



STATEMENT OF
JACOB GADD, DEPUTY DIRECTOR FOR HEALTHCARE,
VETERANS AFFAIRS AND REHABILITATION DIVISION OF
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FIELD HEARING ON
"A MATTER OF LIFE AND DEATH: EXAMINING PREVENTABLE DEATHS,
PATIENT-SAFETY ISSUES AND BONUSES FOR VA EXECs WHO OVERSAW
THEM"
SEPTEMBER 9, 2013

This page blank

**STATEMENT OF
JACOB GADD, DEPUTY DIRECTOR FOR HEALTHCARE,
VETERANS AFFAIRS AND REHABILITATION DIVISION OF
THE AMERICAN LEGION
TO THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
FIELD HEARING ON**

**“A MATTER OF LIFE AND DEATH: EXAMINING PREVENTABLE DEATHS,
PATIENT-SAFETY ISSUES AND BONUSES FOR VA EXECS WHO OVERSAW
THEM”**

SEPTEMBER 9, 2013

It has been 338 days since the Pennsylvania Bureau of Laboratories contacted the Centers for Disease Control and Prevention (CDC) regarding a possible outbreak of Legionnaires' disease (LD) in the VA Pittsburgh Healthcare System (VAPHS). Over those 338 days, the subsequent investigation by the CDC has made clear there were at least 21 probable cases of LD in the Pittsburgh system, resulting in 5 patient deaths. The public was not informed of the dangers of *Legionella* bacteria at VA for over a month after CDC was brought in and the Director of the Veterans Integrated Service Network (VISN-4) which oversees Pittsburgh has not been publically disciplined for the failures of the VISN to protect the veteran patients being treated in the system. Instead he received a Presidential Distinguished Rank Award which carries a substantial cash bonus. It has been 338 days for the veterans of Pittsburgh and two things are certain, five veterans are still dead, and the public has not seen any tangible consequences for the leadership failures that led to those deaths.

The American Legion is deeply committed to ensuring veterans receive the best care anywhere as a benefit earned through their service and sacrifice. Over a decade ago, in 2003, American Legion Past National Commander Ronald F. Conley initiated a series of visits to the Department of Veterans' Affairs (VA) Medical Centers throughout the VA health-care system. One of the results of these visits was the acknowledgement that this is indeed "A System Worth Saving (SWS)".

Each year, the System Worth Saving Task Force members conduct a series of site visits to VA medical facilities, as mandated by Resolution 206, "Annual State of VA Medical Facilities Report". Part of the SWS mission is to advocate for the veterans who receive care within the healthcare system. Veterans need to know that the VA healthcare system is a safe place, where they can receive treatment and know patient safety is a top priority. However, there are troubling trends emerging in some regions, and The American Legion believes these concerns need to be addressed before they can fester and corrupt an otherwise excellent resource for veterans.

Errors and lapses can occur in any system. The American Legion expects when such errors and lapses are discovered, that they are dealt with swiftly and that the accountable parties are held responsible. The American Legion's believes "[t]hat bonuses for VA senior executive staff be tied to qualitative and quantitative performance measures¹." Awarding a bonus nearly twice the income threshold that would assign a veteran to Priority Group 8, and thus prevent that veteran from accessing their healthcare through VA, does not seem consistent with that belief. There must be accountability in the system to foster veteran trust in their healthcare.

While the overall system is generally sound, there have been emerging incidents, and The American Legion is concerned about those incidents. As the Veterans Health Administration (VHA) is examined on a national scale, lapses in leadership and accountability cannot be allowed to spread and corrupt an otherwise strong system. These failures need to be addressed swiftly and surely, and publically, so the veterans' community can have faith and trust in the safety of their care.

From October 2010 to November 2012, the VA Western New York Healthcare System allegedly put over 700 veterans who were seen at the healthcare system at risk of a blood-borne pathogen as a result of improperly misusing insulin pens by not properly disposing them after patient use and reusing them again on other patients possibly exposing them to HIV, Hepatitis B and Hepatitis C. Due to the misuse and lack of proper disposal of the insulin pens by the nursing staff, twenty veterans that were treated at the VA Western New York Healthcare System at Buffalo tested positive for hepatitis.

On May 9, 2013, the VA Office of the Inspector General (VAOIG) conducted a healthcare inspection at the VA Western New York Healthcare System at Buffalo. The findings were as follows:

- In October 2012, the Chief of Pharmacy at the medical center discovered three insulin pens that were designed only for single-use and had not been labeled properly identifying the patient names that were located in the supply drawer of the medication cart. After further review, additional insulin pens that were used on other inpatient units were also found not having any patient identification. Further investigation discovered that several nurses indicated that they have used the insulin pens on multiple patients without properly disposing of them, putting veterans at risk of potential exposure to blood-borne pathogens.
- The VAOIG healthcare inspection identified that the misuse of the insulin pens went undetected for 2 years. The staff at the medical center observed insulin pens on medication carts with no patient identification and failed to report it due to not fully

¹ Resolution No. 99: *Increase the Transparency of the Veterans Benefits Administration's (VBA) Claims Processing*, AUG 2012

comprehending the clinical risks of sharing pens and they accepted the unlabeled pens as a standard practice.

- The VAOIG found that the Veterans Health Administration (VHA) did not identify at-risk patients and members of Congress until January 2013 due to the time required for the coordination between the multiple levels of the Department of Veterans Affairs (VA) and VHA's inefficient internal process for review of large-scale adverse event disclosures.
- The VA Western New York Healthcare System at Buffalo response by leadership about the misuse of insulin pens used by the nursing staff was immediate by taking steps to identify the patients that were at risk for possible exposure and offered testing to veterans who were possibly exposed to blood-borne pathogens.

The healthcare system in their immediate response implemented immediate actions in order to prevent further incidents from occurring throughout the VA Western New York Healthcare System such as:

- The medical center staff conducted inspections of medication rooms and carts located on inpatient medical units.
- The medical center's nurse educator conducted training for all nursing staff on proper protocols and procedures
- The medical center directed a team to conduct a root cause analysis (RCA) of the incident that identified system failures and listed action plans specifically identifying system breakdowns and failures.
- The medical center's medication use committee discontinued the use of insulin pens in their inpatient medical units and returned to individually patient labeled multi-dosed medication.
- The VHA's National Center for Patient Safety provided facility staff training on promoting a culture that fully supports patient safety at the facility.

Two April VA inspector-general reports identified serious instances of mismanagement at the Atlanta VA Medical Center that led to the drug-overdose deaths of two patients and the suicide of another. The VA Inspector General linked three patient deaths in 2011 and 2012 to mismanagement and lengthy waiting times for mental health care. The medical center director at the time received a \$13, 822 bonus in 2011. Similar to the situation in Pittsburgh's VAMC, failing to crack down vigorously on failures which impact patient safety is unacceptable, and create a rift in trust between the VHA and the veterans who utilize VHA for the healthcare needs.

In one report, the VAOIG Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding Atlanta VA Medical Center

mismanagement and lack of oversight of a mental health (MH) contract. Following the inspection, the VAOIG recommended that the Under Secretary for Health take and rectify the deficiencies with respect to the provision of quality mental health care and contract management, keeping in mind the goal that veterans receive the highest quality medical care from either the VA or its partners.

In another report, the VAOIG Office of Healthcare Inspections conducted an inspection to assess the merit of allegations that negligence and mismanagement by Mental Health Service Line (MHSL) leadership contributed to the death of a mental health unit inpatient at the Atlanta VA Medical Center.

The confidential complainant alleged that this inpatient's death was due to failure of MHSL leaders to:

- Establish effective unit policies
- Ensure monitoring of unit inpatients
- Staff the unit appropriately
- Care about patients

Following the inspection, the VAOIG recommended that the Under Secretary for Health, the VISN, and Facility Directors ensure that VHA develops national policies that address contraband, visitation, urine drug screens, and escort services for inpatient mental health units.

The VA Office of Inspector General also recommended that the Inpatient MH unit should employ safeguards for documentation that accurately reflect staff observation of patients, strengthens program oversight including follow-up actions taken by leadership in response to patient incidents, and are equipped with functional and well-maintained life support equipment.

The G. V. Sonny Montgomery VA Medical Center in Jackson, MS has also undergone intense scrutiny over the last year. Multiple whistleblower complaints have been raised by employees who were losing confidence in the medical center's ability to treat veterans. The complaints ranged from improper sterilization of instruments to missed diagnoses of fatal illnesses, as well as hospital management policies.

A new medical center director was appointed and has worked to deal with the issues. Approximately a year into the new director's tenure, an Office of Special Counsel (OSC) letter sent to the President highlighted the scope of the previous and ongoing investigations. The OSC letter recognized and acknowledged the whistleblower complaints, citing evidence that there indeed were issues with improper sterilization and missed diagnoses. The director publically stated that he has worked to rectify these issues, and that patient safety is no longer an issue. Additionally, according to the director, the medical center is now delivering quality care, and has

resolved the past troubles. These claims must be verified, and therefore this will be an area of special scrutiny for upcoming System Worth Saving visits.

Just days ago, a veteran calmly walked into a bathroom at the Michael E. DeBakey VA Medical Center in Houston, TX and shot himself in the head, ending his own life and calling into question VA's security practices. Past incidents about instrument sterilization have plagued the VA in Alabama, Georgia, Florida and St. Louis, MO. Any healthcare system of the VA's scale will be subject to incidents, but the manner in which the incidents are dealt with is the chief concern for protecting patient trust. Veterans must know that VA is willing to take the necessary measures to ensure their health and safety are top priorities.

In response to the incidents in Mississippi, Atlanta and New York, as well as Pittsburgh, Dr. Robert Jesse, Principal Under Secretary of the Veterans Health Administration (VHA) met with American Legion staff in August to address these concerns. Dr. Jesse outlined VA's response including a field hearing in Mississippi conducted by Under Secretary for Health Dr. Robert Petzel; and investigation of the system in New York to determine why the incidents happened, as opposed to disciplinary action against individual employees. In Atlanta, Dr. Petzel believes the appointment of a new VISN Director and facility director has solved their problems.

The American Legion believes VHA must act to address reported compliance issues when revising the current Prevention of Legionnaires' Disease directive. Furthermore, by implementing a few additional steps, recommended by VA's Office of the Inspector General, the confidence in the system by those who utilize it for healthcare will be improved. The following steps were recommended in the VAOIG healthcare inspection on August 1, 2013:

- Provide a plan that simplifies implementation of the directive, and that provides guidance, education and monitoring of the implementation of the revised Prevention of Legionnaires' disease directive when issued.
- Consider reevaluation of the current stratification plan that identifies risk of Legionnaires' disease based on transplant status.
- Institute a national water safety committee that will provide expert and technical assistance for collaborative decision-making, at the local level, in the control and prevention of waterborne disease.

The American Legion's System Worth Saving Task Force will be addressing all of these locations in follow up visits in the coming year, and looks forward to sharing the results of our independent research with the Committee and with the public. For the time being the close scrutiny of the veterans' community must be on VA to evaluate their reaction and response to addressing these terrible lapses.

As this issue continues to develop, The American Legion looks forward to working with the Committee, as well as VA, to find solutions. For additional information regarding this testimony, please contact Mr. Ian de Planque at The American Legion's Legislative Division, (202) 861-2700 or ideplanque@legion.org.