verification. The Report of Contact must be documented within VetPro and include the name of the individual who obtained the information within VA (i.e., the VA medical facility credentialing specialist), the name, title, and contact information of the individual who provided the information, and completion of each field with the VetPro Report of Contact electronic forms.

t. **Secondary Source Verification.** Secondary source verification is verification of a specific health care provider's credential from a knowledgeable secondary source who can verify documentation with a high degree of accuracy. Acceptable secondary source verification(s) include but are not limited to: written statements from the leadership of successor organizations, contacting other hospitals where a provider was credentialed to obtain a copy of their primary source verification, obtaining copies of official documents from the provider (as opposed to directly from the medical school or similar organization), and obtaining information published on the provider's credentials from a State Licensing Board (SLB), or published information on the Federation of State Medical Board's website https://www.docinfo.org/. ***NOTE**: When primary source verifications cannot be obtained after good faith efforts, secondary source verification may be utilized. Licenses, registrations, or certifications obtained within the United States, including Puerto Rico, may not be verified through secondary sources. Licenses obtained from a foreign country may be verified through a secondary source after two good faith efforts are made to obtain primary source verification.*

u. **State Licensing Board.** The term State Licensing Board (SLB) in the context of health care means the agency of a State that is primarily responsible for licensing of the physician or provider to furnish health care services. ***NOTE:** For more information on SLBs, see VHA Directive 1100.18, Reporting and Responding to State Licensing Boards, dated January 28, 2021.*

v. **Telehealth.** Telehealth (telemedicine) is the use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health, and health administration.

w. **VetPro.** VetPro is VHA's mandatory credentialing software platform to document the credentialing of VHA health care providers. This system facilitates completion of a uniform, accurate, and complete credentials file. ***NOTE:** For the purposes of this directive, the health care provider's electronic credentialing file will be referred to as the health care provider's VetPro file.*

x. **Without Compensation.** Without Compensation (WOC) is the term for a VA appointment for health care providers who volunteer their services at the VA medical facility and are not paid for their services. Though not receiving compensation, these health care providers must have a VA appointment and must be fully credentialed and privileged prior to providing health care services.

4. POLICY

a. It is VHA policy that all VHA health care providers who are appointed in occupations requiring maintenance of licensure, registration, or certification must be credentialed prior to being onboarded and providing health care (unless the health care provider falls within one of the exceptions outlined in this directive).

b. It is also VHA policy that VetPro must be used for the credentialing process.

c. Finally, it is VHA policy that all standard operating procedures linked to this directive at http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx are required to implement the credentialing process.

d. These requirements apply to health care providers providing care in person at the VA medical facility and to health care providers who are providing telehealth care to Veterans ***NOTE:*** *Providers who perform telehealth must be credentialed as outlined within this Directive and may provide telehealth services as found in VHA Directive 1914, Telehealth Clinical Resource Sharing Between VA Facilities and Telehealth from Approved Alternative Worksites, dated April 27, 2020.*

5. RESPONSIBILITIES

a. **Under Secretary of Health.** The Under Secretary for Health is responsible for VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Quality and Patient Safety.** The Assistant Under Secretary for Health for Quality and Patient Safety is responsible for:

(1) Providing oversight of the Medical Staff Affairs (MSA) Director to ensure they comply with their responsibilities under this directive.

(2) Ensuring the MSA Director has sufficient resources to fulfill MSA's responsibilities under this directive.

(3) Providing senior executive leadership guidance and support to the MSA Director.

c. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the VISNs.

(2) Providing assistance to VISN Directors to resolve implementation and

compliance challenges.

(3) Providing oversight of VISNs to assure compliance with this directive.

d. **Medical Staff Affairs Director.** The MSA Director is responsible for:

(1) Establishing the credentialing process requirements for the VA health care system.

(2) Serving as a VHA subject matter expert for the credentialing process.

(3) Completing the credentialing process for health care providers appointed to and located at VA Central Office.

(4) Overseeing and managing the national credentialing VetPro system and contract.

(5) Maintaining the credentialing process information located at http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx.

e. **Office of Academic Affiliations Director**. The Director of the Office of Academic Affiliations is responsible for serving as a consultant to the Medical Staff Affairs Director or VA medical facility Executive Leadership to assess educational credentials to determine compliance with VA qualification standards if a question arises during the credentialing process.

f. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that all VA medical facilities in the VISN comply with this directive and informing leadership when barriers to compliance are identified.

(2) Ensuring that all VA medical facilities in the VISN have the resources to implement this directive.

(3) Ensuring that all VISN employees are credentialed whose positions would require credentialing in a VA medical facility. ***NOTE:*** *For more information on this responsibility see paragraph 2.b.*

g. **Veterans Integrated Service Network Chief Medical Officer.** The VISN CMO is responsible for:

(1) Providing oversight of the credentialing process at all VA medical facilities within the VISN to ensure compliance with this directive and initiating and overseeing corrective action when opportunities for improvement are identified. ***NOTE:*** *The results, actions for remediations of findings, and verification of ongoing compliance will be reported to the VISN lead clinical committee, e.g., Health Care Delivery Committee.*

(2) Completing an annual analysis of VA medical facility credentialing self-

assessments utilizing the self-auditing tool located at: https://vaww.rtp.portal.va.gov/OQSV/10A4E/MSAR/_layouts/15/start.aspx#/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(3) Reviewing a health care provider's credentials when the malpractice thresholds outlined below are met and making a documented recommendation to the respective VA medical facility on appropriateness of continuing with the credentialing process within the VetPro file.

(a) Three or more medical malpractice payments in payment history.

(b) A single medical malpractice payment of $550,000 or more.

(c) Two medical malpractice payments totaling $1,000,000 or more.

NOTE: *This review must be completed prior to presentation of the health care provider's credentials to the* Executive Committee of the Medical Staff (ECMS)*, so that it may be included in the ECMS's review of the health care provider's VetPro files. See http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx for additional details. This is an internal website that is not available to the public.*

(4) Overseeing the internal controls for credentialing at each of the VA medical facilities within the VISN. and addressing and remediating any deficiencies identified. ***NOTE:*** *Tools for monitoring credentialing internal controls, including credentialing report card templates and other reports can be accessed at. http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crLanding.aspx. This is an internal website that is not available to the public.*

(5) Reviewing credentialing processes on an annual basis, at minimum, at each VA medical facility within the VISN via a face-to-face site visit, when feasible, to validate internal controls and ensure that credentialing is completed prior to onboarding of any health care provider and initiating corrective process action, as necessary. ***NOTE:*** *The site visit should take place after the VA medical facility has completed the credentialing and privileging program facility self-assessment located at https://vaww.rtp.portal.va.gov/OQSV/10A4E/MSAR/_layouts/15/start.aspx#/SitePages/Home.aspx. This is an internal website that is not available to the public.*

(6) Partnering with the VISN Chief Nursing Officer, or comparable position, for credentialing program oversight, issues, opportunities, and concerns related to the credentialing of providers reporting to the Assistant Director of Patient Care Services (ADPCS) at the VA medical facility level.

h. **Veterans Integrated Service Network Human Resources Officer.** The VISN Human Resources Officer (HRO) is responsible for:

(1) Working with the VA medical facility Senior Strategic Business Partner and the VA medical facility Credentialing Specialist to ensure credentialing is completed prior to onboarding of any health care provider, unless the exceptions outlined in this directive

are met.

(2) Ensuring that credentialing information is utilized during the hiring process to ensure that applicants meet the qualifications of the available position.

i. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Providing oversight to ensure identified and appropriate VA medical facility staff comply with this directive.

(2) Ensuring the VA medical facility credentialing program is adequately staffed and resourced to ensure compliance with this directive. ***NOTE:*** *Recommended staffing benchmarks are available at: http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx . This is an internal VA website that is not available to the public.*

(3) Ensuring credentialing is completed prior to the onboarding of any health care provider.

(4) Receiving weekly report cards for awareness of the status of the credentialing process within the VA medical facility from the VA medical facility Chief of Staff (COS).

(5) Working with the VA medical facility COS, ECMS chair and Credentialing and Privileging Manager to ensure internal controls are in place within the VA medical facility to track critical credentialing program benchmarks including but not limited to:

(a) Licensure, certification, or registration expirations required as a condition of employment through qualification standards or contractual requirement;

(b) Appointment expirations;

(c) Credentialing timeframes;

(d) Enrollment in the National Practitioner Data Bank (NPDB) Continuous Query (CQ) enrollment; and

(e) Active appointments with no license ***NOTE:*** *The template for the report card for this report is located at:http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crLanding.aspx. This is an internal VA website that is not available to the public.*

(6) Ensuring VA medical facility Credentialing Specialists complete required training. ***NOTE:*** *More information on required training associated with this directive can be found in paragraph 7.*

(7) Ensuring all credentialing documents are maintained in accordance with the System of Records Notice 77VA10A4, Health Care Provider Credentialing and Privileging Records – VA Systems of Record Notice (SORN). ***NOTE:*** *This SORN may*

be accessed at:
http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx. This is an internal VA Website that is not available to the public.

(8) Appointing an individual at the VA medical facility to lead completion of the VA medical facility self-assessment. ***NOTE:*** *Though the Credentialing and Privileging Manager has the responsibility to serve as a subject matter expert (SME), the self-assessment must be completed by someone outside of the VA medical facility Credentialing and Privileging office. The lead will likely organize a multi-disciplinary team for completion of the VA medical facility self-assessment.*

(9) Reviewing the results of the annual VA medical facility credentialing self-assessment after the appropriate VA medical facility executive leader has reviewed the assessment and approving the results before they are sent to the VISN CMO.

j. **VA Medical Facility Senior Strategic Business Partner.** The VA medical facility Senior Strategic Business Partner is responsible for:

NOTE: *This position was previously referred to as the VA medical facility HRO.*

(1) Working with the VA medical facility Credentialing and Privileging Manager to ensure that the credentialing and the HR onboarding processes occur concurrently to expedite the hiring and appointment of VA medical facility health care providers.

(2) Reviewing all licensure actions identified during the credentialing process to ensure the health care provider meets the position qualification requirements. The required licensure review process is available at http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

(3) Utilizing primary source verified credentials to determine eligibility of applicants during the appointment process.

(4) Providing technical advice related to findings in the credentialing process which may impact the eligibility for appointment and hire by HR (e.g., violation of Title 38 U.S.C. § 7402 and VA Directive 5005, Staffing (Staffing and Recruitment), dated April 15, 2002). ***NOTE:*** *Determination of qualification for VA appointment should be made within one business day. If it is determined that a finding during the credentialing process, such as a licensure action, disqualifies the health care provider for VA appointment, the VA medical facility Senior Strategic Business Partner is responsible for notifying the* management official within an employee's chain of supervision who is *authorized to take immediate action as required by VA Directive 5005, Staffing and Recruitment.*

(5) Notifying the VA medical facility Contracting Officer if the VA medical facility Senior Strategic Business Partner determines that a contracted health care provider no longer meets the requirements for the occupation in which they are contracted as a result of a licensure action.

(6) Notifying the management official within an employee's chain of supervision who is authorized to take immediate action when notified by the VA medical facility Credentialing and Privileging Manager, COS, or clinical service chief that a LIP has failed to obtain credentials within the time frame required by their licensure, certification, or registration and all credentials.

(7) Tracking unlicensed health care providers (e.g., unlicensed social workers who have a defined period of time upon completion of training to obtain their license) to ensure they obtain appropriate credentials within the required timeframe and notifying the management official within an employee's chain of supervision who is authorized to take immediate action if the health care provider fails to do so. ***NOTE:*** *For additional information on tracking credentialing of unlicensed health care providers, please visit http://vaww.ogsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx. This is an internal website that is not available to the public.*

j. **VA Medical Facility Contracting Officer.** The VA medical facility contracting officer is responsible for:

(1) Working with the VA medical facility Credentialing and Privileging Manager and the Contracting Officer's Representative (COR) to ensure that credentialing is completed prior to scheduling of a contract health care provider and the provision of patient care by the contractor.

(2) Removing a contractor health care provider if the VA medical facility Senior Strategic Business Partner determines that the contractor no longer meets the requirements for the occupation for which they are contracted.

k. **VA Medical Facility Contracting Officer's Representative.** The VA medical facility COR is responsible for:

(1) Working with the VA medical facility Credentialing Specialist, Credentialing and Privileging Manager and the Contracting Officer to ensure that credentialing is completed prior to scheduling of a contract health care provider and the provision of patient care by the contractor.

(2) Notifying the VA medical facility Credentialing and Privileging Manager and the Credentialing Specialist when a contract health care provider is no longer providing care at the VA medical facility so that the appointment in VetPro can be expired and the Credentialing and Privileging Manager can inactivate the health care provider's VetPro File.

(3) Working with the VA medical facility Credentialing and Privileging Manager to ensure contracts for health care providers contain appropriate requirements related to credentialing.

l. **Executive Leadership.** Executive leadership at the VA medical facility is responsible for:

NOTE: *This responsibility applies to all members of executive leadership at the VA medical facility who oversee service lines with credentialed health care providers.*

(1) Ensuring that all health care providers covered by this directive within service lines under the oversight of the Executive Leadership position at the VA medical facility are fully credentialed prior to onboarding and the provision of patient care.

(2) Ensuring that clinical service chiefs are reviewing the available credentialing information for an application and utilizing that information to form a basis for decisions when recommending an applicant for appointment.

(3) Reviewing documentation received related to Federation of State Medical Boards (FSMB) Disciplinary Appeals Board (DAB) alert (for physicians) and National Practitioner Data Bank (NPDB) reports to determine the impact on the health care provider's ability to practice within the scope of their assigned clinical duties.

(4) Reviewing and signing off on the results of the VA medical facility credentialing self-auditing before reporting those results to the VA medical facility Director, who must sign off on the results before they are submitted to the VISN CMO.

(5) Ensuring that appropriate administrative, disciplinary, or other corrective action is taken when a health care provider is found to be noncompliant with this directive.

m. **VA Medical Facility Chief of Staff.** The VA medical facility COS is responsible for:

(1) Overseeing the credentialing program within the VA medical facility.

(2) Providing oversight of the VA medical facility Credentialing and Privileging Manager to ensure they are implementing the requirements of this directive.

(3) Working with the VA medical facility Director to ensure that the VA medical facility has appropriate staffing resources to meet the credentialing needs and workload of the VA medical facility.

(4) Ensuring that internal monitoring of credentialing activities is in place, reviewed, and acted upon when issues are identified in accordance with this directive. ***NOTE:*** *Reports must include monitoring and updating of time limited credentials such as licensure, registration, and certification required by the health care providers to remain qualified for VHA appointment.*

(5) Working with the ADPCS to address any credentialing program issues and opportunities for improvement related to the credentialing of providers within the ADPCS's scope of authority.

n. **VA Medical Facility Clinical Service Chiefs.** VA medical facility clinical service chiefs are responsible for:

(1) Reviewing the credentialing package to form a basis for decision for recommending an applicant for appointment.

(2) Ensuring that no health care provider within their service at the VA medical facility is onboarded or provides patient care prior to completion of the full credentialing process as outlined in this directive.

(3) Ensuring that no provider within their service at the VA medical facility is scheduled to perform patient care at the VA medical facility, including on-call services, prior to completion of credentialing as outlined in this directive.

(4) Reviewing NPDB reports and related primary source verifications and take required action as appropriate.

(5) Investigating a licensure action for a VA medical facility health care provider when notified by the VA medical facility Credentialing and Privileging Manager of a licensure action identified through the credentialing process or through an alert received from the NPDB.

o. **VA Medical Facility Executive Committee of the Medical Staff Chair.** The Executive Committee of the Medical Staff (ECMS) Chair is responsible for:

(1) Working with the VA medical facility COS to provide oversight of the VA medical facility credentialing processes, including privileging actions and clinical performance monitoring, in accordance with the Medical Staff Bylaws.

(2) Recommending to the VA medical facility Director whether or not a health care provider should be appointed or recredentialed at the VA medical facility based on ECMS discussion and review of the VetPro file. ***NOTE:*** *This recommendation must be made in VetPro on the Committee Screen. This includes the responsibility to discuss any FSMB DAB alerts or NDPB reports uncovered during the credentialing process or are received outside of the normal credentialing cycle, via the CQ alert system to determine the impact on the health care providers continued ability to practice within the scope of privileges granted with recommendation made to the VA medical facility Director as to next action to be taken.*

p. **VA Medical Facility Credentialing and Privileging Manager.** The VA medical facility Credentialing and Privileging Manager is responsible for:

(1) Providing direct technical and administrative supervision to employees within the Credentialing and Privileging Office at the VA medical facility.

(2) Ensuring that Credentialing Specialists are completing the credentialing process in compliance with statutory and regulatory requirements and procedures, The Joint Commission standards, this directive, and related credentialing policy.

(3) Partnering with the ADPCS to provide credentialing reports, priorities, and status are communicated on an ongoing basis relative to providers in the Patient Care

Services structure.

(4) Serving as the VA medical facility Point of Contact to respond to credentialing and privileging related needs during a presidentially declared emergency.

(5) Working with the VA medical facility Senior Strategic Business Partner to ensure that the credentialing and HR onboarding processes occur concurrently to expedite the hiring and appointment of VA medical facility health care providers, and on other joint HR and credentialing issues and initiatives. ***NOTE:*** *Examples of joint issues include but are not limited to, provider onboarding, provider exit reviews and assessments, privileging actions, review of previous or current licensure actions, and guidance related to clinical performance concerns.*

(6) Expeditiously initiating a licensure review when a licensure action for a VA medical facility health care provider is identified through the credentialing process or through an alert received from the NPDB, ideally within 1 hour of receiving the alert during a normal business day. For information on the requirements for the credentialing process when there is a licensure action please visit http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx.

(7) Requesting and responding to inquiries from other VA medical facilities related to a health care provider's performance competency within VA as part of the credentialing process.

(8) Partnering with the VA medical facility COR to ensure contracts for health care providers contain appropriate requirements related to credentialing.

(9) Working with the VA medical facility COR and Credentialing Specialist to ensure that credentialing is completed prior to scheduling of a contract health care provider.

(10) Communicating with the COR when a contract health care provider is no longer providing care at the VA medical facility and inactivating the health care provider's VetPro file.

(11) Reporting to the VA medical facility COS weekly on the status of credentialing within the VA medical facility. ***NOTE:*** *Reports must include monitoring and updating of time limited credentials such as licensure, registration, and certification required by the health care providers to remain qualified for VHA appointment*.

(12) Serving as a subject matter expert for the annual self-assessment utilizing the facility self-assessment tool. ***NOTE:*** *The self-assessment tool is located at:* *https://vaww.rtp.portal.va.gov/OQSV/10A4E/MSAR/_layouts/15/start.aspx#/SitePages/Home.aspx. This is an internal VA website that is not available to the public.*

(13) Partnering with the VA medical facility Telehealth Coordinator as needed to provide information required for health care provider's performing telehealth services in accordance with VHA Directive 1914, Telehealth Clinical Resource Sharing Between VA Facilities and Telehealth from Approved Alternative Worksites.

(14) Providing guidance and support to VA medical facility leadership and clinical service chiefs on the credentialing process and their roles and responsibilities.

(15) Timely completing the VHA NPDB/SLB Tracker to ensure timely reporting is occurring and acts when timeliness concerns are identified in the reporting process.

q. **VA Medical Facility Credentialing Specialist.** The VA medical facility Credentialing Specialist is responsible for:

(1) Processing health care provider's credentialing application through VetPro. ***NOTE:*** *The requirements for the credentialing processes can be found at http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx. This is an internal VA website that is not available to the public.*

(2) Tracking credential expiration dates and bringing credentials expiring within two weeks or less to the attention of the health care provider's supervisor and the Credentialing and Privileging Manager.

(3) Assisting with the transfer and sharing of credentials within the VA medical facility. ***NOTE:*** *For more information on Transfer of Credentials, visit http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx.*

(5) In States offering a grace period after the licensure, registration, or certification has expired, verifying that the State Licensing Board (SLB) or other certifying board considers the license in an active, full and unrestricted status, and documenting this verification in the health care provider's VetPro file and the final date of the grace period entered as the license expiration date. ***NOTE:*** *Documentation of this grace period applies to any other registration or certifying body if applicable.*

(4) Monitoring expiration dates for each VA medical facility health care provider's enrollment in the NPDB Continuous Query process. ***NOTE:*** *For more information on Continuous Query process, visit http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx.*

r. **VA Medical Facility Health Care Provider.** The VA medical facility health care provider is responsible for:

(1) Submitting a complete credentialing application within VetPro and maintaining credentials as required by their occupation specific qualification standards including licensure, registration, or certification in good standing.

(2) Monitoring expiration dates of required time limited credentials and renewing prior to the expiration date. ***NOTE:*** *Failure to do so may result in an adverse action including immediate termination.*

(3) Informing their Service Chief in writing of any changes in the status of credentials at the earliest date after notification is received by the health care provider, but no later than 5 calendar days after the change, including, but not limited to, any

pending or proposed actions. ***NOTE***: *Failure to notify their supervisor on these matters may result in administrative or disciplinary action.*

(4) Obtaining and producing all information required for evaluation of professional competence, character, ethics, and other qualifications for recredentialing. The information must be complete and verifiable. ***NOTE:*** *Failure to keep VA fully informed on credentialing issues may result in administrative or disciplinary action.*

(5) Providing a written explanation for any credentials which are no longer held or are no longer full and unrestricted.

6. ADDRESSING URGENT PATIENT CARE NEEDS

a. **Provisions**. Health care providers must be fully credentialed prior to initial appointment or reappointment unless initially appointed through the temporary appointment process as outlined in this directive and SOP for the credentialing process. ***NOTE:*** *Guidance can be found at the following http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx.* ***NOTE****: This is an internal website that is not available to the public.*

b. **Temporary Medical Staff Appointments for Urgent Patient Care Needs.** Temporary appointments are to be used in an emergent situation when clinical skills are required to address an emergent patient care need. The Temporary Medical Staff Appointment must not be used for administrative convenience or as a route to bypass credentialing requirements due to failure of supervisory oversight and planning. Further details of the Temporary Appointment process may be found at http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crPolicy.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

7. TRAINING

Resources to assist VA medical facilities with credentialing and privileging related training can be found at the Medical Staff Affairs intranet website located at: http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crLearning.aspx. ***NOTE:*** *This is an internal VA Web site and it is not available to the public.* This website contains information about the recommended and mandatory training requirements.

8. RECORDS MANAGEMENT

All records in any medium (paper, electronic, electronic systems) created in response to this directive, including records obtained pursuant to System of Records Notice 77VA10A4, Health Care Provider Credentialing and Privileging Records – VA, must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management should be referred to the appropriate Records Manager or Records Liaison.

9. REFERENCES

a. Pubic Law (P.L.) 99-166 § 206.

b. P.L. 99-660 § 422.

c. P.L. 104-91 § 221.

d. P.L. 105-33 § 4331(c).

e. P.L. 106-117 §. 209.

f. 38 U.S.C. §§ 7301, 7401, 7402, 7405, 7409, 7461 – 7464.

g. 5 C.F.R. Part 315, 731, and 752.

h. 38 C.F.R. Part 46.

i. 45 C.F.R. Part 60

j. VA Directive 5005, Staffing, dated April 15, 2002.

k. VHA Directive 1100.18, Reporting and Responding to State Licensing Boards, dated January 28, 2021

l. VHA Directive 1914, Telehealth Clinical Resource Sharing Between VA Facilities and Telehealth from Approved Alternative Worksites, dated April 27, 2020.

m. VHA Handbook 1100.17, National Practitioner Data Bank (NPDB) Reports, dated December 28, 2009.

n. VHA Handbook 1100.19, Credentialing and Privileging, dated October 15, 2012.

o. VHA Office of Quality, Safety & Value, Medical Staff Affairs (C&P) Intranet page, http://vaww.oqsv.med.va.gov/functions/mindfulness/msa/cr/crLanding.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

p. Federation of State Medical Board website, http://www.docinfo.org.

q. National Student Clearinghouse website, https://www.studentclearinghouse.org/

r. The Joint Commission Standards

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