STATEMENT OF
DANIEL M. DELLINGER, NATIONAL COMMANDER
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"A CONTINUED ASSESSMENT OF DELAYS IN VA MEDICAL CARE AND PREVENTABLE VETERAN DEATHS"

APRIL 9, 2014

In November of 2013, on the heels of delays and patient deaths at the G.V. (Sonny) Montgomery VA Medical Center referred to as "kerfuffles" by senior VA officials[1], the Oversight and Investigation (O&I) subcommittee of this committee held a hearing entitled "Correcting 'Kerfuffles' – Analyzing Prohibited Practices and Preventable Patient Deaths at Jackson VAMC" During that hearing, Chairman Coffman requested a report from the Department of Veterans Affairs (VA) witness on how the facility is specifically addressing the concerns raised by whistleblowers about understaffing, overbooked patients, lack of oversight and lack of access, and requested that report be delivered within 30 days.

The very next day, November 14, 2013, The American Legion contacted the Veterans Health Administration (VHA) and requested a copy of the same report. As of today, nearly five months later, VHA has yet to provide that report.

During an American Legion System Worth Saving Task Force site visit to Jackson, Mississippi from January 20-22, 2014 facility director Joe Battle was unable to provide the action plan the facility was using to address problems with patient deaths. Director Battle stated he could not release the report because it had not been cleared by VA Central Office (VACO). Repeated follow up requests for information to VHA by American Legion staff have been met with the response that VHA cannot release this information to The American Legion. The reason provided has been that could VA's Office of Congressional Legislative Affairs (OCLA) has not cleared or sent this response to Congress. The American Legion is not acting as an arm of congressional oversight and should have access to, and should expect timely delivery of information about patient safety.

This lack of communications with key stakeholders hurts the entire healthcare system because it undermines veteran trust in what is otherwise an excellent healthcare system designed and operated for veterans. The American Legion has historically enjoyed excellent communications with VHA and with Congress. We are not sure what has caused the recent breakdown, but as a congressionally chartered veteran service organization, The American Legion has a responsibility to its members, congress, and a nation of veterans to gather and inform this necessary information. Clear, complete and open communication is of paramount importance in

[1] http://www.cnbc.com/id/101187855 "There have been some public kerfuffles in the paper that don't in my mind reflect the Jackson VA facility,"

matters of patient security and safety. These lines of communication must be opened and must remain open.

Chairman Miller, Ranking Member Michaud and distinguished Members of the committee, on behalf of the 2.4 million members of The American Legion, I thank you and your colleagues for the attention you are devoting to the serious concerns that have surfaced in some locations within the Department of Veterans Affairs (VA) Healthcare system. The VHA oversees the nation's largest integrated healthcare system, operating 152 medical centers, nearly 1,400 Community Based Outreach Clinics (CBOCs), community living centers, Vet Centers, and Domiciliaries. Over 8.3 million veterans rely on VHA for their healthcare needs. Most of the time, those veterans receive excellent care and have justified trust in the system. When that trust is broken, restoration of trust is critical.

The American Legion's primary healthcare evaluation tool is the "System Worth Saving" program. The program was designed and implemented in 2003[2] by American Legion Past National Commander Ron Conley. The mission of the System Worth Saving program is to assess the quality and timeliness of veterans' healthcare and to gather feedback from veterans on their level of care. The System Worth Saving Task Force conducts site visits to 15-20 Department of Veterans Affairs (VA) Medical Facilities every year and each year focuses on one or more quality of care and/or health care issues affecting veterans. The reports from these site visits are compiled into an annual publication which is distributed to the President, Members of Congress, Senior VA Officials and American Legion members. This is our 10th year conducting the program and as such we want to focus on VA's accomplishments and progress over the past ten years, current issues and concerns as well as VA's five-year strategic plan for several program areas.

Many of the visits over the past year have also made a specific effort to focus on the sites where areas of VA mismanagement have recently been highlighted by news events or whistleblowers. Because The American Legion believes in the importance of eyes-on fact finding, having boots on the ground is critical to our responsibility in the role of third party oversight. The American Legion has 2.4 million members, many of whom utilize VHA facilities on a regular basis. It is vital to them and to all veterans we serve that they have trust in their healthcare system through transparency and honest reporting.

The following summarizes some of the key findings at critical locations from the last year's System Worth Saving visits:

Pittsburgh, Pennsylvania (NOV 4-7, 2013)

Issue: By now, the struggles of the VA Pittsburgh Healthcare System (VAPHS) have been well documented. During the fall of 2012, VAPHS noticed an unusual pattern of *Legionella* pneumonia cases. This observation led the facility to investigate a possible environmental link between its patient cases and their internal water system. In April 2013, the VA Office of the Inspector General (OIG) performed an evaluation to determine whether VAPHS was adequately

[2] http://archive.legion.org/bitstream/handle/123456789/401/2004n206.pdf?sequence=2 Resolution 206 - Annual State of VA Medical Facilities Report - AUG 2004

maintaining its system for preventing Legionnaire's Disease. Ultimately, that review found systemic failures within VAPHS that led to the Legionella outbreak. Three days after the OIG review, VA Regional Director, Michael Moreland received the government's highest career award for civil servants that included a $62,895 bonus.

Veteran Feedback: During the Veterans Town Hall Meeting conducted by The American Legion's System Worth Saving Task Force, veterans expressed disappointment with the medical center's lack of ability to properly communicate how it was handling the Legionella outbreak. The veterans were not initially aware of the outbreak, nor were they informed of the steps VA was taking to ensure their safety. Veterans at the Town Hall also voiced their concerns with access to mental health care. Several veterans stated reaching an actual operator through the phone system and getting access to the pain-management program was difficult. One veteran had to wait three months before getting into VA's pain-management program. Another veteran had waited more than eight months to have his eye condition taken care of.

Legion Response: The System Worth Saving Task Force conducted a site visit of the Department of Veterans Affairs Pittsburgh Healthcare System's Oakland Campus. For this visit specifically, the Task Force also addressed the medical center's issue of *Legionella*. During the visit, the Task Force was able to meet with the medical center's Water Safety Committee, which provides oversight on all issues related to the ongoing mitigation of *Legionella* in the water distribution system. After the medical center conducted a Root Cause Analysis (RCA) on *Legionella,* the report found that not everyone understood their roles and responsibilities with *Legionella,* which led to the establishment of a Water Safety Committee in January 2013. The Committee meets twice a month and reviews ongoing remediation efforts, assures policy adherence, testing schedule adherence, and records maintenance with the goal of assuring that VAPHS water supply is safe for the consumer. While VAPHS now claims it is the "safest medical center in the country" when it comes to testing for *Legionella*, The System Worth Saving Task Force discussed the medical center's challenges with transparency and public relations, and recommended that the medical center make better use of getting the word out to Veterans Service Organizations and communicate their aggressive approach taken to test the water.

The American Legion recommended that significant improvement is needed in the ability of the local VA medical center to respond to crises. According to VAPHS, and in discussions with VACO staff afterwards, VAPHS facility staff had a press release and response to the crisis prepared, but VACO's review process takes several weeks to a month to provide approval, and ultimately the release was never approved by VACO leadership. The American Legion believes VACO must examine the communication structure and policies to look at opportunities to reduce time in responding to crises, along with delegation of authority, responsibility and accountability to local VA facility leadership to more effectively and efficiently respond during a crisis.

Jackson, Mississippi (JAN 20-22, 2014)

Issue: The G. V. Sonny Montgomery VA Medical Center in Jackson, Mississippi (JVAMC) 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.

On November 13, 2013 the JVAMC participated in a House Veterans Affairs Committee (HVAC) subcommittee hearing entitled, "Correcting Kerfuffles." The purpose of the hearing was to discuss the policies and response of the Department of Veterans Affairs (VA) in the wake of allegations concerning the JVAMC. The hearing originated from a letter that was sent from the Office of Special Counsel (OSC)[3] about several complaints at the JVAMC. The letter was sent to the President and congressional leadership stating it had found a pattern of problems at the JVAMC. The letter cited five separate complaints over the last six years to include poor sterilization procedures, chronic understaffing of Primary Care, and missed diagnoses and poor management by the radiology department.

The heartbreaking focus of that hearing was a veteran who had been hooked up to a hospital machine without proper supervision, ultimately resulting in all of the blood being drained from the veteran's body. The American Legion was concerned that VACO leadership had referred to the problems cited by whistleblowers as "kerfuffles" when veteran lives had been lost.

Veteran Feedback: Over 70 local veterans as well as the JVAMC Director and several members of his staff attended the Town Hall Meeting hosted by The American Legion Task Force. The medical center said that it was important for them to be present to answer any questions that the veterans would have. As The American Legion has noted elsewhere in this testimony, direct communication between local VA facilities and the communities they serve is critical to maintaining a trusting relationship.

Throughout the meeting, veterans were given an opportunity to express their concerns about the Jackson VAMC. A mother of an OIF and OEF veteran stated that her son suffered severely from PSTD upon his return from the conflicts and that the veteran was placed on several medications that were changed constantly, without an explanation. The mother went on to say that after several visits to the mental health clinic, her son's primary care physician told him to "Man Up". The head patient advocate spoke directly to the mother and assured her that he would get to bottom of it.

The veterans at the Town Hall meeting felt reasonably confident that the local JVAMC staff was addressing the past issues addressed in the Congressional hearing.

Legion Response: During the November hearing mentioned above, Chairman Coffman requested that JVAMC provide a full accountability report within 30 days to the Oversight and Investigation (O&I) subcommittee. So far VA has not released this report. On November 14, 2013, The American Legion requested a copy of the report and as of this hearing; The American Legion has not received a copy either.

During our System Worth Saving Task Force site visit, facility director Joe Battle was unable to give The American Legion a copy of the action plan the facility has taken to address the

[3]Re: OSC File Nos. DI-11-1625 and DI-11-2518, March 18, 2013

preventable deaths. Director Battle stated that he could release the report because it was not cleared by VA Central Office.

Upon further requests for this information after our site visit, Veterans Health Administration staff told us that they could not release the report because Office of Congressional Legislative Affairs (OCLA) had not cleared or sent this response to Congress. Not only is Congress waiting for this information but the delays in OCLA responding to Congress have now spilled over and are affecting the abilities of The American Legion to effectively conduct our site visits and inform veterans in the communities of the risks, or mitigations of those risks within these hospitals. In conversations with VACO staff, they reported that OCLA was first sent the action plan from VHA on December 6 has not approved or sent the response to Congress. Furthermore, OCLA came back to VHA on March 26 to have VHA update the document due to the time lag and the information is now outdated.

Congress, Veteran Service Organizations, and veterans that are being treated at medical centers are frustrated, confused and feel inherently out of the loop. Nobody knows what steps VA has taken to resolve problems and that has led to a diminished confidence and renewed interest to press for more accountability on management of these facilities. Veterans in these communities continuously read newspaper articles which may or may not accurately portray the action plan and steps VA is taking to correct issues. Because of the lack of communication and timeliness of VA offices in Washington DC to work together across VA Central Office and in responding to congressional inquiries, the problem is only exacerbated.

According to a source from the Jackson facility that preferred to speak anonymously, three of the five complaints have been closed. The last review of Supply Processing Service (SPS) conducted by the network occurred in December 2012; this resulted in no corrective action needed. SPS is monitored on a daily basis and complies with VACO inspection and monitoring requirements, according to the medical center. Of the two current complaints, one alleges Quality of Care issues from a staff Radiologist identified in a 2010 non medical (pay issue) lawsuit. These issues were extensively reviewed at the time and closed in 2008. The Radiologist in question left VA employment in 2007.

Again, The American Legion cannot stress more clearly the importance of free and open communication between VHA facilities and the veterans in the communities they serve. Veterans died at this facility due to preventable errors, but the facility is not empowered to directly engage the community and allay any fears they may have about seeking care there.

Atlanta, Georgia (JAN 28, 2014)

Issue: The VA Office of the Inspector General identified serious instances of mismanagement at the Atlanta VA Medical Center in two reports dated April 17, 2013[4][5]. The incidents chronicled in the reports 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.

[4] http://www.va.gov/oig/pubs/VAOIG-12-03869-179.pdf
[5] http://www.va.gov/oig/pubs/VAOIG-12-02955-178.pdf

Veteran Feedback: During the Veterans Town Hall Meeting conducted by The American Legion's System Worth Saving Task Force, veterans primarily expressed their concerns with Atlanta VAMC's phone system, and poor customer service.

Legion Response: Unfortunately, The System Worth Saving Task Force visited Atlanta's VAMC was condensed to one day due to severe weather conditions. Because of the compressed schedule, each department of the medical center provided abbreviated interviews. Nevertheless, in the short time the Task Force was there, the Atlanta VA Medical Center claimed that VA OIG has closed out all of their recommendations.

The recommendations addressed included:

- Employing safeguards for documentation that accurately reflect staff observation of patients
- Strengthening program oversight including follow-up actions taken by leadership in response to patient incidents
- Equipping functional and well-maintained life support equipment

The medical center also claimed there was no direct linkage between the three patient deaths and mismanagement in mental health care.

The American Legion followed up with a conference call with Atlanta VAMC in an effort to further understand what happened and what steps are in place to reassure veterans' confidence in Atlanta's mental health care. The American Legion found that between 2009 and April 2013, the Medical Center had referred out a total of 4,912 Veterans to the community for contract mental health care. During that time, the Medical Center lacked a reliable process for following up on outsourced services and was unable to determine the treatment status of its referred veterans.

Atlanta VAMC's ultimate goal is to provide most, if not all, veterans' mental health care in house, and the Community Service Board (CSB) contracts were the medical center's way of ensuring that veterans were receiving mental health care in a timely manner. The Atlanta VA strengthened its monitoring and management of its contract mental health program and the facility has reduced the number of contracts it has with mental health organizations (from 26 to 6) while it has strengthened and added quality assurance monitors to the contracts. The Atlanta VAMC currently has 11 licensed clinical social workers/case workers embedded in CSB sites to coordinate care for veterans; they now have improved mechanisms to track clinical and financial data for every referral. The average number of individuals assigned to each VA case worker is 180 and an experienced supervisory social worker manages the embedded case worker program.

In order to reduce the number of veterans on CSB contract, the medical center needs additional space and staff in order to treat more, if not all, veterans in house. In 2015, the medical center plans to activate a new 86,000 square foot outpatient annex and a 15,000 square foot clinical addition that will provide much needed space for additional mental health services. The VAMC is awaiting final congressional approval for its replacement clinic in Cobb County that will increase the clinic's size from 8,000 square feet to 60,000 square feet. With the inability of

Congress to resolve the Congressional Budget Office (CBO) scoring issue, more veterans are being treated outside the VA system.

The medical center has requested The American Legion's assistance in restoring veterans' confidence in the medical center, and the medical center plans to restore this confidence with increased communication, increased transparency, and training for staff to directly communicate with veterans and stakeholders.

The American Legion believes resolution of the CBO scoring issue for CBOCs will help alleviate some of the scheduling concerns, and reiterates the need for better contact with the community. Chairman Miller and Ranking Member Michaud's bipartisan "Department of Veterans Affairs Major Medical Facility Lease Authorization Act of 2013[6]" would provide immediate solutions for many CBOCs, and The American Legion supports this legislation[7] and is is glad the House of Representatives saw fit to pass this bill in December of 2013. It is critical the Senate take action and help resolve this problem for the CBOCs.

Augusta, Georgia (MAR 11-12, 2014)

Issue: At the Charlie Norwood VA Medical Center (CNVAMC), medical center leadership first learned of delays in providing gastrointestinal (GI) services to veterans on August 30, 2012 according to interviews conducted during The American Legion System Worth Saving Task Force site visit. Of the 4,580 delayed GI consults, a quality management review team determined 81 cases required physician case review. Seven of the 81 cases may have been adversely affected by delays in care. Six of seven institutional disclosures were completed and three cancer-related deaths may have been affected by delays in diagnosis. Factors contributing to the 4,580 patient backlog included an explosion of baby boomers turning 50 who now require screening, the medical center's non-anticipation of a spike in GI consult demand, lack of an integrated data base for tracking GI procedures, and GI physician recruitment challenges.

Veteran Feedback: During the Veterans Town Hall Meeting conducted by The American Legion's System Worth Saving Task Force, veterans voiced concerns with the medical center's ability to provide other timely specialty care, specifically pain management and eye care rather than focusing solely on the backlog of GI patients. One veteran waited 8 months for a pain-management appointment and wait times for eye care appointments averaged 6 months. Veterans and family members mentioned problems with receiving service dogs, information sharing, problems with prescription inaccuracies, and a lack of care giver resources.

Legion Response: The American Legion Task Force focused on the VAMC's steps taken to address 4,500+ delayed GI consults, as well as the quality of care offered at the Charlie Norwood VAMC.

During the visit, the Task Force found that the medical center needs to increase transparency, provide crisis information immediately, and provide general health care information, on a regular

[6] H.R. 3521
[7] Resolution 24: "Congressional Budget Office Scoring on Department of Veterans Affairs Leasing" MAY 2013

basis. CNVAMC needs improved communication with the local community, including media representatives, potential hires, current employees, veteran's service organizations (VSO), family members, and patients.

The American Legion recommended strategic communication improvements, including empowering the CNVAMC public affairs office and other VAMCs to share information immediately, especially when responding to local media requests. Since patient safety is first and foremost, the Department of Veterans Affairs Central Office (VACO) should delegate information release at the lowest level that is still properly trained to respond, especially in response to crises, such as a possible link between GI backlog and 3 cancer-related veteran patient deaths.

According to discussions with CNVAMC staff, the medical center had a communications plan to address GI backlog developments, but the release of information from VACO leadership was not approved in a timely manner. VACO should examine its communication structure and policies and harness opportunities to reduce time in responding to crises, along with delegation of authority, responsibility and accountability to local VA facility leadership to effectively and efficiently respond during a crisis.

The Charlie Norwood Medical Center is faced with negative news stories based on 18-month-old information because the communications team is not empowered to proactively communicate with their community. With two sides to every story, Charlie Norwood and the VA are missing opportunities to restore veterans' confidence in their health care, entice new veteran enrollees, and entice future VA staff, in an economy where potential employees can work at other local better publicized medical facilities with higher wages**.**

Columbia, South Carolina (APR 15-16, 2014)

Issue: In September 2013, six deaths were linked to delayed screenings for colorectal cancer at the veterans' medical center in Columbia, S.C. The VA's inspector general determined that the William Jennings Bryan Dorn VA Medical Center fell behind with its screenings because critical nursing positions went unfilled for months. It also found that only about $275,000 of $1 million provided to the hospital to alleviate the backlog of screening cases had been used over the course of a year. The hospital had also made an effort to reduce the care provided to veterans by doctors outside the VA system, and such care had in the past been used to address backlogs.

Legion Response: Following the OIG's report[8], The American Legion reached out to the OIG in early December 2013 to discuss their findings. During the discussion, OIG discussed the process involved that led to the backlog. According to the OIG, the patient's Primary Care Provider (PCP) sends a GI Consult electronically in the medical center's GI administration system. The OIG found a lack of proper oversight of this process led to no one monitoring the consults coming in, which ultimately led to the backlog buildup. According to OIG, another

[8] VA OIG Report No. 12-04631-313 Healthcare Inspection Gastroenterology Consult Delays William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina

factor that may have led to the buildup was the high turnover and numerous positions filled in an "acting role" that had been occurring in all of the medical centers within the Veterans Integrated Service Network (VISN) 7. This turnover may have hampered continuity and moral issues.

From April 15-16, 2014, The American Legion's System Worth Saving Task Force will conduct a site visit of the William Bryan Jennings Dorn VA Medical Center in Columbia, SC. During the visit, the Task Force will focus on the VAMC's steps taken to address the delayed GI consults, as well as the past, present, and future of healthcare offered at the medical center.

Overall Conclusions:

Veterans need to know that the VA healthcare system is a safe place, where they can receive treatment and feel assured that patient safety is a top priority. However, because 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 responsible parties are held accountable. This is why The American Legion supports H.R. 4031: the Department of Veterans Affairs Management Accountability Act of 2014.

When veterans see mismanagement practices in their healthcare system that put the patient's health at risk, veterans want to see a leadership commitment from the top down that says their health and safety are the top priority of VA. H.R. 4031 gives the Secretary of Veterans Affairs the tools he needs to help convey that message back to veterans and help ensure veterans have faith and trust in the systems designed to provide health care to them and to care for their wounds of war. This legislation would also provide tools to the Secretary to better manage Senior Executive Service employees, and hold them accountable when they fail to perform their duties in a manner that better serves the veterans entrusted to their care.

In addition to accountability, better transparency and communication is needed. Veterans are left with questions and concerns that local facilities cannot respond to due to restrictions placed on their ability to communicate with the community by Central Office in Washington, DC. The American Legion believes that VA's 152 medical centers should be trained and empowered to respond and provide proper disclosure during events (good or bad) and that VA consolidate and streamline their crisis response time standards regarding reporting and on communication.

Time and time again, throughout the System Worth Saving Task Force visits, The American Legion found situations where improved communication on a local level with the veterans' community would have helped reduce fear and alleviated concerns about safety. The relationship between the veterans and the Department of Veterans Affairs that serves them must be based on trust and mutual support. None of this can exist without free, open and honest communication.

The American Legion thanks this committee again for their diligence in pursuit of the troubling concerns of patient safety. The commitment of all parties to ensuring veterans receive quality healthcare in a safe environment is a sacred duty.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or ideplanque@legion.org

DANIEL M. DELLINGER
NATIONAL COMMANDER
THE AMERICAN LEGION

Daniel Dellinger of Vienna, VA., was elected National Commander of the 2.4 million-member of The American Legion on August 29, 2013 in Houston, Texas during the 95th national convention of the nation's largest veterans organization.

He became an Army Infantry officer after graduating with a degree in criminology from Indiana University of Pennsylvania. He served at Fort Benning, GA., during the Vietnam War and entered the U.S. Army Reserve in 1972, separating from the service in 1984 at the rank of captain.

A member of the Dyer-Gunnell American Legion Post 180 in Vienna since 1982, he was made a life member in 1990. He has served as post, district and department commander and chaired numerous committees. At the national level, he chaired the Legislative, National Security, and Economic commissions as well as the Aerospace Committee. He served as chairman of the Legislative Council and Membership and Post Activities Committee. He has been a member of the Foreign Relations Council, Policy Coordination, Veterans Planning and Coordinating committees as well as the Legislative Council.

Dellinger is a member of the Sons of the American Legion, Past Commanders and Adjutants Club, Past Department Commander's Club, ANAVICUS and the Citizens Flag Alliance. He has served as a presidential appointee on the Federal Taskforce on SBA Hiring and as vice mayor of the Town of Vienna, Virginia as well as serving three terms as town councilman. He is a member of the Loyal Order of the Moose and the Loyal Order of the Kentucky Colonels.

He owned and operated a construction management and general contracting firm for twenty years specializing in commercial, institutional and industrial construction.

Dellinger and his wife, Margaret, reside in Vienna. Margaret served as American Legion Auxiliary Unit 180 President for four years; daughter, Anne, is a 23-year member of Unit 180; and son, Scott, is a 28-year member of Sons of The American Legion Squadron 180.

Commander. Dellinger's theme is **"Building for Tomorrow – Today."**