FAILURES AT MIAMI VETERANS AFFAIRS MEDICAL CENTER: WINDOW TO A NATIONAL PROBLEM

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WEDNESDAY, OCTOBER 12, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Stutzman, Flores, Johnson, Denham, Runyan, Benishek, Huelskamp, Amodei, Turner, McNerney, Donnelly, Walz, and Barrow.

The CHAIRMAN. Good morning. I want to thank everybody for coming to the hearing this morning.

We were going to do a business meeting first, we do not have the necessary requisite number of Members of the Committee in order to conduct the business, and one of our new members has got to leave to go to a markup in Homeland Security, but I would like to have an opportunity to welcome Bob Turner from the 9th District of New York where he has been a lifelong resident. Forty years in the television industry, leader in large and small businesses, and a veteran, and we welcome you to this Committee.

And Mr. Turner, you are recognized for any remarks you may wish to make.

[The prepared statement of Jeff Miller appears on p. 51.]

OPENING STATEMENT OF MR. TURNER

Mr. TURNER. Thank you, Mr. Chairman.

It is a delight to be here. I am very proud to serve on the Veterans' Committee as a veteran, lo those many years ago, but there is a lot I haven't forgotten and I will discharge these responsibilities with enthusiasm.

And thank you, I yield.

The CHAIRMAN. Thank you, Mr. Turner.

Mr. Donnelly.

Mr. DONNELLY. On behalf of all the Democratic members I want to welcome you to the Committee and thank you for your service to our country, we are in your debt for that and look forward to having you as part of the team here.

The CHAIRMAN. We have another new member, or will, once we do hold our business meeting, but Mark Amodei, who is from the

2nd District of Nevada, which actually covers most of the entire state, but he is also a veteran, a Jag officer in the United States Army. He was a state senator in Nevada before he came here in a special election, so without question we welcome another veteran to this Committee.

And I would yield to Mr. Donnelly also.

Mr. DONNELLY. And we welcome you as well. I want to thank you for your service to the country, we are proud to have you here, and you will find this is a committee where people don't really even think about politics, it is how can we serve our veterans, and so we look forward to having you as a great part of the team.

The CHAIRMAN. Mr. Amodei, do you have any comments you would like to make to the Committee? You are recognized.

OPENING STATEMENT OF MR. AMODEI

Mr. AMODEI. Thank you, Mr. Chairman, and I will follow in the lead of my co-classmate from New York, I would just say that I am actually proudest of being the father of a Gulf War veteran, my daughter who served in the Navy for 4 years, so look forward to working with everybody on the Committee, and I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. And at a time when we have enough members we will go ahead and make the assignments to your committees. We understand that people are having to go in and out. We do appreciate you being here this morning.

I would like to go ahead and ask the witnesses if they would go ahead and come forward to the table.

Because of some of the detail that we are going to be covering in this hearing today I gave great thought, thought long and hard about deviating from a standard practice of this Committee, and that was requiring that you be sworn in as witnesses. I do not think that is going to be necessary this morning. I trust that each of you would and will provide nothing but truthful and complete answers to us.

That being said, we are going to be listening, and I reserve the right to swear you in at any time in the deliberations this morning. Is everybody clear?

OPENING STATEMENT OF CHAIRMAN MILLER

Some of the issues plaguing the VA Medical Center in Miami are not new to this Committee.

Members of the Miami delegation, including the chairman of the House of Foreign Affairs Committee, Ms. Ros-Lehtinen, have been talking with me on a regular basis about the medical center in Miami, but it came into the spotlight in 2009 when it was discovered and reported that endoscopes were not being reprocessed correctly, placing over two thousand veterans at risk of exposure to disease.

Nearly 2 years later, after the initial round of notifications, 12 additional veterans have been identified as being at risk of exposure, and I think all of us would agree that putting any veteran at risk is not acceptable, but failure to identify and notify everybody at risk because patient logbooks were locked away in a safe

is almost impossible to believe. I only say nearly impossible because that is in fact what occurred.

The issues we are going to discuss today extend well beyond sterilizing reusable medical equipment. At the heart of this issue is leadership at VA at all levels and in all parts of this great country.

It is my belief that the failures in leadership and patient safety that were brought to light in 2009 are still occurring today.

Multiple investigations have taken place, disciplinary recommendations have been put forth, new processes and procedures developed, new policies established, yet problems still exist and have not been fixed.

Earlier this year VA told this Committee in a briefing that things were running smoothly in Miami; however, the VA Inspector General released a report in August detailing how in one case 50 percent of the facility employees still failed to properly sterilize reusable equipment.

Recent news reports are also troubling. For example, This summer we read about an Air Force veteran was brought to the Miami Medical Center from a neighboring hospital, Jackson Memorial. The veteran had been admitted to the hospital earlier by a friend after threatening suicide. Once it was realized that she was a veteran she was transferred to the Miami VA Medical Center. The veteran then escaped and committed suicide by cop just one day after she had been admitted to a system that should have protected her in her clearly fragile state of mind.

In another troubling story released last month the Miami Herald reported on its findings contained within one of several administrative investigation boards. This board was conducted in the wake of the colonoscopy equipment cleaning problems and subsequent notification of veterans. And as the Herald noted, disciplinary action was recommended for a lack of oversight by hospital leadership.

The article also noted that the hospital's director, who was reinstated less than 2 months after the report's recommendations were completed, and that VA declined to comment on what actions were taken based on the recommendations.

It is this Committee's desire that today's witnesses outline a clear process for VA's leaders in preventing and fixing failures that compromise the safety of veterans.

The Committee also needs to hear about how a stricter and comprehensive process can be put into place so that necessary information flows to all levels at VA from the local level to the network level to central office.

We know that currently there is much that goes unreported, and given the public, repeat offenses, a solution from VA is overdue.

VA must also outline how compliance with department policies is enforced. If employees are circumventing patient safety procedures they have to be held accountable. If policies made by central office can easily be circumvented, then policy makers at VA must be held accountable, and meaningful, enforceable policies put forth.

A related expectation by the Committee is that existing VA policies in place can and will be followed by all employees. If policies are disregarded or will fully ignored there should be enforcement

mechanisms in place and the right people held accountable, otherwise policies become words on paper and little more.

An important point to keep in mind throughout today's hearing and moving forward is that the problems we are discussing are not limited to Miami or even to VISN 8. The Committee is well aware of similar problems at medical centers all across this country.

More than once VA has come before us and said problems at its facilities are fixed and all is well. More than once that has been shown not to be the case.

The Miami facility is one glaring example of this national occurrence. Just as it should not be acceptable to Secretary Shinseki to be told one thing about how VA facilities are faring only to be subsequently told otherwise, it is beyond unacceptable for that to occur before this Congressional Oversight Committee.

All of us must be vigilant in rooting out misleading or incomplete information that only serves to keep the truth from full view and ultimately harms those who all serve in a common mission, the veterans of this country.

I appreciate everyone's attendance this morning, I now yield to the Ranking Member—a stand in, I like you—for an opening statement.

[The prepared statement of Jeff Miller appears on p. 51.]

OPENING STATEMENT OF MR. DONNELLY

Mr. DONNELLY. Thank you, Mr. Chairman, I like you too.

Patient safety should always be the VA's top concern. Our veterans go to our hospitals because they are one of the best in this country. In obtaining optimal health care should not come at the cost of veterans health.

Veterans trust their doctors, but what they might not trust is the system, and when they get the news that there has been a data breach and their personal information might have been stolen or the news that they are at risk of contracting diseases because staff did not properly sterilize reusable medical equipment veterans rightly lose trust and start to have concerns.

Even when these or other incidents come the light we often find out that they could have been prevented if hospital administrative officials would have implemented proper guidance or enforced protocols to avoid significant breakdowns of patient safety.

Many questions come to light with the many recent issues at the Miami VAMC, particularly the veteran suicide 2 months ago after that veteran was not held the mandatory 72-hour VA required evaluation period.

Taxpayers are also curious to hear why this fault is running under a $30 million budget deficit.

While the Committee has examined these issues in both the 111th and 112th Congresses today we have the opportunity to hear from the hospital director who has witnessed this firsthand.

I hope that we will be able to receive insight into the experiences at the Miami VA Medical Center with the delays that occurred in notifying individuals of contamination, what lead to these delays and the notification to 79 veterans, and what the Miami VAMC is doing to correct previous deficiencies and improve patient safety.

Mr. Chairman, I look forward to this morning's testimony and I yield back the balance of my time.

The CHAIRMAN. Thank you very much.

Our first and only panel that we are going to hear testimony from today is William Schoenhard, Deputy Under Secretary for Health and Operations and Management in the Veterans Health Administration.

In this position he is responsible for VA's 21 veterans integrated service networks, or VISNs, including their operation and their administration.

Mr. Schoenhard is accompanied by Mr. Nevin Weaver, the director of VISN 8, which encompasses much of the part of Florida and parts of southern Georgia.

Also accompanying Mr. Schoenhard is Ms. Mary Berrocal, director of the Miami VA Healthcare System within VISN 8.

Mr. Schoenhard, your complete statement will be entered into the record as a part of this hearing and you are recognized for five memberships.

STATEMENT OF WILLIAM SCHOENHARD, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY NEVIN M. WEAVER, FACHE, NETWORK DIRECTOR, VETERANS AFFAIRS SUNSHINE HEALTH CARE NETWORK/VETERANS INTEGRATED SERVICES NETWORK 8, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; MARY D. BERROCAL, MBA, DIRECTOR, MIAMI VETERANS AFFAIRS HEALTHCARE SYSTEM, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF WILLIAM SCHOENHARD

Mr. SCHOENHARD. Thank you, Mr. Chairman and Members of the Committee, good morning, and thank you for the opportunity to appear here to speak to care regarding the Bruce W. Carter VAMC in Miami, Florida.

As Congressman Donnelly and the chairman emphasized, patient safety is our first priority, what is in the best interest of our patients in any hospital, certainly in a VA hospital is to provide a safe and effective treatment for all of our veterans, and as a veteran myself I take this responsibility very seriously.

The written statement that we have submitted speaks to a lot of detail regarding the actions and events at Miami, and I would like in these few brief minutes to back away from that a little bit and speak from a national perspective regarding the issues that particularly the chairman rose.

We really find in patient safety both in the private sector where I had 35 years of experience before coming to VA, as well as in the public sector, that there are three essential elements to providing safe patient care in a hospital.

First is to do all we can do prevent harm. Second to develop a culture of safety, psychological safety where people can raise concerns. And finally to hold leaders accountable to ensure a safe environment.

Let me just speak a little bit to each of those. First and foremost we have an obligation to do all we can on a continuous basis every day to prevent harm in our Nation's hospitals and particularly those that serve our veterans through systems, processes, training, equipment, all that we know in health care can be applied to ensure safe and consistent care, we have an obligation to do that.

This is a job of continuous improvement. You will never hear me say we have arrived and the destination has arrived. This is a journey that requires continuous improvement as new technology, new process, new insight both from practice within VA as well as outside of VA are brought forward. That is why root cause analysis, RCAs of serious events, training our issue briefs, the development of administrative investigative boards to do fact finding when we have breakdowns in care are so important, and that is what we are obligated to do as first and foremost ensure that we provide preventative care and safe care to our patients.

This has been facilitated in recent months by a realignment within the VACO, the VA Central Office organization where we now have in operations the SPD, or Sterile Processing Department, operation directly in our line, and I will speak to that a little bit more.

The second major issue is a culture of safety, and I would suggest to you that culture trumps strategy in everything we do. By that I mean open lines of communication to ensure that people who come forward with concerns, suggestions for improvement, concerns about patient care are heard by leadership and that follow-up action is taken in a timely and vigorous manner.

Also as has happened in recent months in our hospitals, to empower the staff to stop the line when it is necessary in the interest of care for our veterans. That is to say when we see something that doesn't look right to have the courage to stop the line and make sure before any veteran is put at risk that we understand completely what may be in the case of a breakdown and process that needs further study before any patients are put at risk, and leadership needs to support that and that is certainly a big part of what we need to do as we go forward. And as you see in a number of our hospitals is being fully accounted for.

Finally as the chairman and Ranking Member have described, holding our leaders accountable. And I would just say most importantly for those first two things that is doing all we can to prevent harm in the first place through full implementation of everything we know both in and without VA to prevent harm and develop a culture of safety, and secondly to ensure that culture of safety is evident throughout our organization.

Secretary Shinseki, Dr. Petzel and all of us are committed to accountability, transparency, and full disclosure of all that we do on behalf of our veterans. That is probably no more evident than in our ASPIRE program where we put out those indicators of quality, which I don't of know of any system in the Nation does, that are indicators of care that we aspire to perfection, and that is an effort that we will continue to focus.

So finally, Mr. Chairman, out of our values, integrity, commitment, advocacy, respect, and excellence we are committed to providing the best possible care to our patients and we will do this on

a continuous basis every day to ensure those who have served our country receive the best possible care in the United States.

And we are happy, sir, to answer your questions.

[The prepared statement of William Schoenhard appears on p. 53.]

The CHAIRMAN.. Thank you very much for your testimony and providing a global view of VA and the health care that it provides. Obviously we are focusing specifically today on Miami, so I first would just like to ask Mr. Weaver as the VISN 8 director, are you satisfied with where Miami is? And can you tell me where you would recommend improvements?

Check your mic too, please, Mr. Weaver. Thank you.

Mr. WEAVER. There we go. Thank you, Mr. Chairman.

First I am pleased with the direction that Miami is headed. We have been through a lot of challenges over the last couple years. I think that we have made some of the necessary changes that we needed to do.

Having the national leadership develop new programs to provide oversight, our establishing oversight at the network level, including a SPD board that oversees all of the activities at the medical centers, and also having a number of unannounced visits during the year from my office, and then at the medical center level the same kind of activity is going on.

They have a team that goes in and does unannounced visits and ensures that the training is accomplished, that policies are up to date, and that the work is being done correctly.

In looking at the Miami performance. First of all at the network level we have a performance improvement council that reviews performance of all medical centers on a monthly basis. We look at the performance measures that are the standard for VA and we have the leadership present to us, along with our program managers in our office, talking about any areas that need to be improved.

Miami has continued to move in a positive direction. We have relied on Miami to work with other medical centers within our network. We had surgeries that are referred by West Palm Beach to Miami, to Orlando to Miami, and from Bay Pines to Miami. We continue to look at other kinds of opportunities to send referrals to Miami.

And areas that need to be worked on are areas that continue to look at administrative processes to ensure that we are working as efficiently and effectively as possible.

The three drivers in our network are quality. That is number one. We will not do anything to compromise quality. We look at those quality measures and performance.

The second driver is our satisfaction. We look at patient satisfaction which has been high. We have looked at employee satisfaction which continues to be at the higher level.

And then the third driver is our cost effectiveness, and we try to do this in a very cost effective way.

And then finally with Miami on a real positive note is that even though we had a lot of negative publicity over the last couple years the workload at Miami continues to grow. We continue to reach out to our veterans and our veterans continue to come to the VA, and

those numbers have continued to increase. In fact they are above the national average.

The CHAIRMAN. Thank you very much. I would like to recess the hearing for just a moment procedurally. We do have a quorum present to take care of Committee business. Mr. Donnelly, if that is okay with you.

Mr. DONNELLY. Yes.

[Whereupon, Committee broke for Business Meeting.]

The CHAIRMAN. Ms. Berrocal, would you like to comment on—since it is your facility—how you feel things are going in Miami?

Ms. BERROCAL. Thank you, Mr. Chairman. Things in Miami, as mentioned before, are steadily improving.

I will note that upon my arrival at Miami, shortly after my rival, a year almost exactly, the AIB pointed out a number of areas that had been—or irregularities that had been going on for a number of years. Upon realizing, that what the AIB did is it provided me the opportunity to address those areas with the proper degree of urgency to ensure that we were addressing with specificity the area of the RME.

I will mention that in the RME area in the Sterile Processing Department we have done a number of changes. We have changed the organizational structure. We have the department reporting directly to the Nurse Executive. Previously it reported to the administrative arm of the Medical Center. We have ensured that the staff that is in that section has high credentials to be in that area and that they have a clear understanding of the things that go on in that area.

In addition to that, the individual that leads that area as well as the Nurse Educator for the sterile processing area are certified in instrument sterilization. And we steadily replaced staff as appropriate to ensure that we are hiring operating health technicians to people who are much more sensitive to those areas.

There are a number of other things that we have done in the area including physical restructuring. We have bought all new equipment that is of the same kind of vendor so that it reduces variability in the number of processes that the individuals have to remember.

We have provided extensive training. We do competency reviews on annual basis on these individuals.

We have set up an RME committee that reviews the processes. We have the RME committee reporting to the Medical Executive Board who then reports to the Patient Center Executive Leadership Board.

I will indicate that my mantra has always been to be patient centered, and I made that clear to the staff from day one that my decisions would always be patient centered.

My father is a Veteran like several of you and my father is a physician so health care is something—and my mother a nurse—so health care is something that I have been—that has always been in my DNA, if you wish.

I am keenly cognizant of the impact anything that would be less than perfect, could have in particular for our Veterans.

I have worked serving the Veterans for other 30 years and am honored to have the opportunity to do that and I take that job very seriously.

Our performance measures, in particular our outcomes, would show that we have worked steadily to improve the confidence of our patients in the care that we deliver at the Miami VA, and evidence of that is the fact that we have, as Mr. Weaver indicated, increased the number of patients that are coming to our medical centers. I work very hard to ensure that we are reaching the Veteran population so that we can provide proper care to them.

In addition to that to restore some of the confidence that we have in the processes that we are providing to our Veterans—the number of colonoscopies that are being done at the Miami VA since 2009 have increased by approximately 20 percent, so I think that we have put the necessary oversight systems in place to ensure that we are not placing our Veterans at risk.

In addition to that I try to receive feedback from the stakeholders, so I meet often with the veteran service organization members, with members of the veterans—the PVA, Paralyzed Veterans of America, I am in communication, I have also tried to develop partnerships with the community so that we can ensure that we are strengthening our relationships with the ability to provide the best care anywhere.

We in addition, because some of the questions have arisen about whether or not we hold staff accountable, and I believe that we do hold staff accountable when there are areas that have not been properly addressed or addressed as we would expect.

We have set policies in place, and when members of our staff deviate from those policies we have a variety of areas that we—systems that we have put in place to review each instance to ensure that—to understand what happened.

So we have the root cause analysis system, as has been mentioned previously, we also have the administrative investigation boards.

It is my policy to always start by looking at the process, because I believe that if we are able to—if there is something wrong with the process and we can fix the process we will be able to standardize the care that we provide and in doing so, diminish the number of errors that might happen.

In addition to that, whenever during the process of a root cause analysis we determine that there has been some degree of negligence or something that reflects poorly on the conduct of an employee, we establish either an administrative board of investigation or if the facts are fairly clear we might do a fact finding. In conclusion of that we would then take the necessary actions to discipline employees or to train employees or whatever it may call for.

In terms of patient safety let me tell you that the Miami VA in the last 3 years has been recognized by the National Patient Safety Center for the completion and thoroughness of their RCAs. We received the bronze award in 2008, the bronze award in 2009, and the gold award in 2010.

We have also been recognized by external bodies. We hold ourselves accountable for the type of work we do and as such we get oversighted not only by this Committee, but by many internal and

external bodies. We received probably on the average of I believe it was over 30 visits in the past year, and in each of those visits there might be some findings.

The CHAIRMAN. If I could, and thank you. We will have an opportunity to discuss more.

Ms. BERROCAL. Okay.

The CHAIRMAN. And my time has pretty much expired, but since you brought up the issue of root cause analysis, in my opening statement you heard me talk about the suicide by cop. Are you familiar with the issue that I am referring to?

Ms. BERROCAL. Yes, sir.

The CHAIRMAN. Okay. It is my understanding that this individual was an Air Force veteran, had in fact told her family and friends that she was going to commit suicide by cop, and was acting very irrationally, was taken to Jackson and Baker Acted; is that correct?

Ms. BERROCAL. That is correct.

The CHAIRMAN. And from that point once Jackson heard that she was a veteran she was transferred to Miami; is that correct?

Ms. BERROCAL. That is correct.

The CHAIRMAN. So this individual was involuntarily committed through the Baker Act, correct?

Ms. BERROCAL. There was some confusion as to whether it was involuntary or voluntary.

The CHAIRMAN. But she was Baker Acted into Jackson, correct?

Ms. BERROCAL. Correct.

The CHAIRMAN. That is involuntary, correct?

Ms. BERROCAL. Correct.

The CHAIRMAN. Okay. Where was the confusion?

Ms. BERROCAL. In the communication between Jackson and the VA. There was initially some miscommunication about whether she was being transferred on a voluntary or involuntary.

A full root cause analysis has been done on the case and they had found several things, in addition to the root cause analysis, there are some areas that we have conducted a fact finding. As you know the root cause analysis is—basically focuses on processes and doesn't allow us to utilize that information to take the necessary action on individuals, so we have——

The CHAIRMAN. So it is your recollection that Jackson did not inform you that she had been involuntarily committed?

Ms. BERROCAL. My recollection was that there was some verbal communication which was not clear, but that upon——

The CHAIRMAN. Is that normal that it is done verbally on somebody that has been committed to another facility?

Ms. BERROCAL. I cannot speak that if it is normal. I know that upon arrival of the individual the papers indicated that it was involuntary.

The CHAIRMAN. Jackson's papers indicated that it was voluntary or VA's papers indicated it was voluntary?

Ms. BERROCAL. Jackson's papers when they came in indicated that it was involuntary. So the verbal communication was that it was involuntary, the paperwork upon receipt was that it was voluntary. That was my recollection.

The CHAIRMAN. So she was Baker Acted, Jackson informed she was Baker Acted and involuntarily committed, and then she walked out the front door, shot a cop, and was killed.

Ms. BERROCAL. The resident that was at the ER at the time interviewed the veteran extensively and——

The CHAIRMAN. It doesn't matter at that point because there was paperwork saying that she had been involuntarily committed; is that correct?

Ms. BERROCAL. That is my understanding.

The CHAIRMAN. Okay.

Ms. BERROCAL. And the resident then spoke to the patient and at that time determined that they would—that it was going to be a voluntary—she felt comfortable after interview that it would be a voluntary admission.

The CHAIRMAN. Oh, so she can be Baker Acted and then Unbaker Acted and then can walk out the door and be killed?

Ms. BERROCAL. You know, I cannot——

The CHAIRMAN. Let me ask you this. What would be the difference—and I will ask Mr. Weaver—reporting requirements from the hospital to you at the VISN. And I apologize to my colleagues for the lengthy question.

If this person had been involuntarily committed and it had been communicated as such and this person eloped or escaped or walked out from your facility, was killed by a cop after saying that she was going to commit suicide by a cop, would that be something that would be reported to you, and how was it brought to your attention? How did the hospital handle the communication?

Mr. WEAVER. Okay. Mr. Chairman, we were notified immediately of the situation and——

The CHAIRMAN. What did they say had occurred? This person had voluntarily committed themselves and walked out?

Mr. WEAVER. The person had I believe involuntarily committed themselves, and as Ms. Berrocal mentioned, mistakes were made. The response by the staff was not appropriate.

The issue is, is that we looked at an RCA looking at the process, but we also looked at individuals who were responsible for and we held them accountable.

I think that any time a patient is admitted we have to do our due diligence and make sure that the patient remains with us and is safe and secure and that we respond appropriately by having the person placed in the facility—in the medical center.

The CHAIRMAN. So was this a failure or not a failure?

Mr. WEAVER. I think the event was a—it was I think a failure.

The CHAIRMAN. And somebody has in fact been reprimanded for the failure?

Mr. WEAVER. Go ahead.

Ms. BERROCAL. We have done a series of things. We recognize that there were some process failures through the RCA, in addition to that we recognize that there were some failures of individuals to follow the policy, to conduct their job appropriately.

What we have done is we have addressed the process issues. One of the main things that they——

The CHAIRMAN. Has anybody been disciplined for this veteran being allowed to walk out of a hospital after saying they were going

to commit suicide by cop, allowing her to pull a gun on a police officer, shoot the police officer, and being killed by that police officer? Has anybody been disciplined at your facility?

Ms. BERROCAL. I have taken the people out of the position and the fact finding is being——

The CHAIRMAN. So they still have a job.

Ms. BERROCAL [continuing]. The fact finding is being finalized.

The CHAIRMAN. They still have a job.

Ms. BERROCAL. Sir?

The CHAIRMAN. They still have a job.

Ms. BERROCAL. As of today they do. They are not in that position and the actions have not been finalized, but because I am in the middle of the deliberations with the fact finding I—there are strong actions being taken.

The CHAIRMAN. Mr. Donnelly.

Mr. DONNELLY. Thank you, Mr. Chairman.

I have a question regarding Dr. Vera and the green notebook with 79 names in it. Are you familiar with the 79 veterans who were not contacted that that information had been put in a safe?

Ms. BERROCAL. The——

Mr. DONNELLY. Ms. Berrocal, I am sorry.

Ms. BERROCAL. Sorry. Okay. The logbooks had been reviewed in the initial review of the endoscopy in trying to make identification of the veterans, and when they reviewed the logs the logs were determined to be inconclusive, it didn't have complete information, and because it didn't have complete information it was determined by clinicians that it wasn't a reliable source of information.

Mr. DONNELLY. Well, what was Dr. Vara's explanation for those 79 folks not being contacted and their names being in a safe?

Ms. BERROCAL. So what we did with it was that as soon as we learned about it, and I think that this is an important piece to note——

Mr. DONNELLY. But what I asked you was what was his explanation as to why that happened?

Ms. BERROCAL. Because at the beginning when they reviewed the logs they determined them to be an unreliable source of information to determine which individuals were affected by the endoscopy issue—event. And it was determined to be an unreliable source because it was incomplete, these were handwritten, names were incomplete.

Mr. DONNELLY. So did he not believe those 79 people had suffered possible contamination?

Ms. BERROCAL. No. At the time the 79 individuals had not been identified.

Mr. DONNELLY. But their names were in this book.

Ms. BERROCAL. What had happened was—actually there is two—the 79 is—it was the result of a patient coming up with a letter.

Mr. WEAVER. There are two different events that happened. One with a logbook and others were already in the system. The logbook was identified—there was a decision made in combination with the medical center, the network, and central office that the logbooks were an unreliable source. The logbooks were composed—were in various clinics—and by the way, the logbooks are no longer—new

logbooks do not exist anymore because they are not allowed to use them.

Mr. DONNELLY. Did you feel you had any reliable source if the logbooks are not a reliable source?

Mr. WEAVER. Yes. The computerized patient record was a reliable source, and that is where most of the—that is where the data was mined to get the first list. The logbooks came on like the third stage.

The second part was the 79 individuals that were identified, they came when the clinicians went back and started looking at data again.

What prompted that was a patient came in, said he was not identified, so they went back and they started to look. And Ms. Berrocal can explain that process.

Ms. BERROCAL. Yeah.

Mr. DONNELLY. So the source though—the source that you had, the computerized patient records that you said was the reliable source didn't even include these 79 people, is that what you are saying?

Mr. WEAVER. No, it did. What——

Mr. DONNELLY. Well, if it did how did you not have these 79 people?

Ms. BERROCAL. What has happened in that process, if you would allow me to walk you through the process, when we originally looked at trying to identify all the patients we had contacted central office and we had received the look back manual which gave some guidelines as to how we go about a look back, so we identified as many individuals as we could by utilizing a series of methods, which in fact even enhanced the methods that were in the previous look back, and that allowed us to identify the bigger cohort of people that were at potential risk.

Subsequent——

Mr. DONNELLY. But what were the holes that you couldn't find those 79 people to start with? I mean here they are walking around at possible risk.

Ms. BERROCAL. So we continued to enhance our methodology by bringing additional experts to enhance the methodology further and further and further so we continued to refine the methodology. We thought we were completed in that process and one of my residents received a letter from a veteran indicating that he had not been identified and he had had a colonoscopy during that period of time.

So that letter—and I think this is important to note because it speaks to the culture that I have worked so hard to establish in Miami—and that is one that where people will stand up whenever they find that there is a problem and we will stand up and take responsibility for it and do the right thing on behalf of our Veterans.

So the 79——

Mr. DONNELLY. But how did we miss those 79 to start with?

Ms. BERROCAL. The 79 individuals—as a result of the letter that we received——

Mr. DONNELLY. Okay, I understand the letter, my question is, how did we do all these enhanced methodologies that you are talking about and we still didn't even know we had 79 folks we missed?

Mr. WEAVER. What happened was when they went through the process of going to the computerized patient record there were pages that were behind pages that they were looking at and they found that they had not drilled down far enough and that is when they started to look at that process and started to drill down further and found out that there were 79 additional.

Mr. DONNELLY. So I guess the question comes down to were they in the records but we missed them or were they not in the records? Were the pages stuck together, is that what you are saying?

Ms. BERROCAL. The particular patient had had more than one procedure at that time.

Mr. WEAVER. Yes. The answer is yes, it was in the record.

Mr. DONNELLY. And we missed it.

Mr. WEAVER. It was in there but they had not drilled down far enough because of the way the record is set up to identify those 79 individuals.

Mr. DONNELLY. Mr. Chairman, my time is up. Thank you, sir.

The CHAIRMAN. Thank you.

Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

You know I have reviewed the materials that have been compiled for this hearing and I can tell you that as a veteran I am extremely concerned. And I can tell you that as the Chairman of the Oversight Investigation Subcommittee I am not going to let loose of this one. There is some accountability that must result, and I am looking forward to working with the Chairman and the full Committee to make sure that that happens.

Mr. Schoenhard, am I pronouncing your name correctly? You talked about holding the leaders accountable.

Mr. SCHOENHARD. Yes, sir.

Mr. JOHNSON. I have already heard enough testimony to want to ask you, what is your definition of holding leadership accountable?

We got veterans that are escaping the facility and committing suicide, what is your idea of holding leadership accountable?

And I know in my military days I know what holding leadership accountable means. What is yours?

Mr. SCHOENHARD. Our definition of holding leaders accountable is creating what I said before, the process for ensuring safe effective——

Mr. JOHNSON. No, no, no, no, no, that is holding leadership—that is making leadership responsible——

Mr. SCHOENHARD. Okay.

Mr. JOHNSON [continuing]. Creating processes.

Mr. SCHOENHARD. Yes.

Mr. JOHNSON. What happens when the process fails and veterans die? How do you hold leadership accountable?

Mr. SCHOENHARD. In this case, sir, as we are here doing complete fact finding to determine what went wrong.

Mr. JOHNSON. Okay, thank you.

Mr. Weaver in your testimony you talked at being pleased with the direction that the Miami facility is going. I can assure you, sir,

I am not, and I want to make sure you understand that as we get into these questions.

Ms. Berrocal and Mr. Weaver you have explained your efforts to continually provide and improve environment and care.

VA provided this Committee with a document identifying an eventual mock Joint Commission survey from your facility. Ms. Berrocal, are you familiar with this document?

Ms. BERROCAL. Yes, sir, I am familiar with the fact that they did a mock survey.

Mr. JOHNSON. When there you schedule a mock Joint Commission survey?

Ms. BERROCAL. What we do is——

Mr. JOHNSON. When? Not how, when? When will you be scheduling that survey?

Ms. BERROCAL. We schedule it, you know, in——

Mr. JOHNSON. When? Is there a date for the survey?

Ms. BERROCAL. It is not a particular date. We schedule the survey as we——

Mr. JOHNSON. So you haven't done one yet?

Ms. BERROCAL. We had a mock survey, we were anticipating the joint commission to come in last year, and they did and we were fully accredited at that time.

Mr. JOHNSON. So you have already conducted the mock survey?

Ms. BERROCAL. We conducted a mock survey.

Mr. JOHNSON. When was that conducted?

Ms. BERROCAL. I don't recall the exact date, sir.

Mr. JOHNSON. Okay. Well then if that survey was conducted, Ms. Berrocal, how is it that radio—that a radio isotope could be left out in the open and unattended?

Ms. BERROCAL. You know, the idea of—again, we are an organization of continuous improvement, and what we are trying to do is identify issues so that we can correct them on the spot. So we are trying to be in a position of continuous readiness, and that means that we set different processes in place to try to identify issues so that we can correct them.

Mr. JOHNSON. Why is preventive maintenance not being documented?

Ms. BERROCAL. So we do EOC, which are environment rounds, we are doing those now on a weekly basis, and I have one of my executives attend those so that we can be on top of all the different issues to determine what is happening.

Mr. JOHNSON. Well, you know, the results of the mock survey that we have been—that has been made available to us was conducted on August 2nd and it indicates that preventive maintenance is still not being documented. So I am confused about how your process on continuous improvement is working, because I don't think it is producing the results that America's veterans expect or the American taxpayers expect.

Why is your emergency management program not conducting drills and reports?

Ms. BERROCAL. We have had a turnover on the emergency management.

Mr. JOHNSON. Since October 2nd?

Ms. BERROCAL. No, sir.

Mr. JOHNSON. Okay. All right.

Mr. Weaver, these issues are not new and you talk about being pleased, and Mr. Schoenhard you talk about holding leadership accountable. They appear on report after report in one form of another, what are you doing to hold leadership accountable for these kinds of failures?

Mr. WEAVER. I will take the first response.

Sir, at the network level we have individuals that have responsibility to go out and do surveying and audits, and we review the performance, we review surveys, we do crosswalks with the environmental——

Mr. JOHNSON. Mr. Weaver, I don't mean to cut you off. I am not talking about how your process works. Your process and the surveys that have been conducted and the results of veterans going out and committing suicide after escaping the facility in Miami are evidential.

I am looking for accountability. You have both talked about leadership accountability and I have not heard either one of you say yet what leadership accountability is being enforced.

Mr. WEAVER. Okay, I am sorry, I didn't answer your question, sir.

My approach to this is looking at performance.

Mr. JOHNSON. Who has been disciplined? You got any disciplinary records as a result of these things that the surveys say still are not being conducted? Who has been counseled? Can you give me a name?

Mr. WEAVER. On those specific issues we have not worked through those yet. A lot of this is going to deal with the performance appraisal process.

Mr. JOHNSON. I am familiar with the civil service performance appraisal progress, Mr. Weaver, that is not going to get it, that is not accountability, not when patients are leaving your facility and dying.

Mr. Chairman, I think I have extended my—I hope we are coming around for another round of questions, because I am not finished.

The CHAIRMAN. We may have five rounds.

Mr. JOHNSON. Okay, thank you. I yield back.

The CHAIRMAN. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. Schoenhard, do you agree that there is still a problem within the Veterans Health Administration with compliance of established patient safety protocols, policies, and procedures? And if so, what is being done about this?

Mr. SCHOENHARD. Sir, we are continually inspecting both at the VISN level and at the medical center level for compliance. And as I said in my opening statement, this is an area that requires ongoing vigilance.

And I if might just say earlier in terms of accountability, it is important that our leaders are ensuring that steps are taken to correct deficiencies that occur in joint commission mock reviews, that occur in CAP reviews and the rest. We invite those kinds of inspections. We know they will find things.

Where we hold leadership accountable is not necessarily for finding areas for improvement because we want areas for improvement. What we hold leaders accountable for is ensuring full implementation of those recommendations, and that would extend to this effort as it relates to patient safety.

Mr. MCNERNEY. Well good. Then what specific actions are being taken to investigate and fix the reported problems at the Miami Medical Center?

Mr. SCHOENHARD. Well, let me just go back and say at my level as the Committee I am sure is well aware, a national AIB was convened in the second iteration where the veteran called and indicated that he had not been notified as part of the initial review.

We wanted at that time to understand what happened, because we obviously missed a veteran, we wanted to understand what more veterans might be at risk that were missed, and we wanted to understand not just for Miami, but nationwide, what we would learn from this experience. Because if we had a glitch in the initial review, we missed a veteran in Miami, we could have done that elsewhere.

Part of also what I wanted done were recommendations regarding whatever corrective action might be taken, and there were as a result of this AIB disciplinary actions taken with regard to local leadership.

I might just add that when the initial report came back from the board it was moot on the subject of whether at the VISN level or at VACO level, at our level, there was a lack of leadership and accountability with that first disclosure, and I charged them to come back with information.

Mr. MCNERNEY. I am surprised that we are here again today. I mean the problem is in my mind that there are specific issues at the Miami Center.

Mr. SCHOENHARD. Right.

Mr. MCNERNEY. But how does that reflect across to the other centers in the country? Are we just looking at the tip of an iceberg here or are we really talking about an isolated set of cases that involves specific performance at that facility?

Mr. SCHOENHARD. Well, I think that every facility varies in its level of performance, and the reason that we are here supporting Mary Berrocal and her leadership is that she is turning this ship around. It takes time to change the culture, it takes time to be able to ensure that people are held accountable at the local level and that we really are a patient center, and if I did not believe, if our leadership did not believe Mary Berrocal was making improvements we would not be supporting her leadership in place there.

Mr. MCNERNEY. Well, I mean I have been to many hearings of this nature—not many, but I have been to hearings of this nature—and there are times when you get the feeling that yes, things are moving in the direction they need to move in, I think there are times when you don't get that feeling and that is the case we are in right now. I just don't get the feeling we are moving in the right direction. But it worries me because I want to make sure that this isn't something that is more broad and that could have bigger implications for our Nation's veterans than the bad enough case that we are seeing in Miami.

Mr. SCHOENHARD. Well, sir, I can assure you that at the VISN level and at the central office level we continually monitor the operation of our facilities, and I know there has been some question about whether we get ground truth, and part of what we are working very hard to ensure is timely reporting and accurate reporting. We are making great strides in that respect, and that again comes back to the culture, it comes back to an accountability to ensure first and foremost that the Mary Berrocal calls of our system, the medical center directors have full visibility of issues. You cannot solve what you don't see, and that is what Mary is turning around in Miami.

Mr. MCNERNEY. So you are saying that Mary didn't see these problems from her position?

Mr. SCHOENHARD. I think frankly there has been a culture in Miami. This varies from institution to institution both in VA as well as it does in the private sector of a culture that did not have the psychological safety that Mary is bringing to it.

That there would be—typically when we have problems in health care, whether it is in the private or the public sector it can be sometimes the case that people bring forward concerns and leadership doesn't act. That is back to the congressman's question, what I hold people accountable for.

I don't fault that there is opportunity to improvement, what I fault and hold accountable are leaders who don't act on that information and improve care for veterans and don't create the conditions whereby people can freely come forward without recrimination and be heard and supported on behalf of our veterans.

Mr. MCNERNEY. And so have people come forward and have there been recriminations?

Mr. SCHOENHARD. Excuse me, sir?

Mr. MCNERNEY. Have people come forward and have there been recriminations for that activity in Miami?

Mr. SCHOENHARD. No, but that can happen or rather it can be perceived. And one thing that I have learned after the last 2 years in VA is that there has been considerable concern in the past regarding whether people can freely come forward without recrimination. I have had a number of members express concern to me about that.

We are working very hard in keeping with our values to ensure accountability and transparency, and the first thing I would hold a leader accountable for is creating a culture where we know what is going on and that we act on. Because there is always opportunity for improvement in any hospital that serves patients.

Mr. MCNERNEY. Okay, thank you. I yield back.

The CHAIRMAN. Before I recognize Dr. Benishek for the next question I just find it troubling that you have said that the Miami VA Medical Center is moving in the right direction.

We extrapolated some of the numbers, and I apologize this may be a little difficult, but I think you kind of get the gist, in fact here it is, they are showing it up on the screen. Senior management satisfaction down. I mean the ship may be going in the right direction, but I think it is sinking. Psychological safety down. These are your numbers. Customer service down. Overall satisfaction down. I

mean that is not the direction that any of us want to see our medical centers heading.

Dr. Benishek.

Mr. BENISHEK. Thank you, Mr. Chairman.

Mr. Schoenhard, what is the average tenure of a director of a medical center?

Mr. SCHOENHARD. Sir, I do not have that information, but we can provide that to you.

Mr. BENISHEK. Mr. Weaver, would you happen to know in your VISN?

Mr. WEAVER. In my network it is not very long.

Mr. BENISHEK. Ms. Berrocal, how long have you been the director of the Miami VA?

Ms. BERROCAL. It will be 4 years in March.

Mr. BENISHEK. And you say you started just a year before this incident?

Ms. BERROCAL. Yes, sir.

Mr. BENISHEK. Where were you before that?

Ms. BERROCAL. Before that—this is my sixth VA—before that I was in Los Angeles, California.

Mr. BENISHEK. And how long were you there?

Ms. BERROCAL. About a year and a half or so.

Mr. BENISHEK. And the place been that, how long were you there?

Ms. BERROCAL. I was in Loma Linda, California for roughly 11 years or so.

Mr. BENISHEK. But that was not as a director?

Ms. BERROCAL. No, I was the Associate Director there.

Mr. BENISHEK. Mr. Schoenhard, this is the point of my questioning, is I worked at a VA hospital for 20 years and for that 20 years there was 10 directors, the director lasted 2 years and then they went on that their next appointment, and in my opinion, you know, the director of a medical center it takes a while to understand the function of a medical center, and my impression of what was going on is that people were just biding their time and preparing for their next job, and I think that there is a structural problem in the fact that people turn over rapidly as a director of a medical center because they can't understand their own facility enough to delve into each and every problem like that because they are just preparing for their next job. And I think that that particularly is a problem in the way the VA is managed, not from the individual job, I mean I think people try to do the best they can, but you know, a year being there and then moving onto the next job it is a problem, and I think it is throughout the system. Can we fix that?

Mr. SCHOENHARD. I might yield to Mr. Weaver to speak because he had previous responsibility for workforce and human resources at the central office and has more experience and perspective than I have, but I would agree, it takes time to turn the culture of a hospital.

Mr. BENISHEK. But I mean it is not the hospital, it is the administrative people that are switching these people around on an every other year basis so that the person is not invested in that hospital

and can't get to know that facility as well as they should to be the director.

Mr. SCHOENHARD. Well, let me just clarify. We post openings and people are free to apply for those. We do not mandate turn over, we do not force people to transfer after a certain time.

Mr. BENISHEK. But neither do you facilitate people staying in one facility.

Mr. SCHOENHARD. Actually in this economy and with the situation on relocation there is more staying in position than we have——

Mr. BENISHEK. All right, let me just go on because my time is limited.

I have a question, Ms. Berrocal, about these logs. You know, I mean I fill out a log whenever I get colonoscopies at the VA and I don't understand what information was missing from the log, because usually they are quite complete. So you said they were unreliable, but why were they unreliable?

Ms. BERROCAL. Again, they were unreliable because it was incomplete information. It was——

Mr. BENISHEK. What information was incomplete?

Ms. BERROCAL. Names were not spelled correctly, there was not exact information on the——

Mr. BENISHEK. So people are not filling out their logs correctly, is that what you are telling me on a routine basis?

Ms. BERROCAL. Our official record is the electronic medical record.

Mr. BENISHEK. But you already told us that that method of doing it doesn't work very well because you can't go back other than—you know, a paper log is permanent.

Ms. BERROCAL. No, we did no back . . .

Mr. BENISHEK. Well, but you couldn't find the people that you were looking for on the electronic medical records. Did the 79 names occur on the paper record?

Ms. BERROCAL. We looked at—it was an electronic medical record——

Mr. BENISHEK. Were the 79 names on the paper record, yes or no?

Ms. BERROCAL. Actually from the logs what we found was 12 individuals. The 79 were from the letter that the patient wrote.

Mr. BENISHEK. So those people, those 79 people were not in that paper log?

Ms. BERROCAL. The 12 individuals were not in the record—in the electronic record.

Mr. BENISHEK. But in the paper log were those 79 people in that paper logbook?

Ms. BERROCAL. No, the 79 individuals came as a result of a letter that we received and were put back into the electronic——

Mr. BENISHEK. So they were not in the log is what you are saying.

Ms. BERROCAL. No. Right. We went back into the electronic medical records and found those 79.

Mr. BENISHEK. Mr. Schoenhard, I just wanted to express my problem with the electronic medical record as it exists, because obviously there is some sort of problem here where people cannot go

back easily and find out what the deal is, and that to me is really frustrating, as is the fact that the log did not contain 79 names.

I don't understand what is going on here, but you know, this kind of stuff doesn't happen where I work, and I mean I don't think it should be happening where you work.

Mr. SCHOENHARD. Yes, sir, and I would just acknowledge, I think it is important for the Committee to know, that we have taken the Miami experience with the 79 and with the 12 and that has been gone into as part of the national AIB. There were a number of recommendations having to do with data collection and the rest.

Part of the issue we learned in Miami is that the average medical center director maybe in their career will have one or two of these kind of instances that is involved with putting a data group together and making sure we mine the data and get it right the first time.

The AIB included a number of recommendations at the national level to ensure we bring experts to bear when we have an incident like this, to ensure we get all of the veterans that we can get to in the first place.

But let me urge this, I think it is important for veteran safety that we be always in discovery, always looking, did we miss anybody, always having our receptacles open to is there anybody that we might have missed? Because first and foremost is our responsibility to every veteran to ensure if we have any reason to believe they should be notified that they are notified.

Mr. BENISHEK. Well, I just——

Mr. SCHOENHARD. And that is what we would continue to urge in our culture.

Mr. BENISHEK. Well, to tell you the truth, I like to have the paper record because then there is something actually written down, whereas, you know, like the electronic medical records sometimes things disappear and then you can't really find them afterwards, so I like to have this written document, so I would encourage that to be a part of it. And I think I am out of time. Thanks.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman, and I want to thank all of you for being here and the work you have done.

I think we do all know this is a zero sum proposition with our veterans, and I have said it and I will continue to say it, I am the staunchest supporter of the VA and because of that I am the harshest critic because the job is too important.

I would like to say, Mr. Schoenhard, thank you as a naval officer for your service. I would also like to get your perspective earth first on this. Am I right that you were CEO of SSM Health care for 22 years?

Mr. SCHOENHARD. No, I was the chief operating officer.

Mr. WALZ. Chief operating officer.

Mr. SCHOENHARD. Yes, sir.

Mr. WALZ. Okay. What did they do?

Mr. SCHOENHARD. Excuse me?

Mr. WALZ. What did SSM Health care do?

Mr. SCHOENHARD. Very much like VA, it is a multi-state, but much smaller health care system. At the time I left we were in four states and it is a faith-based Catholic sponsored organization.

Mr. WALZ. How did SSM report their medical errors?

Mr. SCHOENHARD. They came through the report similar to what we have here in VA through——

Mr. WALZ. Which is stricter in terms of every incident that happens, the private sector or the VA?

Mr. SCHOENHARD. Well, I want to be careful to——

Mr. WALZ. The reason I ask is there is no error acceptable, but I want to be very clear on this, the requirements that this is not—and I am going to say this, and I appreciate you taking a macro position on this because trying to lump them all together I am going to stand firmly with the three that I supervise in Minneapolis and in Toma and in Sioux Falls of what is happening and try and get at the systemic cause of where this is at, that is the reason I ask this.

Mr. SCHOENHARD. Let me say this. I do not want to cast aspersions on the private sector, but I can tell you after the years I have spent in the private sector our system is the most transparent, the most rigorous in VA, the most accountable for holding people accountable that I have seen.

Mr. WALZ. Well, I can back you up, I represent the Mayo Clinic and they would agree with you.

And with that being said that doesn't remove from where we are at trying to figure this out systemically, but I do think we need to note that if we are starting to make changes I am very, very hesitant here that if this is systemwide we need to understand what happens because I do not want the quality of care being reduced at VA Minneapolis because of an incident at Miami or if that is the case if that is clear.

Just a couple of things, I will move on. Mr. Weaver, I do think my colleagues are right, I think you used an unfortunate choice of words with Miami. I think one thing you said was is that Miami VA had challenges. No, the veterans there had challenges. You had some problems that needed to be addressed, so I think you—and saying we are making progress and feel good about it I think maybe again, and I am not going put words into your mouth, is a zero sum. If one veteran doesn't get the care they need I am sure you are not happen. I will let you speak on that.

I will ask you though, Mr. Weaver, on this, how long have you served in the VA?

Mr. WEAVER. I have 32 years in.

Mr. WALZ. Are all VA medical centers created equal?

Mr. WEAVER. No.

Mr. WALZ. Okay. Is that important to keep in mind in your opinion?

Mr. WEAVER. I think it is.

Mr. WALZ. Okay. Ms. Berrocal, I am going to come to you on the specifics of running this. The endoscope issue. I am with my colleague's frustration on this one too because in 2009 I sat in that hearing and some of these folks were there too and we went through that trying to understand what happened, trying to be transparent, trying to make as my colleague said, someone accountable for this, but more importantly making sure that it never happened again.

I had all of these folks, and you were right there were 11 different contractors that provided these I believe, I had the folks come in and actually assemble and had me reassemble in my office an endoscope. We know the problem was a two-way valve amongst one of the contractors If I am not mistaken.

So what I ask on this is, is at that point in time it became very clear to me, and we had a great commitment from our VA, that new processes would go out, because I made the statement at that time is my local quick trip convenient store has a little chart in a bathroom that shows who cleaned the damn toilet each hour, there was no such thing for this endoscope.

So that being the case, did you adopt what others adopted that did not have a reoccurring problem? Did that happen?

Ms. BERROCAL. Yes. We have, you know, we haven't perhaps applied everything, I haven't seen all of the system, but we from a system perspective we did an after action review as a system to understand what others were doing.

I will tell you that I don't stop at the endoscopy issue alone, I take the OIG reports that come from every facility in the system where they identify an issue and I have trended the problems that have been found and I issue that to my facility to ensure that those concerns are not concerns at the Miami VA.

We have done consistent improvements as I mentioned before. My Nurse Exec, who the sterile and processing section reports to has gone above and beyond and she has gotten certified herself in this certification, which is an international certification that—on sterilization of instruments.

In addition to that the nurse that oversees that section as well as the Nurse Educator for the sterile processing sections have received that certification as well and they are certified nurses in instrument sterilization.

Mr. WALZ. Okay.

Ms. BERROCAL. As well 80 percent and within the year 100 percent of the individuals who we have hired in that area will have received the certification.

Mr. WALZ. That is international.

Mr. Schoenhard, again, I don't want to put you in a position to be speaking for the private sector, you just have the most experience here is one of the reasoning I am asking, you have a foot in both camps.

If there would have been a problem with an endoscope at the private hospital and I was due for my colonoscopy would there be a place I could find that easily to know that hospital had a problem?

Mr. SCHOENHARD. I don't think as transparent as we have in the VA. And I would tell you, sir, we lead the industry and we are working with the FDA in this very area. We are making contributions not only to veterans care, but care to all Americans in this work.

Mr. WALZ. Okay. Well, I do want to make it clear that I am with my colleagues here on this accountability. I am with making sure that there is a sense that we are getting better, but I also understand, and I would leave with this, I think Mr. Schoenhard you had said—I am a systems analysis guy too by graduate training—but I also know I do believe in systems, but I understand that you are

only as good as the people who are there, and I think we need to keep that in mind. And this might come back and I certainty don't want to speak for my colleagues that if there are people that there can't do it they need to move.

Mr. SCHOENHARD. Let me just assure you, congressman, we will always put in place leadership that is in the best interest of our veterans.

Mr. WALZ. Well, I thank you all and thank you for coming today to help us understand this.

I yield back and thank you for the extra time, Mr. Chairman.

The CHAIRMAN. Yes, sir. Mr. Huelskamp. Hit your mic button.

Mr. HUELSKAMP. Sorry for that, Mr. Chairman, I appreciate the time and opportunity to ask some questions.

The first question would be for Mr. Schoenhard. What is the VA doing to promote transparency as well as providing protections for employees that would like to report misconduct?

Mr. SCHOENHARD. Let me just again elude to what I mentioned in the opening statement, sir, regarding transparency. On our ASPIRE Web site, there is no other system that I am aware of anywhere that is putting out aspirational goals to improve care for our patients, and our performance to date in getting there, as we have seen under Secretary Shinseki's leadership in putting this kind of level of transparency forward, it is unprecedented.

As it relates to ensuring that we have a safe culture where people can come forward let me mention a couple things, and if I could yield to Mr. Weaver who will talk at specifically what is being done in VISN 8, which we may adopt nationwide.

First we hold all employee surveys, we have a good high return on that going forward and that is an indication of employees comfort in going forward with psychological safety.

We have a program called CREW, which is civility, respect, and engagement in the workplace. We take teams like the OR teams and those that are in highly critical functions like an aircraft carrier flight deck crew might be and build comradery and ability to treat people with respect there. We are undertaking throughout all of VHA leadership appraisal teams.

Part of what has become apparent where we have breakdowns in terms of people going forward and acting on information that requires improvement, is in that front office, the top leadership of the medical center. We want to get a good idea of how that team works together through a formal process and we are undertaking that now, because I am convinced it starts at the head of an organization in terms of the health with which even that senior team is able to effectively communicate with each other.

Mr. HUELSKAMP. And what happens when that fails? I mean who is held accountable?

Mr. SCHOENHARD. The medical center director is the captain of the ship would be responsible for the culture of the hospital as well as the front office.

Mr. HUELSKAMP. And systemwide, and I am new this congress, I am a freshman, how many medical directors have been disciplined in any way or removed for failures in their sphere of responsibility?

Mr. SCHOENHARD. Sir, if I could take that question and bring it back it would depend on the period of time that you are going back to. There have been a number of——

Mr. HUELSKAMP. When was the last one removed or punished at that level?

Mr. SCHOENHARD. Probably—I lose track of time, and I am doing this off the top of my head—but it would be several months ago a director was removed, and I can get you the specifics on that, I just—I want to give you the accurate information.

Mr. HUELSKAMP. And I appreciate that and I appreciate the description of the model of how things would occur, but I have been in this position for about 9 months and other folks and my colleagues have talked about this incident.

I would say I am particularly angry at what has occurred and I am angry about things that occurred in my district, complaints that have come to my attention and the absolute failure of the VA to respond to those complaints.

The inability of members of Congress to get accurate information—it is just like pulling teeth. And I cannot imagine if a victim of a situation and the family was trying to get that information that I can't even get, it is one thing after another.

There is not transparency in this particular situation, it is a very troubling incident and the idea that we can talk here about holding people accountable and responsible, but we can't even get accurate information, it certainly seems like an attempt to cover that up. I don't know how widespread it is, I don't know if it is in just one particular incident, but I am just very disappointed, and that is not the medical director's fault, it is the system, it is the folks at the top. It is your job to hold them accountable. And if I can't get the information what am I supposed to do? Just continue to ask after six, seven, 8 months of trying to get information and having, you know, apparently the response from the VA is we will give him enough to make him satisfied for 2 weeks and then he will call again and then we will give him just a little bit more. What am I supposed to do, Mr. Schoenhard?

Mr. SCHOENHARD. First, Secretary Shinseki has made it very clear that we are to be transparent and accountable, and we would like to follow up with you in ensuring that we understand the root of where you are having problems getting information. I insist that we get good information from the medical center to the VISN to me and to VACO and then for the rest of the leadership of VA.

If we are having difficulty getting information to your satisfaction in a timely fashion we need to work on that. I understand that sometimes it is the process of request—and I don't mean to describe this generally—but I think there is probably an area where we could improve in terms of what information requests, because I think at times we are not clear what is being asked and we probably could do a better job of clarifying that.

In any case we both own the problem, and certainly VA owns the problem of ensuring if it is not clear what is being requested that we get timely clarification and we do the timely review and the release, because we honor and respect this committee's responsibility for oversight.

Mr. HUELSKAMP. And I don't know as far as who owns the problem, all I know is there is a deceased veteran and some possibilities of failure of the system, and again, I don't want to start digging in there and find out it is a much broader situation than one particular individual, but I appreciate your willingness to help, but I will just say that it hasn't happened, it is no excuse, you know, we are going to help you sometime in the future, but this complaint and complaints related to that are again make me very angry.

So we should call you directly if we want that information?

Mr. SCHOENHARD. Yes, we work with our OCLA staffer office of Congressional Legislative Affairs, but I can assure you that we will work together with you. I would like to have us follow up with your office offline.

Mr. HUELSKAMP. Absolutely, and I would appreciate later today or first thing tomorrow morning that you call my office and we will get started and maybe we can get over a few levels of bureaucracy.

Mr. SCHOENHARD. Yes, sir.

Mr. HUELSKAMP. Thank you. Sorry for taking too much time, Mr. Chairman.

The CHAIRMAN. Thank you very much.

Ms. Berrocal, let us go back to the veteran that escaped your facility. A root cause analysis has been done?

Ms. BERROCAL. Has been completed.

The CHAIRMAN. How long did it take you to approve that root cause analysis?

Ms. BERROCAL. We have a 45-day window to complete these root cause analysis. We initiated the root cause analysis quickly. I don't have the exact information, you know, on hand, but I am happy to get it for you. We invited people from the network——

The CHAIRMAN. But how long did it take for you to approve the RCA?

Ms. BERROCAL. As soon as the formal RCA was presented to me I signed it.

The CHAIRMAN. Okay. Let us all go back to my opening statement about being open, honest, and transparent. Did you alter the text? Did you do anything to the root cause analysis that was presented to you prior to signing it?

Ms. BERROCAL. What happens in the root cause analysis is that I did not alter the text, but——

The CHAIRMAN. You changed nothing in the root cause analysis?

Ms. BERROCAL. Not to my knowledge. What I—no. What happens in the root cause analysis is they—the team comes and presents and questions—they present to the whole executive leadership team and at that time we do ask questions, we ask clarification, and then the written document and recommendations are presented to me and I sign them.

The CHAIRMAN. And here is why I am having a little bit of a problem, because we have asked Legislative Affairs to be provided every AIB and every root cause analysis from '08.

Ms. BERROCAL. Uh-huh.

The CHAIRMAN. I think there have been 14 AIBs done, we have gotten 3. We haven't gotten any root cause analysis, none.

Ms. BERROCAL. At the facility level we have submitted everything that has been requested of us, and there is a vetting process.

The CHAIRMAN. Well, since we are here in an open discussion, were there any management issues raised in the root cause analysis of the veteran that escaped your facility, walked out, shot a police officer, and was killed?

Ms. BERROCAL. I would like to recollect exactly all the recommendations.

The CHAIRMAN. If it was pointed at you, you probably would know it wouldn't you?

Ms. BERROCAL. Yes.

The CHAIRMAN. Was there anything in the root cause analysis that pointed at leadership at your facility?

Ms. BERROCAL. You know, I—honestly, I mean I am trying to be honest because that is what you have asked me to do and I am honestly not recalling a specific recommendation. You know, I——

The CHAIRMAN. But I am asking now—I am asking you now to provide that root cause analysis to this Committee. Can you do that?

Ms. BERROCAL. Yes, sir.

The CHAIRMAN. When?

Ms. BERROCAL. As soon as I get back to Miami.

The CHAIRMAN. Can they transmit it before you get back to Miami?

Ms. BERROCAL. I will.

The CHAIRMAN. Thank you.

Ms. BERROCAL. I will get that to you.

The CHAIRMAN. What happens if a veteran presents at the facility with congestive heart failure?

Ms. BERROCAL. They are—you know, I rely on my clinicians to take care of the patients and they are—if they present to the ER they are taken care of in the ER.

The CHAIRMAN. And for what reasons would a patient not be admitted if they had congestive heart failure?

Ms. BERROCAL. You know, I am not a clinician and I would have to defer to my clinicians in making toughs decisions. On a daily basis I must rely on my clinicians to make clinical decisions. Day in and day out our doctors are making decisions on our patients and I cannot possibly replace their judgment with mine.

The CHAIRMAN. So would you know if a veteran had come to your facility, presented with a particular disease, returned home and then expired the next day? Would you have any way of knowing that?

Ms. BERROCAL. Usually what happens is we—any deaths we do review and there is where indicated we do peer reviews, where the death is not expected there are peer reviews that are done and we review to see what happened.

The CHAIRMAN. There is a way that you would know if a veteran presented 24 hours prior to their death at your facility but was sent home, you would have a way of tracking that?

Ms. BERROCAL. Every morning we get a report on anything that is unusual that might have happened on that evening before or that day before, we get a report every single morning. I meet with my leadership, the staff in the ER presents their information, following that, you know, we stay with the leadership and discuss anything that we might need to follow up on.

The CHAIRMAN. Is it unusual that a veteran would come to your facility, be discharged—not discharged, but just be sent home, not admitted, and would pass away the next day? Would you consider that unusual? And if you do consider that unusual, is that something that you would report then to the VISN that this has occurred?

Ms. BERROCAL. We would normally report deaths—unexpected deaths to the network, yes.

The CHAIRMAN. So if an instance like this did occur it would have been reported to the VISN?

Ms. BERROCAL. It would be any expectation that it would be reported. If it is an unexpected death there are reports that go forward.

The CHAIRMAN. Regardless——

Ms. BERROCAL. No, we don't independently like on an issue for something report every single death if it is an expected death.

The CHAIRMAN. Regardless of what the peer review may have found you would still report it?

Ms. BERROCAL. The peer reviews focus specifically on the provider to determine whether it was something that didn't go the way it should be in that direction. So yes.

The CHAIRMAN. Okay. Let us go inside the facility, now we have somebody who has been admitted to the facility and is having surgery. If there is a death on the operating table what would prevent that death from being reported to VISN?

Ms. BERROCAL. Those would be reported to the network.

The CHAIRMAN. All deaths on an operating table are reported?

Ms. BERROCAL. Are reported. Should be reported. There is a system that we put through to report unexpected deaths.

The CHAIRMAN. All deaths on the operating table are reported to the VISN?

Ms. BERROCAL. Yes, sir.

The CHAIRMAN. All deaths?

Ms. BERROCAL. Unexpected deaths are reported.

The CHAIRMAN. There is a difference now. Unexpected deaths or deaths? If a patient dies on the operating table is that reported? Regardless is that reported to the VISN? And if not, why not?

Ms. BERROCAL. It would be my expectation that it would be reported.

The CHAIRMAN. Is there a root cause analysis on every death on an operating table?

Ms. BERROCAL. There would be a root cause analysis again if it is an unexpected death there would be a root cause analysis.

The CHAIRMAN. What would be an expected death on an operating table? I would expect if I went in for surgery you wouldn't expect me to die, you would expect me to recover. Now what is an expected or an unexpected death? What is that?

Ms. BERROCAL. Again, it is—you know, I am not a clinician.

The CHAIRMAN. You are the director of the medical center.

Ms. BERROCAL. Correct, not a clinician.

The CHAIRMAN. For now.

Ms. BERROCAL. I am not a clinician, but I would expect that—I would—any unexpected death would be something where, you

know, if they found something that they were not expecting to find I—you know, I believe that any deaths would be reported.

The CHAIRMAN. Who makes the determination as to whether it is expected or unexpected?

Ms. BERROCAL. There are systems in place to report, and we have had a variety of groups come in look and determine, you know, that we have done things appropriately. All deaths are reported and they are investigated, but not necessarily through the RCA process. We do investigate. Again, we do peer reviews to determine——

The CHAIRMAN. Is a peer review punitive?

Ms. BERROCAL. It could lead to be, but not necessarily. A peer review, there is a group of peers that review to see whether or not the care that was provided was adequate care.

The CHAIRMAN. So if everybody just decides that the care was adequate and that it was an expected death you may not even report that to the VISN, correct?

Ms. BERROCAL. There is a committee that reviews after. You know, there is the peer review, it goes to a committee to review and then a determination is made. There is—there are rankings or scores that are provided determining whether or not it is a——

The CHAIRMAN. Who makes the final determination as to whether or not it is sent to VISN?

Ms. BERROCAL. They are reported to the VISN. The deaths are reported to the VISN.

The CHAIRMAN. All of them?

Ms. BERROCAL. No.

The CHAIRMAN. Is there ever a death that is not reported to the VISN?

Ms. BERROCAL. We have, for example, deaths in hospice, these would be expected, you know.

The CHAIRMAN. I am talking about on the operating table.

Ms. BERROCAL. I would expect——

The CHAIRMAN. I will let you think on that.

Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Schoenhard, you and I talked before the hearing started, we are both veterans, you know, and from your experience in the private sector, I agree that, you know, there is some good to be found anywhere, but I think based upon our mutual experience with the culture that we had where these veterans come from as a squadron commander if my moral factors were going down like VAMC in Miami is, if my customer service statistics were going south like theirs are, I can assure you I know what accountability would mean in that case.

I am just curious, are you astutely hearing the responses to the questions that this Committee is asking and some of the answers that we are getting? Because you made a statement that you are prepared to hold leadership accountable, and I believe you, I am anxious to see the results of that. That is a statement, let me ask you a question.

Mr. SCHOENHARD. Yes, sir.

Mr. JOHNSON. Last month the Miami Herald reported that an administrative investigating board conducted by the VISN that

they had obtained through a FOIA recommended disciplinary action for both Dr. Vara and Ms. Berrocal at the Miami VAMC. When asked for comment on whether these actions had taken place the VA had none.

In documents submitted to us just last night by the VA only a draft, unsigned, and undated recommendation for action was provided.

And then 30 minutes before today's hearing a notice of admonishment was provided that was dated in December of 2010 with no specific day.

Can you clarify and explain this discrepancy and how that fits into your we are going to hold leadership accountable?

Mr. SCHOENHARD. Yes, sir. The AIB recommended administrative action. The one that I convened, the national IAB after the second disclosure of the veteran who had not been contacted, found that there was reason to take administrative action against the medical center director and the chief of staff.

The way that works in VA then is that I shared that report with Mr. Weaver and he took the administrative action. He may want to speak to the process we use in VA and in government to——

Mr. JOHNSON. What administrative action was taken?

Mr. SCHOENHARD. An admonishment was issued against both individuals.

Mr. JOHNSON. A veteran escapes the facility——

Mr. SCHOENHARD. No, sir.

Mr. JOHNSON [continuing]. And dies.

Mr. SCHOENHARD. That was—this was predating this incident.

Mr. JOHNSON. Okay. All right, so this admonishment that came through the Miami Herald incident from a previous AIB, correct? Have I got this right?

Mr. SCHOENHARD. That is correct, sir.

Mr. JOHNSON. Then the patient that escaped the center and subsequently committed suicide happened after that, correct?

Mr. SCHOENHARD. That is correct, sir.

Mr. JOHNSON. All right. So do you think the admonishment worked?

Mr. SCHOENHARD. I think——

Mr. JOHNSON. Next question. Next question. Can you provide to this Committee, Mr. Schoenhard or Mr. Weaver, a record of disciplinary actions from the Miami VAMC over the last 24 months? I would specifically like to see, and with The CHAIRMAN's approval, I would like to see the incident. You don't have to give us names for privacy. I would like to see the incident and the action and what level of leadership and management that action was taken against.

Ms. Berrocal, last week one of your employees was arrested for selling names of veterans. In the past 6 years it is estimated that more than 3,000 veterans information has been sold.

Mr. JOHNSON. Have you alerted any veterans that their information may have been compromised? And if so, how have you done that?

Ms. BERROCAL. Actually this was an investigation that was done by the IG and it was a covert operation. I learned about it at the time shortly before they were going to be arresting the individual,

and at the time what we knew was that there was information on 18 individuals that was compromised, and then on——

Mr. JOHNSON. Have those veterans been notified?

Ms. BERROCAL. The——

Mr. JOHNSON. Yes or no, have those veterans been notified? You talked earlier about a process for making sure that veterans are notified. I have heard that from various pieces of testimony this morning.

Ms. BERROCAL. We are in the process of notifying the individuals.

Mr. JOHNSON. So they have not been notified. When was the guy arrested?

Ms. BERROCAL. This just happened in the last——

Mr. JOHNSON. And you didn't know any about the investigation prior to his arrest?

Ms. BERROCAL. I knew that they were doing an investigation and they had some concerns. The individual——

Mr. JOHNSON. So prudent leadership would be poised and ready to act if the investigation proved out, right, that you would then immediately begin to notify those veterans whose information had been compromised? And you are saying that as of today there still have been no veterans notified, you are only in the process of? Eighteen veterans, how long does that take? I can make 18 phone calls in 30 minutes.

Ms. BERROCAL. We have worked with our privacy officer to make sure the information is done and that we communicate to those veterans as we need to.

Mr. JOHNSON. Okay. And have they been communicated with?

Ms. BERROCAL. I believe so.

Mr. JOHNSON. You believe so.

Ms. BERROCAL. Yes, sir.

Mr. JOHNSON. But you are not certain.

Ms. BERROCAL. The 18 have been communicated. The individual indicated that——

Mr. JOHNSON. Well a few minutes ago you told me that you were in the process of notifying them, now you are saying that they have been notified?

Ms. BERROCAL. We have communicated with the privacy officer——

Mr. JOHNSON. No, no, no.

Ms. BERROCAL [continuing]. Whose responsibility is to communicate——

Mr. JOHNSON. I am not asking if you communicated with the privacy officer. Have the veterans whose information been compromised been notified that their information has been compromised and sold by an employee under your direction?

Ms. BERROCAL. I will have to get that information for you.

Mr. JOHNSON. Okay. So now you don't know. First it was you got a process, then they have been notified, and now you don't know.

Mr. Schoenhard, if I am the wing commander I am paying real close attention to these answers.

Mr. Chairman, I yield back.

Mr. SCHOENHARD. I can answer the question for you. According to the OIG last night they have not been contacted.

The CHAIRMAN. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. Schoenhard, I thought it was interesting that you had assessment—your assessment was that the transparency at the VA hospitals is superior to the transparency in the private sector, and I actually do believe that, but in this particular case is the problem that we are seeing in Miami, is that a transparency issue or is something else going on that is causing this set of problems or what—what is going on here? I don't understand why this facility is having so many problems.

Mr. SCHOENHARD. Well, sir, we have a culture which is in the process of improving, and I saw the chairman's bar graphs earlier in terms of the results, but what we are doing is holding people more accountable over time than has been done in the past, and that is what we expect a medical director to do. And there will be issues and concerns that arise what to——

Mr. MCNERNEY. So in prior years people weren't being held accountable.

Ms. Berrocal.——

Mr. SCHOENHARD. They were, sir. I want to be careful with the impression left there. But there is now increased sense of accountability.

And the thing which I would also say that is beneficial here is that we have the support of our union partners and our veteran service organizations in making this change under Ms. Berrocal's leadership.

Mr. MCNERNEY. Ms. Berrocal, what is your assessment of why there are so many problems in Miami?

Ms. BERROCAL. Miami I think in part had—when I arrived Miami had a number of critical vacancies, including the nurse exec who had been selected for a previous position, the associate director who oversees the administrative part of the operation who had been—who left shortly after I arrived. There were at least ten vacancies at the time from senior leadership positions that would set the tone and lead the organization.

I have had—at this point, and there have been——

Mr. MCNERNEY. Have these been filled now?

Ms. BERROCAL. Sir? Yes.

Mr. MCNERNEY. Have these vacancies been filled?

Ms. BERROCAL. I have spent whatever time I haven't been dealing with these kinds of situations I have spent trying to recruit a really incredible team of competent people to see this organization through this.

Mr. MCNERNEY. The thing is that in 2009 we had this institution in front of us because of the endoscopy issue, so—and I take it Mr. Schoenhard's statement that it takes time to turn around, but 2 years it is a fair amount of time. I mean you can do a lot in 2 years.

Ms. BERROCAL. I am sorry?

Mr. MCNERNEY. So why are we seeing you again here in 2 years? I don't understand why more hasn't happened in this one institution.

Ms. BERROCAL. I believe that, you know, we again had—I have spent these 3 years, the initial year assessing the organization and preparing the organization to face the challenges that we have with

our Veterans and the ones coming up. I have had the opportunity to review the strengths and the weaknesses of our—of the staff and to not only fill the positions that were vacant, and that includes many of the service chief leadership positions, we have done almost a complete turn around there, and in addition to that, I have moved positions—individuals from previous positions to positions where their skills are enhanced.

Mr. MCNERNEY. So are these positions hard to fill? Are people not wanting these positions?

Ms. BERROCAL. Some of these positions are hard to fill.

Miami has gone through, in the last three and a half years, through a tremendous amount of scrutiny, and unfortunately when these situations happen they—it takes a toll on the organization. It is difficult to recruit people to come to an institute that has this amount of oversight.

Mr. MCNERNEY. Well, let us talk about cost overruns for a little while. How does the facility run a $30 million deficit? I mean what does that mean? Does the money come from other facilities? Are other facilities being hurt because the Miami facility is running a deficit? Do bills not go paid? I mean how do you do that? How does that operate?

Mr. WEAVER. Sir, what happens at the—just to talk a little bit about the budget process. At the national level they allocate X dollars for each network and then the network through a collaborative effort partnership with the directors make a determination of what the budget should be for each medical center based on the unique number of patients that are there, the complexity of the patients, et cetera.

During this past year—well, first of all the network holds a small amount of money in reserve for emergency situations like hurricanes, wild fires, et cetera, and we also hold some funds in reserve that the medical centers have agreed to have for high-tech/high cost and some other kinds of things.

So as Miami moved forward, and we have other medical centers in the same situation, they—this past year they had some financial challenges that were not anticipated and they were also making some changes within their organization which creates—when you bring in—trying to meet the priorities of the agency we had to add some staff, and when you do that sometimes there is some overruns because you are waiting for people either to transition out or we have to move them from one program to another.

So within that—those dynamics we were faced—Miami specifically was faced with a deficit, and the network worked with them to meet their needs.

And I go back to one of my earlier statements, is that our focus is on quality of care, that cannot be compromised. We look at satisfaction and cost effectiveness.

So this past year we were able to work with Miami and they ended the year with a balanced budget.

Mr. MCNERNEY. All right, I am going to have to yield back.

The CHAIRMAN. Ms. Berrocal, I was going go another line of questions, but since we are talking about budgets and funding is it correct that—I think it may have recently been filled—but is it correct that the public affairs position at your facility was vacant

for 2 years and during that time basically it was filled by rotating service chiefs to fill those duties?

Ms. BERROCAL. The specific public affairs position at Miami has been vacant for quite some time, and during that period of time I had established a communications and protocol section. The chief of that section has responsibility for the media session, for the public affairs area, and for outreach section of the medical center.

The CHAIRMAN. But there is a vacant public affairs position today?

Ms. BERROCAL. No, there is not a vacant position today.

The CHAIRMAN. There was 2 years up til now. I mean this was an open position for 2 years.

Ms. BERROCAL. Approximately, that is correct.

The CHAIRMAN. Okay. Where does the salary money for a position like that go when that position is unfilled?

Ms. BERROCAL. It goes into operations into what we might need to run the medical center.

Our medical center, as I indicated before, has increased the number of veterans that we have seen, more—almost double the national average, so we are seeing a lot more patients.

In addition to that we are a referral facility as Mr. Weaver had indicated for several of the other facilities within our Network, so we receive patients from the other facilities in the medical—in the Network to be able to address their needs and that also impacts on our budget.

In addition to that we—fewer Veterans have insurance right now and so it impacts our ability to collect from insurance also to supplement our budget, which is also something we utilize.

So those—in addition to that during this current year we have finalized a very robust budget briefing where each department received what money they would get and they were asked to review their programs to let us know how they were going to be accomplishing the work that needed to be done.

So the budget briefings brought in every single one of the service chiefs to provide information as to how we were going to meet the budget moving forward, including efficiencies that we could create such as merging different departments under one leadership, working with other facilities to collaborate on workload, redesigning positions.

The CHAIRMAN. Mr. Weaver, how many facilities within VISN 8 ran a deficit this year?

Mr. WEAVER. We have approximately five out of our seven.

The CHAIRMAN. Five ran a deficit out of seven.

Mr. WEAVER. Right.

The CHAIRMAN. Who was the highest?

Mr. WEAVER. The highest—well, I am not going—I don't recall the highest. I don't remember if it was Tampa or—I don't recall, sir.

The CHAIRMAN. Okay. Would you report back to us who has the highest?

Mr. WEAVER. I will. I will give you the deficits for each of the facilities. In fact I can probably get it now.

The CHAIRMAN. How short was Miami? You said that number I think already. What kind of deficit did they run?

Mr. WEAVER. I have them here, sir.

Miami at the end was 19.7 million, and our highest was Tampa at $28.4 million.

The CHAIRMAN. Did you approve the two and a half million dollar executive suite renovation at Miami?

Mr. WEAVER. I am sorry?

The CHAIRMAN. Did you approve the two and a half million dollars executive suite renovation in Miami?

Mr. WEAVER. That would have—I think that would have come through my office.

The CHAIRMAN. It would have?

Mr. WEAVER. I think I had better get back with you on that. I want to be 100 percent sure that I am clear on that.

The CHAIRMAN. Ms. Berrocal, did you suspend golf cart service for the veterans?

Ms. BERROCAL. Did I suspend what, sir?

The CHAIRMAN. I am sorry. Did you suspend golf cart service for the veterans in the parking lot?

Ms. BERROCAL. We did. In the parking lot we did suspend the—that service. We—what we did was when——

The CHAIRMAN. That is all.

Ms. BERROCAL [continuing]. At the Fisher House——

The CHAIRMAN. I just wanted to know if you did. You did.

Now how did you determine that the current office renovation of approximately $1 million to your executive suite wasn't sufficient and that two and a half million renovation was more important than golf cart escorts for the veterans trying to come into your facility?

Ms. BERROCAL. Sir, I would have to get back to you on that.

The CHAIRMAN. Well, which one is more important, your office or golf carts for the veterans to get to the hospital?

Ms. BERROCAL. I would always put the Veteran first, sir.

The CHAIRMAN. But you canceled the golf cart.

Ms. BERROCAL. The golf cart issue was canceled during this year. I would have to look at the information that you are giving me about the renovations, but——

The CHAIRMAN. Have you renovated your office?

Ms. BERROCAL. My office is not renovated.

The CHAIRMAN. Are you going to be renovating your offices?

Ms. BERROCAL. What we have done with the office was we painted the—I would have to look at the information that you have on hand.

The CHAIRMAN. Are you going to be renovating your offices?

Ms. BERROCAL. No, sir.

The CHAIRMAN. Okay. So if I produced a contract executed that said you were would you change your answer?

Ms. BERROCAL. I really would need to see what—I really would need to see what we are——

The CHAIRMAN. We will produce it for you. We will show it to you. You are. You have contracted for that to be done.

I just think it is egregious that you would stop golf carts from escorting veterans to the front door but you would sign a contract or somebody would sign a contract to expand the executive offices. Doesn't that sound odd?

Ms. BERROCAL. Yes, sir.

The CHAIRMAN. Dr. Roe, welcome back. Took a trip to Afghanistan over the weekend, thank you very much. You and Mr. Walz I know went along with some other members, thank you for making that trip.

You are recognized if you have some questions.

Mr. ROE. Thank you, chairman, for recognizing me, and yes it was a great trip. Mr. Walz and I, along with other members of the Veterans Affairs Committee, had a great visit with our troops in Afghanistan.

One of the problems I have as a health care provider when you look at some of the issues here, Ms. Berrocal, how would you—because I have had to do this my entire life—be able to sit down with a family of a patient that has had a mistake made, an error like the way these scopes were cleaned, and sit down and talk to them? That would be one thing. But how would you sit down and talk to the 79 who didn't get notified and 12 others that were picked up by somebody else? How would you look them in the eye and say I am sorry, or would you look to have procedures that that could never happen again?

Because whether the virus was transmitted or not is irrelevant, the fact is these people weren't notified that something could have happened to them, is inexcusable. I had to be the one that would sit down and say hey, I didn't get this lab test.

Can you sit down eyeball to eyeball with that patient across the table from you and give them a correct answer about why that didn't happen? Why maybe their life was put at risk?

Ms. BERROCAL. I have always strived to be very patient centered, and precisely the reason why those patients were identified——

Mr. ROE. Did you talk to any of them personally?

Ms. BERROCAL. Sir?

Mr. ROE. Did you talk to any of them personally? Did you sit down yourself as basically the CEO responsible for patient care at that hospital and say this happened?

Ms. BERROCAL. What I did was I submitted an apology in the original letter of notification that was heart felt, and in addition to that I had my clinicians meet with them so that if there were any follow-up questions they had in terms of the clinical——

Mr. ROE. How do you explain that that happened, I mean when there were so many that fell through the cracks? In other words how did that big a mistake happen?

Ms. BERROCAL. You know, as the AIB points out there were a series of areas that had problems for years, and the AIB identified them and I proceeded to address those issues.

Mr. ROE. So there are no issues like that now?

Ms. BERROCAL. I don't have those issues right now.

Now I—you know, I would like to point out that the additional members that were identified were identified because Miami did the right thing to—I personally did the right thing to report that there was a problem and that we should continue to look further, and my commitment to this committee and to anyone who will listen is that I will continue to look.

Mr. ROE. I know you mentioned or Mr. Weaver mentioned that five of the seven VISNs were in a deficit, and I certainly under-

stand from talking to my own VA at home in the VISN why that is correct is that they are collecting less private insurance dollars. But to go with The CHAIRMAN's questions a moment ago, if I were having problems buying food, which is pretty basic, I wouldn't go remodel the inside of my house.

And the question is, if we are not providing basic health care needs for our veterans, why are we fixing up my office so it looks nice?

Ms. BERROCAL. You know, I would like——

Mr. ROE. Wait, I want to ask Mr. Weaver that. Is that being done? I know you didn't answer the question the chairman asked a minute ago, maybe you couldn't and that is if you can't.

Mr. WEAVER. I think I misunderstood what he said. I thought he was saying emergency room and I was thinking about the trailers outside of the facility, so with my apology I just misunderstood that.

As far as executive offices no, I think we have to take a look at what this contract has, and if that is indeed what it is then we need to take a look to see——

Mr. ROE. I guess a question, let me ask it again. You can't buy food in your house, that is pretty basic.

Mr. WEAVER. Right.

Mr. ROE. Would you be remodeling the bedroom?

Mr. WEAVER. No.

Mr. ROE. No.

Mr. WEAVER. You are absolutely right, sir.

Mr. ROE. You wouldn't, you would be spending that money on veterans, on their health care, the men and women that I went out to the forward operating base with Sergeant Major Walz and shook their hands and looked at them in the eye, that is who ultimately will be your client or your patient in the VA system.

One other question, and they may not have this answer, Mr. Chairman, but because of this problem in Miami there have been numerous settlements in the legal system and it is not clear to me in the briefing we have here how much that has been. How much money have the taxpayers spent because of this error? And I certainly know in the private sector where I came from what would happen in that case who would pay that money, but how much money has been paid out? And so far it is not clear to me. It looks like it is in the millions, but I would like to know that number if anybody has it.

Mr. WEAVER. I did not submit that information, but I know we would have that information and we can get that from general counsel.

Mr. ROE. Okay. But I would like to have that so the Committee would know through this error that was made how much the taxpayers were on the hook for, plus the risk that the patients had.

I yield back my time, Mr. Chairman. Thank you.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman, and again, as I said, this is a zero sum proposition we are at and I certainly take no pleasure, and I can assure all of you that it is not through collaboration that this hearing is taking a pretty direct turn in a very frustrating and quite honestly a very troubling manner for me.

I will defend anyone's right on due process to the end of days, but I want to be very clear, and I have to say Mr. Schoenhard, Mr. Johnson might have given you some good advice to listen to the wing commander, I am going to speak now as the senior NCO and some recommendations, I am going to ask a couple things.

Just some troubling decision-making that I have. Did we have a contract to replace locks on the doors?

Ms. BERROCAL. We currently have a contract to replace locks on the doors.

Mr. WALZ. What happened? Why did we do it twice for $24,000?

Ms. BERROCAL. Sir?

Mr. WALZ. Why did we have to do it twice for $24,000?

Ms. BERROCAL. The most recent contract has to do with the keys being lost.

Mr. WALZ. Who lost them?

Ms. BERROCAL. I was personally responsible for that. I don't recall the details of why I had—there was something happening at the medical center that evening and I took the keys out of the lock where I keep the keys in my office, they were in a single ring unidentified by anything else. I am currently raising a 9-year-old grandson and after addressing whatever it was that I had to pull the keys out for I was running late to pick him up at school, so I rather than going to my office and locking the keys again and leaving I left from the location and had the keys in my purse. The——

Mr. WALZ. But I would say, and don't want to cut you off, Ms. Berrocal.

Ms. BERROCAL. My car was broken into.

Mr. WALZ. I am certainly sympathetic, but it comes down to that accountability piece again in a very strong way.

And next thing is we have police officer shortages, but are we paying police officers overtime to escort employees to their car?

Ms. BERROCAL. We are paying police officers overtime. We have a remote parking lot because we had to engage in that process because we had the Fisher House as well as the mobile hours, it took away most of our parking space.

Mr. WALZ. This is the best contract we could get? So we signed a contract for parking, it is in a bad neighborhood, we are paying 13,000 overtime to escort employees while we are shorting officers that are there in case of, and we know that VA hospitals can have problems with folks coming in and need to have that there. Could that contract have been better written?

Ms. BERROCAL. You know, we do have a contracting session that does take care of the contracting options, and we did listen to concerns from the employees about with the parking area, so we did go and check and it was a safe area.

I will tell you that the medical center has received approval to purchase a piece of land to bring the parking closer to the medical center.

Mr. WALZ. Well, my moral is low and I don't work at Miami from the things I have heard. Again, perceived reality can be reality many times, Mr. Schoenhard, and I am going to leave, there is a few things on people removed, reinstated and that.

I appreciate the candidness here, I will say that. I certainly appreciate your devotion, and I know this doesn't come from a desire to not provide for veterans at all, but at the end of the day outcomes, effectiveness have to be measures that we live by.

And I have to tell you, I have been in numerous VA facilities and this is not the norm, it is certainly not there.

And so again, I am very respectful of the due process and this was not meant to be—I can tell you I was hoping it wouldn't go this direction, but it is very obvious to me that the facts stand pretty strongly.

So Mr. Chairman, I will yield back to your side for some follow up.

The CHAIRMAN. Mr. Amodei, do you have any questions?

Mr. AMODEI. No, sir.

The CHAIRMAN. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Schoenhard, in your last few comments you talked about how you didn't want the wrong perception to be left here. You talked about how you thought when asked what the problems were what was the root cause of so many problems in Miami you talked about the cultural problems and the fact that you thought the culture was improving.

Ms. BERROCAL. has been there for 4 years. How much time do you give to see cultural improvement? I have a follow-up question so please answer that one quickly.

Mr. SCHOENHARD. Sir, let me just again emphasize, and I appreciate the opportunity to respond. We will put in leadership that which is in the best interest of our veterans.

Mr. JOHNSON. Great, great, I am glad you are going to do that, so then let me ask you the question. You were the COO of what company again?

Mr. SCHOENHARD. SSM Health care.

Mr. JOHNSON. Okay. How many locations, how many operating locations—I am not particular with them—but how many operating locations did you have?

Mr. SCHOENHARD. We had about 20 hospitals.

Mr. JOHNSON. Okay. All right. Did you know when you went into your staff meetings with your CEO—I set on the executive level of a company as well.

Mr. SCHOENHARD. Uh-huh.

Mr. JOHNSON. When you went into the meetings with your CEO did you know the operating parameters financially and otherwise of those 20 locations?

Mr. SCHOENHARD. Yes, sir.

Mr. JOHNSON. And you could speak to those details in that meeting, correct?

Mr. SCHOENHARD. Yes, sir.

Mr. JOHNSON. And yet you have a VISN director here who has seven and couldn't answer the chairman's question about which one had the highest deficit. Does that seem odd to you?

Mr. SCHOENHARD. Well, sir——

Mr. JOHNSON. In that same line of questioning the chairman asked repeatedly about a contract to renovate the executive office suite and somehow Mr. Weaver heard emergency room trailers.

You know, I am not sure what is going on here, but I really hope that you are sincere about your comments about wanting to establish leadership accountability.

I have a few more questions.

Mr. SCHOENHARD. May I respond?

Mr. JOHNSON. Yeah, please.

Mr. SCHOENHARD. Thank you.

Let me just emphasize again that leadership shapes a culture of any organization, you and I——

Mr. JOHNSON. Starts at the top, you and I both know that.

Mr. SCHOENHARD. That is correct, sir. And——

Mr. JOHNSON. But what changes have been made at the top since you got there since these problems came to your attention, what changes at the top and how have you established accountability with Mr. Weaver and Mrs. Berrocal?

Mr. SCHOENHARD. And we will continue to monitor all of what is going on. I can assure you——

Mr. JOHNSON. Not monitor. Monitoring doesn't establish accountability.

Mr. SCHOENHARD. By monitoring——

Mr. JOHNSON. Are you denying any of these facts that are coming out?

Mr. SCHOENHARD. No, but I will say this, we will make judgments regarding what is in the best interest of our veterans in service.

Mr. JOHNSON. Well, I am going have to disagree that you are making those judgments up until now. I am going trust that you are going to make those because you have told this Committee that that is what you stand for.

Mr. SCHOENHARD. Yes, sir.

Mr. JOHNSON. I am going to hold you to your word. Those judgments have not been made thus far, that is what concerns me.

Mr. SCHOENHARD. But could I——

Mr. JOHNSON. Mr. Weaver, based on our investigation it appears that staff directly connected to the Miami VAMC director identified employees to be interviewed by the VISN during the administrative investigative board and that the VISN used those names for their interviews.

Now I am not a rocket scientist, but to me this seems like a conflict of interest given that Miami leadership, if the people being interviewed about leadership works directly in the leadership team they can influence the investigation.

Why would VISN seek such input from the people that are under investigation?

Mr. WEAVER. Which AIB was that?

Mr. JOHNSON. I don't have a number right here in front of me. Leadership. The leadership administrative investigative board.

Mr. WEAVER. Okay. That would have been on the third one, the unanimous letter.

The individuals who would have been interviewed would have been anyone who would have been cited in the letter, and then also we would ask the leadership to look at the letter and see if there was anything that we needed to include, plus the chairman of the AIB had latitude to chose who he—or his team wanted to inter-

view. And his team was composed of people outside of the network, they were not members of Miami or VISN 8.

Mr. JOHNSON. Mr. Chairman, I think I am going to yield back any remaining time. And I am just going to summarize by saying this. You know, I am sort of at a loss for words with what I have heard here today and what I have read in the documents that have been provided to this Committee thus far.

And Mr. Schoenhard, I don't envy your position because I think you have some tough decisions to make sir if you are going to stand firm on your commitment to establish leadership accountability.

Mr. SCHOENHARD. Sir, I assure you and Members of the Committee and all veterans, we will provide the leadership that is in the best interest of your veterans.

I just want to say also we have in Mr. Weaver and Ms. Berrocal two dedicated public servants who have given their lives to this mission. This is the most mission driven organization I have ever been a part of. We have executives like Mr. Weaver and Ms. Berrocal who have options to go to the private sector. They could make more money than they do, but they care about this mission.

Mr. JOHNSON. You know, sir, I would recommend that you let them go. That would be my recommendation.

I yield back, Mr. Chairman.

The CHAIRMAN. I apologize, I was just given some numbers, and this came from VA and I don't know where the conflict is and we will try to research and see if the numbers that VA provided us are incorrect, but it says five medical centers in VISN 8 received additional funds at the end of fiscal year 2011, those stations and the amounts they received are as follows, and the number one was Miami at 29.7 million. Now you said it was only 19 million. Where is the discrepancy?

Mr. WEAVER. The information I have is information that was prepared for me by my fiscal officer and we will see if there is some kind of correction that is needed.

The CHAIRMAN. Okay. Ms. Berrocal, how many acting chiefs are there for physical medicine and rehabilitation services?

Ms. BERROCAL. Right now there would be one acting chief.

The CHAIRMAN. Okay. I have a letter that you signed on September 1st of 2011, which would have been a month ago, effective August 1st until further notice two physicians are designated as acting chiefs. Why would that be and how are they being compensated and is this the same job?

Ms. BERROCAL. There would be one individual serving at a time as the acting chief. If there were two individuals it would be——

The CHAIRMAN. This says instructions, effective August 1st until further notice doctor and doctor are designated as acting chiefs of physical medicine and rehabilitative service at the Miami VA health care system. Signed Mary D. Berrocal.

Ms. BERROCAL. As a general rule we would have one individual serve at a time being the leader of the section.

In terms of their compensation at this time no additional compensation has been received to my knowledge. What we have done in the past is as individuals had served——

The CHAIRMAN. So wait, so they are both being compensated as physicians——

Ms. BERROCAL. As physicians.
The CHAIRMAN [continuing]. But not as——
Ms. BERROCAL. As acting.
The CHAIRMAN [continuing]. As the chief.
Ms. BERROCAL. Correct.
The CHAIRMAN. Okay. Where does that money go?
Ms. BERROCAL. Sir?
The CHAIRMAN. Where does the chief's salary go then? If nobody is being paid that salary where is it going?
Ms. BERROCAL. Any money that is the result of vacancies would go back into operations.
The CHAIRMAN. Okay. Let me see if I can jog your memory just a little bit about the executive office and relocation from the 2nd floor to the 12th floor A and B. Were you aware that you were moving from the 2nd to the 12th floor?
Ms. BERROCAL. Oh, okay, now I know what you are talking about. Yes, what we are doing—thank you for the clarification.
What we are doing is Miami has had tremendous space issues because we are kind of like locked down by space, and——
The CHAIRMAN. And let me also, I understand you are locked down by space, but I understand this renovation is going to take patient rooms in order to accomplish; is that correct?
Ms. BERROCAL. Well, what we are doing is actually we have a master space plan——
The CHAIRMAN. Is it going to take patient rooms?
Ms. BERROCAL. What we are doing is shifting it. We are going to be trying to do the patient care services in the lower floors and consolidate so that we can gain some efficiencies. Right now we have individuals from different departments that are in different areas.
So what I set up for that was a three-tier program to review the space needs of Miami. One of the issues was we had somebody from central office come and do an assessment of the physical plan to see moving into the future what the needs were going to be, and with that determined, for example, how much square footage we would need for different areas.
Separate from that then I had a clinical group that is looking at patient flow to determine once we have that piece of——
The CHAIRMAN. But I am looking specifically. So you are not expanding the size of your executive offices by your move, okay, they are going to be the same size or less.
Ms. BERROCAL. Sir, that is what I would anticipate, yes.
The CHAIRMAN. Okay.
Ms. BERROCAL. The intent is to create more space——
The CHAIRMAN. But when I asked you the question at a two and a half million dollar renovation why would you not have known? I mean if your whole offices are being moved ten floors.
Ms. BERROCAL. This is a very long-term plan that we have in place.
The CHAIRMAN. This is actually a contract. And by the way, I have a service that tracks government contracts——
Ms. BERROCAL. Uh-huh.
The CHAIRMAN [continuing]. So we have the ability to see all of this information, and the notice was on June 13th of 2011.

Ms. BERROCAL. I believe that the idea of moving the executive office onto the 12th floor has been in the plans for quite some time. The idea was to be able to move the administrative functions to the higher floors and allow all the patient care functions to happen in the lower floors so that we can become more efficient and more patient centered.

We have also done—as I said had a clinical group look to make sure that our space is fully utilized in the way that it is patient centered and that we do not have the patients going from one place to another to try to receive their care in a way that doesn't make any sense. So we are improving patient flow.

The CHAIRMAN. Thank you, that is your explanation and I appreciate you being so candid with your explanation.

Mr. Weaver, are bonuses for directors—is one of the facets of bonuses for a director tied to patient safety reports?

Mr. WEAVER. We take everything—when we do a recommendation for a bonus we look at the performance measures and then any other information that would be relevant, and then the recommendations go to central office.

The CHAIRMAN. But are patient safety reports one of those facets?

Mr. WEAVER. That would be a factor.

The CHAIRMAN. Did Ms. Berrocal receive a bonus in fiscal year 2011?

Mr. WEAVER. No, she did not.

The CHAIRMAN. Did she receive one in 2010?

Mr. WEAVER. No, she did not.

The CHAIRMAN. You are absolutely correct?

Mr. WEAVER. No bonus, she——

The CHAIRMAN. You are sure?

Mr. WEAVER. Yes, but retention—now she has retention, that is not a bonus.

The CHAIRMAN. Oh, she got retention money.

Mr. WEAVER. Right.

The CHAIRMAN. Okay. And we need to keep Ms. Berrocal?

Mr. WEAVER. Well, my position is that in 2009—well, she came in 2008—but 2009 we had obviously some significant problems, we have been——

The CHAIRMAN. You obviously still have significant problems.

Mr. WEAVER. Well, yes, sir.

The CHAIRMAN. How much has she received in retention money?

Mr. WEAVER. Ten percent of——

The CHAIRMAN. Both years?

Mr. WEAVER. Correct.

The CHAIRMAN. So roughly 25,000?

Mr. WEAVER. Probably—I think it is——

The CHAIRMAN. Ms. Berrocal, would you——

Mr. WEAVER [continuing]. $18,000 about, and so it would be——

The CHAIRMAN. Per year.

Mr. WEAVER. Per year.

The CHAIRMAN. Okay. So we are talking 36——

Mr. WEAVER. Correct.

The CHAIRMAN. Okay. Ms. Berrocal, does the facility have all the supplies it needs to properly care for veterans?

Ms. BERROCAL. I believe at this point we do. We have looked at all of our equipment and I have requested information from the different departments to ensure that we have adequate supplies and equipment.

The CHAIRMAN. Well, all of your labs or services are okay, they are not having any difficulty in getting any needed pharmaceutical supplies?

Ms. BERROCAL. Some of the things that we are receiving should be, you know, it is a process that goes on the whole year so some of the things that they identify that they need they submit them to us, we review through a committee, and then we allocate the money appropriately to ensure that we have the equipment.

The CHAIRMAN. Are you aware of any service or lab having to cancel a service because of lack of the necessary items to perform that service?

Ms. BERROCAL. I am not aware of a specific instance, unless——

The CHAIRMAN. Are you aware of any instance?

Ms. BERROCAL. Where we have canceled services for lack of——

The CHAIRMAN. You didn't have the supplies to perform whatever the job was. Maybe you are just not aware. Could that be? I would hope that you would, but maybe you are just not aware.

Ms. BERROCAL. The service we have in place is that when services have a need that has not been met they submit those requests through the equipment committee and then it makes it to our level to make decisions. So anything that the services have requested would have been reviewed with the appropriate data and with the clinical input to determine whether or not that was something that we needed to get at the time.

The CHAIRMAN. Are you aware of any equipment deficiencies or malfunctions that have impacted patient safety at your facility?

Ms. BERROCAL. Again, whenever there are, you know, equipment needs or equipment malfunctions or anything that needs repairs or anything of that nature I depend on the services to provide that information up through the process we have in place so that we are made aware and we can allocate the money to address the issues.

The CHAIRMAN. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

The last line of questioning highlighted a couple of more questions for me.

Mr. Schoenhard, it has been established here the results of the AIB investigations recommended disciplinary action. You have confirmed that admonishment has been the result. Does it seem odd to you that a retention bonus would be paid to someone that is not meeting their performance standards?

Mr. SCHOENHARD. Sir, we take into account disciplinary action as it relates to retention incentives. There was disciplinary action taken. It was our judgment that in order to continue to turn the ship that it is important that the department have the ability to retain the executives that we think are turning the ship in the way that it needs to go. We do that very carefully.

I want to convey to the Committee that this is done with a lot of care and concern, it is done with fiscal stewardship, and it is done in an effort to keep a highly qualified workforce in place.

Mr. JOHNSON. Well, you have obviously got the patience of Job, because this has been a 4 year trail to lead us to where we are at today.

You saw the performance metrics that the chairman showed earlier, they are headed south, and yet you are maintaining your steadfast support for the leadership that is in place.

Back to your commercial experience. Would you have been able to recommend to your CEO performance incentives and bonuses for executives that were not meeting their performance standards? I can tell you what the answer was in my company.

Mr. SCHOENHARD. Yeah. Sir, let me again clarify. There was no performance bonus paid.

Mr. JOHNSON. No, retention bonus, yeah.

Mr. SCHOENHARD. And that was based on performance.

Mr. JOHNSON. What is a retention bonus?

Mr. SCHOENHARD. A retention incentive is a tool that is available in government to keep highly qualified individuals.

Mr. JOHNSON. Highly qualified.

Mr. SCHOENHARD. Yes.

Mr. JOHNSON. Which would insinuate that they are meeting their performance standards, correct? At least meeting their performance standards. Because again, I worked in the Federal Government so I know what the civilian employee performance standards are.

Mr. SCHOENHARD. Sir, I think the thing that I would like to convey, and Mr. Weaver can speak to this and Ms. Berrocal in more detail, we are improving care at Miami. We are continuing to make progress with the performance measures and that is what is in the best interest of veterans to provide care. Are we there yet? No, sir, we are not.

And when you stopped me earlier in terms of our continuing to evaluate, I can assure you we do a day-by-day valuation of our leadership.

Mr. JOHNSON. Okay. Well, something that I think our veterans——

Mr. SCHOENHARD. And I assure you we will make decisions that are in the best interest of care——

Mr. JOHNSON. Well, I think our veterans are going to expect that. They have a right to expect that.

Mr. SCHOENHARD. Yes, sir, they do.

Mr. JOHNSON. How long does an admonishment stay in an employee's record?

Mr. SCHOENHARD. Two years. I am sorry, I have to——

Mr. JOHNSON. Is it punitive?

Mr. SCHOENHARD. It is a form of disciplinary action, yes, sir.

Mr. JOHNSON. Is it punitive? Does it cost them anything? Is there a suspension? Is there——

Mr. SCHOENHARD. No, it is a level of——

Mr. JOHNSON [continuing]. A reduction in salary?

Mr. SCHOENHARD. No, it is an admonishment. There are different levels. And let me also explain the process by which the level of disciplinary action is rendered.

When there is administrative action proposed that is in the hands of the person who has responsibility to that person. We go

through a process whereby general counsel and the Office of Human Resource Management——

Mr. JOHNSON. Uh-huh.

Mr. SCHOENHARD [continuing]. Review the fairness and the justice and the supportability of the action and that was done in this case with the two people from the national AIB. And we monitor that continuously.

We are looking at continued ways in which to improve that process, but it is done in a very deliberate way that trying to provide fairness and justice for the individual, but also holds the executive accountable for performance.

Mr. JOHNSON. Did you initiate the letter of admonishment or who did that?

Mr. SCHOENHARD. In the case of Ms. Berrocal that came from Mr. Weaver, it comes from the direct report, and in the case of Dr. Vara from the medical center chief of staff.

Mr. JOHNSON. Okay. Well, like I have said, I think our veterans deserve better, I think they expect better, and we got a lot of questions that have been asked and answered here today.

And Mr. Chairman, I am even more concerned leaving the hearing than I was before I came in. I yield back.

The CHAIRMAN. Mr. Weaver and/or Ms. Berrocal, is the domiciliary facility still going to be built in Miami as was originally planned?

Mr. WEAVER. The answer to that is not as originally planned. We had difficulties with the county commissioners in Broward County, they had voted it down.

What we have done as an alternative is to expand the scope of the dom—the domiciliary is going to be built in West Palm Beach on the campus there and we will be expanding that for southern Florida. Once we have that expanded then we can make an assessment of whether we need to go further into Miami to have a—or into Dade County to have a second domiciliary or some expansion for that.

The CHAIRMAN. Can you tell me why there have already been employees hired for the domiciliary now that it is not going to be built in Miami but apparently in Palm Beach. Why were they hired and now what happens with those individuals?

Mr. WEAVER. Okay. First of all the reason they were hired is that as we were planning to open the domiciliary we—part of the rational working at central office they said that we needed to bring—we need to bring staff on so that when the domiciliary comes live that we would be able to move those employees into the domiciliary and have them start working. And Ms. Berrocal can talk about what they have been doing in the interim.

The CHAIRMAN. Why don't we do that, because I would like to know since there is no domiciliary what have they been doing and what will they be doing?

Mr. WEAVER. Okay.

The CHAIRMAN. And Ms. Berrocal?

Ms. BERROCAL. Certainly. We were asked to have the employees in place by the month of June I believe it was and so we proceeded to hire the individuals.

Because a domiciliary would be a new program it required a lot of policy development and just determining how the program would run.

Since the domiciliary—the area where we were going to build, the commissioners did not agree to allow the veterans to—the veterans program to be in their downtown area——

The CHAIRMAN. I mean you didn't know beforehand? I mean we have hired people, we have done planning, we have done engineering and all of the things that are necessary and had no approval from the local governmental entity as to whether or not it met with zoning and codes?

Ms. BERROCAL. We had been requested to hire from the program office, so we have——

The CHAIRMAN. Where is the program office?

Ms. BERROCAL. In central office.

The CHAIRMAN. Okay. So it is up here.

Ms. BERROCAL. Sir?

The CHAIRMAN. So it is in Washington.

Ms. BERROCAL. Yes, sir.

The CHAIRMAN. All right. And it goes around the VISN, not through the VISN but around the VISN directly to you.

Ms. BERROCAL. No. Everything that we do pretty much goes through the Network and then to Washington and we have a very fluid communication between the three groups.

So these individuals, what we have done at the time is the director of the dom is a social worker at our facility and he has been assisting with developing the new proposal that is being submitted to West Palm to have their domiciliary, and some of the other individuals that were hired I am able to absorb within our needs at the medical center.

The CHAIRMAN. So you have one, but how many people have been hired?

Ms. BERROCAL. I don't remember the exact number. I don't remember the exact number, but it is probably like——

The CHAIRMAN. Twenty-one?

Ms. BERROCAL. I don't remember the exact number; however, what I can tell you is that we have looked through the list and on the number of individuals that have been hired that we can absorb within vacancies of the medical center as opposed to going out and hiring wherever we had those needs, and some of the other individuals are continuing to help in the development of policies and that kind of thing so that the new proposal can go into place.

The CHAIRMAN. Ms. Berrocal, I am going to ask a question and it involves a particular employee, but I think they are far enough out of somebody's reach that it should not create a problem.

But I have gotten information regarding some email accounts that may have been confiscated, and I just want to know, have you ever confiscated somebody's email account, and if you did can you describe how you did it, what the policies are within VA?

And you know, I just am concerned that policies continue even things like emails, even though they are on a government system, isn't there a policy in place as to how you lock somebody out of their system and don't allow them to have access again?

Ms. BERROCAL. I think you are referring specifically to the actions that might have been taken with a public affairs officer.

The CHAIRMAN. So the question is——

Ms. BERROCAL. So that I can address it specifically.

The CHAIRMAN. Yes.

Ms. BERROCAL. Are we talking about that?

The CHAIRMAN. Yes.

Ms. BERROCAL. So at the time there were—this happened during the time of the endoscopies.

The CHAIRMAN. Were you authorized to confiscate their email account? And if you did were they ever allowed to reaccess their email again?

Ms. BERROCAL. My recollection of the situation, the individual had compromised, you know, or it was our understanding at the time that they had compromised the medical center, and what we did was we did look into the emails. There is no—as a public officer there is no privacy in terms of the communication.

The CHAIRMAN. That is not what I asked. I mean I understand, but is there not a procedure in which you can take over somebody's email account and you are saying it was because they had compromised the medical center's integrity?

Ms. BERROCAL. Sir, you know, this is approximately 3 years ago and what I would like to do if at all possible is request if I could speak offline with you at some time once I review that folder again.

The CHAIRMAN. That would be fine, but in communications with this individual's attorney all 17—all 17 accusations have been proven false. All of them.

Ms. BERROCAL. The individual—there was a proposed action on this individual.

What I can say is that the individual sought assistance from another individual to move at their choice, to move voluntarily outside of the Miami VA Medical Center and be transferred to another facility.

So there was a proposed action and decision made on the proposed action and the individual consulted with another facility director to request a transfer into that facility prior to the actions being taken.

The CHAIRMAN. So this person was accused and just left the facility?

Ms. BERROCAL. There was a proposed action——

The CHAIRMAN. Proposed by?

Ms. BERROCAL. By myself, and I had made a decision based on the evidence that had been developed.

The CHAIRMAN. And that proposal was to shift this individual to an off-site location totally stripping them of their original job and they have now been separated from their family for some two—or were separated for some 2 years from their family, all accusations as you know have been proven false, there has never been a shred of evidence.

And my question is, how do you make an employee whole when you charge them with something and it doesn't hold up?

Ms. BERROCAL. Sir, there was—again, there was a proposal to an action, and then the evidence was—we had whatever evidence we

had to support the action as they were proposed, and then as I reviewed the evidence then made a decision on the action.

The individual had consulted with another facility director who then made the decision to transfer her prior to the decision being implemented. So it was a decision that was made outside of my scope, I was not aware of it, I did not transfer her to that facility, and as a matter of fact the——

The CHAIRMAN. But if you were a trained public affairs officer and you were used to dealing with the public and you were stuffed somewhere inside of a closed office and not allowed to interact with the public, you were just making telephone calls, wouldn't you want to get out of that environment?

Ms. BERROCAL. What I indicated——

The CHAIRMAN. Don't make it out like she did this because she just decided she wanted to transfer a long way away from her family.

Ms. BERROCAL. What I would like to say is every employee has the opportunity to present their side of the story before a decision is made and that due process is provided, and the time when the individual was moved from the facility was exactly during the time of the endoscopy. I had requested the individual to do certain things and they were not done. It was a very critical time for the medical center and I needed everybody on board and everybody following directions and doing what we needed to do to address things in the best interest of the veterans.

The CHAIRMAN. So this has nothing to do with collaboration or anything, I mean she just didn't do what you wanted her to do.

Ms. BERROCAL. Sir?

The CHAIRMAN. She just did not do what you wanted her to do?

Ms. BERROCAL. The individual was my direct report we were trying to handle a crisis at the medical center, I needed everybody to follow directions and not to go on their own direction. It was important to have everybody. As a leader of the organization it was important to me that everybody was following directions.

The CHAIRMAN. So you took a leadership role, removed her from her position, put her in an environment that you knew she would not be able to do what she wanted to do, and then you represent to this Committee that she just decided to transfer on her own. No?

Ms. BERROCAL. No, that is not what I am proposing, but I really would like to vet the details of this situation.

The CHAIRMAN. No, that is what this hearing is about. So offline, online, you know——

Ms. BERROCAL. Okay.

The CHAIRMAN. Okay. We will do it offline at another time and—no, we will do it offline at another time and I am very appreciative of the candor.

Mr. Schoenhard, I have great respect for you, you know I do, and I know the things that you have said today you mean, and I can appreciate that, but I am so saddened, I am so saddened by what I have heard today, things that are going on at the Miami VA Medical Center that are atrocious, and if it is better today I can only imagine—no ma'am, we are done—I can only imagine how bad it must have been if you think that it is moving in the right direction.

Somebody has to be held accountable and it hasn't happened. People are scared to death of the director. They are scared to tell the truth. Why? Because they will be stuffed in a box somewhere in an office with no windows making phone calls to veterans in an attempt to get them to leave on their own so that it can't be said they were forced out.

I intend to talk to some employees at the facility, and I can only imagine what I will find when I directly engage with rank and file at that facility. Because if there is even one shred of evidence that we have proposed to you today that is true the director should not be the director, much less be given a retention bonus.

And by the way, on September 1st of this year I wrote a letter to the Secretary which it has not been responded to yet in regards to VA using this money for retention bonuses, especially for people who we know are going to be retiring in the future.

And so I appreciate all of my colleague being here today to talk about a very important issue.

And no, I don't use a broad brush to paint the entire VA system, because I know that there are dedicated, hard working individuals at every level of the VA that are taking care of our American heroes because we owe them nothing less, and I am sad today.

With that we are adjourned.

[Whereupon, at 12:57 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable Jeff Miller, Chairman, Committee on Veterans' Affairs

Good morning. This hearing will come to order.

Before we proceed, I would like to take care of an item of Committee business by welcoming our two newest members, Representatives Turner and Amodei, and adopting a resolution filling our Subcommittee rosters for the remainder of the 112th Congress.

Representative Mark Amodei represents the second district of Nevada, which covers most of the state. Representative Amodei is also a veteran, having served as a J.A.G. officer in the United States Army. Before joining us here, he also served as a state senator in Nevada.

I'd also like to welcome another Army veteran to the Committee. Congressman Bob Turner represents New York's ninth district, in New York City, where he has been a lifelong resident. He has also worked 40 years in the television industry as a leader of both small and large companies.

Should either of you like to say a few words, you are now recognized.

For the purpose of creating Subcommittee vacancies for our new members, I first would like to ask unanimous consent of the Full Committee to accept the removal of Representative Flores of Texas from the Disability Assistance and Memorial Affairs Subcommittee and Representative Denham from the Economic Opportunity Subcommittee.

Hearing no objection, so ordered.

I thank Representatives Flores and Denham for their working with the Committee to accommodate our new members.

The list is before the members and I ask Mr. Bilirakis for a motion on this resolution.

Again, welcome to you both.

That concludes our business meeting and I would now turn the Committee's attention to today's scheduled hearing titled "Failures at Miami VAMC: Window to a National Problem".

Welcome to our witnesses. Because of some of the detail we will cover today I have thought long and hard about deviating from standard Committee practice by requiring each of you to be sworn in before giving your testimony. At this time, I do not think that is necessary. I trust that each of you would, and will, provide nothing but truthful answers to us. That said, we will be listening carefully to what you say and I reserve the right, at any moment, to put you under oath. Is everyone clear on that? Good, then let's proceed.

Some of the issues plaguing the VA Medical Center in Miami are not new to this Committee.

The facility came into the spotlight in 2009 when it was discovered and reported that endoscopes were not reprocessed correctly, placing over two thousand veterans at risk of exposure to disease.

Nearly 2 years later, after the initial round of notifications, 12 additional veterans were identified as being at risk of exposure.

Putting veterans at risk is inexcusable.

But failure to identify and notify everyone at risk because patient logbooks were locked away in a safe is nearly impossible to believe.

I only say "nearly impossible" because that is what, in fact, happened.

However, the issues we are discussing today extend well beyond sterilizing reusable medical equipment.

At the heart of this issue is leadership at VA—at all levels and in all parts of the country.

It is my belief that the failures in leadership and patient safety that were brought to light in 2009 are still occurring to this day.

Multiple investigations have taken place, disciplinary recommendations put forth, new processes and procedures developed, new policies established- yet the problems are not fixed.

Earlier this year, VA told this committee in a briefing that things were running smoothly in Miami.

However, the VA Inspector General released a report in August detailing how, in one case, 50 percent of the facility employees still failed to properly sterilize reusable equipment.

Recent news reports are also troubling.

For example, this summer we read about, an Air Force veteran was brought to the Miami VAMC from neighboring Jackson Memorial Hospital.

The veteran had been admitted to the hospital earlier by a friend after threatening suicide.

Once it was realized she was a veteran, she was transferred to the Miami VAMC.

The veteran then escaped and committed "suicide by cop,", just one day after she had been admitted to a system that should have protected her in her clearly fragile state of mind.

In another troubling story released last month, the Miami Herald reported on its findings contained within one of several administrative investigation boards, or "AIBs", conducted at the Miami VAMC in the wake of the colonoscopy equipment cleaning problems and subsequent notifications to veterans.

As the Herald noted, disciplinary action was recommended for a "lack of oversight" by hospital leadership.

The article also noted that the hospital's director was reinstated less than 2 months after the report's recommendations were completed, and that VA declined to comment on what actions were taken based on the recommendations.

It is the Committee's desire that today's witnesses outline a clear process for VA's leaders in preventing and fixing failures that compromise the safety of our veterans.

The Committee also needs to hear about how a stricter and comprehensive process can be put into place so that necessary information flows to all levels at VA, from the local level to the network level to Central Office.

We know that currently there is much that goes unreported, and given the public, repeat offenses, a solution from VA is overdue.

VA must also outline how compliance with department policies is enforced.

If employees are circumventing patient safety policies, they must be held accountable.

If policies made by Central Office can easily be circumvented, then policy makers at VA must be held accountable, and meaningful, enforceable policies put forth.

A related expectation by the Committee is that existing VA policies in place can, and will, be followed by all employees.

If policies are disregarded or willfully ignored, there should be enforcement mechanisms in place and the right people held accountable.

Otherwise, policies become words on paper and little more.

An important point to keep in mind throughout today's hearing, and moving forward, is that the problems we are discussing are not limited to Miami, or even VISN 8.

The Committee is well aware of similar problems at VAMCs all across the country.

More than once, VA has come before us and said problems at its facilities are fixed and "all is well."

More than once, that has been shown not to be the case.

The Miami facility is one glaring example of this national occurrence.

Just as it should be unacceptable to Secretary Shinseki to be told one thing about how VA facilities are faring, only to subsequently be told otherwise, it is beyond unacceptable for that to occur before this Congressional oversight Committee.

All of us must be vigilant in rooting out misleading or incomplete information that only serves to keep the truth from full view, and ultimately harms those we all serve in our common mission . . . the veterans of this country.

Thank you. I appreciate everyone's attendance at this hearing and I now yield to the Ranking Member for an opening statement.

Prepared Statement of Honorable Ileana Ros-Lehtinen

Thank you Chairman Miller, Ranking Member Filner, and Members of the Committee here today. And once again, thank you for your leadership on this issue.

It seems that each time I come to one of these hearings, I find myself saying the same thing: we continue to travel down the same path;

Ever since this shameful failure by the Miami VA Health care System came to light over 2 years ago, we have been reassured time and time again, even in this *very committee room*, by the VA that appropriate actions were being implemented to prevent this from ever happening again.

However, as of the latest report I have read, dated August 2011, there is still a widespread failure within the Miami facility in its handling of RME's, or Reusable Medical Equipment.

While we were told in May of this year that the VA was making efforts to improve its procedures for handling RME's, the VA's Office of Inspector General was discovering a different story.

Their review, which took place in April of this year, concluded that there was still a 50 percent failure rate for properly handling RME's;

And that the Miami VA facility had still not implemented Standard Operating Procedures for sterilization, consistent with the manufacturer's instructions, for half of its RME's.

These are not the only ongoing issues at the Miami VA Medical Center.

This OIG review highlights many deficiencies within the facility in the areas of patient safety, cleanliness, as well as many others.

What is going on in the Miami VA?

I fear that this problem is not just isolated within Miami either.

This is shameful.

We owe our Veterans much more than this.

They served our Nation bravely, and this is how we repay them?

We need a drastic review of the processes in place.

We need to make sure there are proper procedures in place; that we have qualified employees who have received all of the proper training; that we make sure that our veterans get the quality care they deserve—and that they do not have to fear for their safety;

We need to make sure that there is some oversight on how these changes are being effected; to ensure that all VA Medical Centers are compliant to these procedures;

We need to make sure that we have the right kind of leadership in place that can manage these large facilities, with the right kind of experience; and we need to make sure that there is a clear line of communication, and those who are responsible for any shortcomings are held accountable.

We need to make sure that we will not be back here in this committee room again in 6 months asking yet again: What went wrong?

Again, I thank the Chairman and the Ranking Member for their leadership on this issue.

Thank you.

Prepared Statement of William Schoenhard, FACHE, Deputy Under Secretary For Health For Operations and Management Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee: thank you for the invitation to appear before you today to discuss the Bruce W. Carter Department of Veterans Affairs Medical Center (VAMC), in Miami, Florida. I am accompanied today by Mr. Nevin M. Weaver, FACHE, Network Director for Veterans Integrated Service Network (VISN) 8; and Ms. Mary D. Berrocal, MBA, Director, Miami VA Health care System.

All of VA's facilities, including the Bruce W. Carter (Miami) VAMC, are committed to providing the best care for our Nation's Veterans. We want all Veterans who seek VA medical care to have a safe and positive experience. Among our ongoing actions to realize this objective, we have established a new model of patient-centered care, instituted more rigorous measures to ensure staff members are properly trained to handle patient needs, and developed enhanced protocols and policies to ensure compliance, verification, and confirmation with these standards so we deliver Veterans the very best care available. These efforts have produced significant results; last month, 20 VAMCs in 15 different states across the country were recognized by the independent Joint Commission as Top Performers on key quality measures in 2010. The Joint Commission recognized a total of 405 hospitals with this distinction, meaning that VA received a disproportionately large share of commendations for its health care system.

VA has attained this success through a culture of continuous improvement, which is manifested in every one of the more than 1,400 sites of care in the VA health care system. This is especially true of the Miami VAMC. Over the course of the past 2 years, the Miami facility has responded to concerns regarding the quality of patient care.

Since VA identified concerns relating to reprocessing of reusable medical equipment in 2009, VA has taken aggressive action to inform, test, and support all patients who may have been potentially exposed to improperly reprocessed equipment. Additionally, we have increased our inspection and audits of reusable medical equipment reprocessing. My written statement will provide an overview of the Miami VAMC, describe efforts undertaken locally to improve patient safety through policy compliance, and review the facility's management of its budget. I will emphasize the role of leadership, performance measurement, and a culture of patient safety throughout.

Overview of the Miami VAMC

The Miami VA Health care System serves an estimated 285,000 Veterans in three counties in South Florida: Miami-Dade, Broward, and Monroe. This Health care System's parent facility is the Bruce W. Carter VAMC, which provides comprehensive medical, surgical, and psychiatric services. It is home to an AIDS/HIV Center, a Prosthetic Treatment Center, a Spinal Cord Injury Rehabilitative Center, and a Geriatric Research, Education and Clinical Center. The Miami VAMC operates 191 hospital beds and oversees six community-based outpatient clinics (CBOC) in Homestead (Miami-Dade), Key Largo (Monroe), Pembroke Pines, Hollywood, Deerfield Beach, and Coral Springs (Broward), in addition to two outpatient clinics in Sunrise (Broward) and Key West (Monroe).

The Miami VA Health care System was recently approved as a kidney and liver Transplant Center, and these procedures will be performed in a state-of-the-art operating room scheduled to open in the third quarter of fiscal year (FY) 2012. The facility also conducts open heart surgery for other VA facilities in Florida. It is recognized as the Epilepsy Center of Excellence for the Southeast Region, as a Multiple Sclerosis Center of Excellence, and as a Center for Excellence in Spinal Cord Injury Research. In FY 2011, the Miami VA Health care System received the Silver Plus performance award from the American Heart Association/American Stroke Association for excellence in stroke care.

The Miami VAMC has continued to improve its performance and management and has met VA's target for the "fully successful" level in 2010; it is on target to meet the same level in 2011. In FY 2010, the facility demonstrated overall improvement and sustained improvement for both critical and non-critical performance measures. For example, through aggressive efforts involving retraining of personnel on scheduling and new leadership in the Health Administration Service, Miami has continued to show substantial improvement in its access measures in the delivery of both primary and specialty care.

In March 2009, in follow up to a national review of endoscopic equipment, the Miami VAMC's quality control staff identified concerns about reprocessing of reusable medical equipment. VA then initiated an intensive review of patient medical records for Veterans who had specific endoscopic procedures with specific types of equipment at the Miami VA Health care System between May 2004 and March 12, 2009. VA contacted Veterans identified during this review and offered screening for viruses that were potentially associated with reusable medical equipment that was not reprocessed according to manufacturer's instructions. In May 2010, the Miami VAMC discovered more potential Veterans who may have had procedures performed during this time period, and subsequently identified 91 additional Veterans, whom we also notified and offered testing. VA also convened a national Clinical Risk Assessment Advisory Board to make recommendations to the Principal Deputy Under Secretary for Health as to the clinical risk and whether larger-scale notifications or disclosures should be made to Veterans.

The VISN 8 Network Director convened two Administrative Investigation Boards (AIB), and VA also convened a national AIB to review issues associated with this event. The national AIB conducted a thorough review, gathering facts and circumstances surrounding the procedures used to determine the patients in a potential risk pool and our notification requirements. This AIB made several recommendations to improve these procedures, particularly with regard to identifying patients potentially at risk. The AIB concluded that the Miami VA Health care System responded promptly upon finding that equipment tubing was not being reprocessed in accordance with manufacturers' instructions. The AIB further recommended that VA develop national, standardized processes to identify patients po-

tentially at risk. Finally, the AIB credited the staff whose efforts made this process work as well as it did and commended them for their ethical practices and transparency in reporting this event. Miami has taken action to address all AIB recommendations.

Patient Safety

The Miami VA Health care System has been recognized consistently by VA's National Center for Patient Safety through its Cornerstone Recognition Program, which was established in 2008. The Cornerstone Recognition Program recognizes the good work done at VA facilities and enhances the root cause analysis (RCA) process. The RCA process promotes patient safety by identifying the most fundamental reason a problem occurred. RCAs are focused on finding vulnerabilities in the system and remedying them to prevent a recurrence. The Miami VA Health care System received RCA Bronze awards in 2008 and 2009 and was recognized with the RCA Gold award in 2010. These awards signify that the Miami Patient Safety Program is meeting the RCA requirements as outlined in Veterans Health Administration (VHA) Handbook 1050.01 ("VHA National Patient Safety Improvement Handbook," published March 4, 2011).

The number of RCAs conducted at Miami in the past year is comparable to the number performed at other facilities of a similar or higher complexity, and survey results indicate that Miami's scores are well within the normal range in VA for a culture of safety. VA conducted a total of 33 RCAs related to patient safety at the Miami VAMC between January 1, 2009, and September 23, 2011. The facility completed and approved all RCAs within the required 45 day time frame.

Between August 2009, and August 2011, the Miami Patient Safety Program has demonstrated 100 percent compliance with responding to Patient Safety Alerts issued from VA's National Center for Patient Safety. The most recent Patient Safety Program review in 2009 identified no issues or deficiencies in the Miami Patient Safety Program structure. A new report is pending and is scheduled to be published within the next month.

The Miami VAMC has instituted a number of measures and processes to ensure compliance and user competence in reprocessing reusable medical equipment (RME). The Miami VAMC's RME Committee has an active RME Quality Management (QM) interdisciplinary team that conducts observations of processes related to set-up, use, pre-cleaning, cleaning, reprocessing, transport, and storage of RME. The QM Team performs an annual risk assessment, which considers frequency of use and risk factors to guide random selection for observation. These review processes also validate current equipment against the Equipment Inventory List and match standard operating procedures, manufacturers' manuals, and user competency assessments.

The Miami VAMC has developed a "double review" process to ensure Sterile Processing Department standard operating procedures (SOP) accurately reflect the manufacturer's written instructions. These SOPs are reviewed by an independent expert and an Infection Control practitioner who concurs with the final draft.

In response to an RCA action, Miami VAMC conducted a wall-to-wall RME instrument inventory in April 2011 to ensure that all RME was fully accounted for and properly documented. This review also verified that all RME reprocessing instructions are reflected in written SOPs and document user competence. The Sterile Processing Department obtained the services of a contracted company to conduct an inventory of surgical instruments so that a new computerized online count sheet system could be implemented. The Miami VAMC complies with the infection control reporting processes outlined in VHA Directive 2009–004 ("Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities," published February 9, 2009).

The Associate Director for Patient Care Services is responsible for the RME process at the Miami VA Health care System and works with iternal organizations to ensure RME issues are reported and addressed at least once per month. The Miami VAMC has renovated and upgraded its Sterile Processing Department areas and those at the Broward County VA Outpatient Clinic to meet the standards established by the Association for the Advancement of Medical Instrumentation (AAMI). All rooms have traffic-controled doors and require proper attire, and temperature control, humidity, and pressure are managed by the Engineering Graphic Control. The Associate Director for Patient Care Services at the Miami VA Health Care System has completed a course for certification by the International Association of Health care Central Services and Material Management (IAHCSMM). Currently, 80 percent of technicians in the Sterile Processing Department at the Miami VAMC

have attained IAHCSMM certification. All staff at the Miami VAMC will be certified within 6 months of employment in the Sterile Processing Department.

We are fully supporting the Sterile Processing Department's staffing with appropriate supervision, education, leadership, and program support. The Miami VAMC has either purchased or obligated funds to purchase equipment to support RME cleaning, reprocessing, and sterilization. The facility is using enzymatic spray to moisten debris on instruments and ensure their preparedness for the Sterile Processing Department's cleaning and disinfection. The Miami VAMC has replaced single layer aprons used by staff in the decontamination room with new chemical-resistant brands of impermeable gowns.

In April 2011, VA's Office of the Inspector General conducted a Combined Assessment Program (CAP) review, which resulted in six recommendations relating to RME. We appreciate the OIG's recommendations, and the Miami VAMC has strengthened its processes to mitigate and prevent reoccurrence of the findings. All actions in response to the OIG's recommendations have been successfully completed with the exception of one that requires special construction; the Miami VAMC is installing air ducts, a new wall, and a custom made sink, per the OIG's recommendations, and these modifications will be complete within the next 120 days.

Budget Management

For more than 14 years, VHA has used the Veterans Equitable Resource Allocation (VERA) model to allocate the majority of its appropriated resources to VISNs. This model captures medical care delivered at each VA site and weights more intensive or complex care to better align resources with the complexity of care provided. On average, VERA funds comprise 78 percent of the VISN's total operating budget, and another 14 percent of the VISN's budget comes from appropriations in the form of specific purpose dollars. The remaining 8 percent of VISN budgets come from non-appropriated sources, such as Medical Care Cost Recovery funds.

VHA employs a similar model to develop budgets for its medical centers. Beginning in FY 2011, VHA initiated a standardized funding distribution model that all VISNs use to distribute VERA funding to their facilities. This model is based on the same principles as the VERA model, but it aligns dollars with those stations that provide the greatest volume and the highest intensity of care. The model provides VISNs the flexibility to initiate new programs or strategies, such as providing funding for a new CBOC or shifting resources from one facility to another. When the national facility distribution model was released in FY 2011, preliminary results suggested a $4 million reduction in the Miami VAMC's VERA budget. Key drivers to that recommendation were 2 prior years of zero growth in unique patient workload in Miami. The facility's overall workload represented 10.5 percent of the VISN's workload and was subsequently adjusted upward by $14 million at the beginning of FY 2011. This represented a 3 percent increase over FY 2010 levels. While final fiscal year data are not yet available, preliminary figures show the Miami VAMC's total operating budget from all funding sources was $453 million; an 8.3 percent increase over FY 2010 totals.

Mindful of budget constraints, Miami leadership conducted a complete review of the organization and identified efficiencies that can be realized in many areas. These efforts will improve how the facility does business without compromising patient care or the quality of care; for example, some sections will combine administrative resources. Similarly, the facility will centralize the travel and overtime budget for better control, reduce non-emergency equipment and furniture purchases, and renegotiate or cancel non-critical contracts. Other efficiencies were realized in the area of beneficiary travel, records coding, monitoring of patients in the community, and increasing third party collections. The combined result of these actions yielded a cost avoidance of approximately $13 million in FY 2011.

Conclusion

VISN 8 and the Miami VAMC have demonstrated considerable improvement over the past several years and have aligned resources, leadership, and emphasis to realize a better, safer, and more accountable environment for patient care. There has been notable progress, but there will always be challenges, and we will continue to work to overcome them so we can provide the best care to our Nation's Veterans. We appreciate the opportunity to discuss this facility's work, and we look forward to your recommendations. This concludes my prepared statement. My colleagues and I are prepared to answer your questions.

MATERIAL SUBMITTED FOR THE RECORD

Prepared Statement of Hon. Bob Filner, Ranking Democratic Member

Thank you, Mr. Chairman.

Patient safety should always be the VA's top concern. Our veterans go to our hospitals because they are one of the best in this country, and obtaining optimal health care should not come, ironically, at the cost of veteran's health.

Veterans trust their doctors but what they might not trust is the system, and when they get news that there has been a data breach and their personal information might have been stolen, or news that they are at risk of contracting diseases because staff did not properly sterilize Reusable Medical Equipment (RME), veterans rightfully lose trust.

Even when these or other incidents come to light, we often find out that they could have been prevented IF hospital administrative officials (or Director or leadership?) would have implemented proper guidance or enforced protocols to avoid significant breakdowns of patient safety.

What still fails to amaze me is how the VA neglects to effectively respond to these situations. We still have too many workplace assaults and alarming reports of veterans who may have been infected with diseases such as HIV or hepatitis.

Many questions come to light with the many recent issues at the Miami VAMC, particularly the veteran suicide 2 months ago after the veteran was not held the mandatory "72 hour" VA-required evaluation period. Taxpayers are also curious to hear why this facility is running a $30 million budget deficit.

While the Committee has examined these issues in both the 111th and 112th congress, today we have the opportunity to hear from a hospital director who has witnessed this firsthand.

I hope that the director will be able to provide us insight into her experience with delays in notifying individuals of contamination at the Miami VA medical center, such as what led to the delay in notification to 79 veterans, and what the Miami VAMC is doing to correct previous deficiencies and improve patient safety.

Mr. Chairman, I look forward to this morning's testimony and I yield back the balance of my time.

Prepared Statement of Hon. Russ Carnahan, Democratic Member

I want to thank the Chairman and Ranking Member for hosting this important hearing. Even though this hearing is focusing on one medical facility, Cochran Medical Center in my district has struggled with many of these same issues. Like Miami VAMC, Cochran had to notify veterans of possible exposure to disease after dental equipment was improperly sterilized. I have been working with Cochran throughout my time in Congress to make sure that there is never an incident like that again at Cochran, and I believe we are starting to see some signs of progress. It has not been easy, but through the leadership at Cochran changes are being made to ensure that this never happens to our veterans again.

Post-Hearing Questions and Responses for the Record:

Letter from Hon. Bob Filner to Hon. Eric K. Shinseki, dated October 12, 2011

October 12, 2011
The Honorable Eric K. Shinseki
The Secretary
U.S. Department of Veterans Affairs
Washington, DC 20420

Dear Secretary Shinseki:

In reference to our Full Committee hearing entitled "Failures at Miami VAMC: Window to a National Problem," that took place on October 12, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on November 24, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Carol Murray at carol.murray@mail.house.gov, and fax your responses to Carol at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

Department of Veterans Affairs (Deputy Under Secretary Schoenhard)

1. Mr. Scheoenhard, would you agree that there still is a problem within the Veterans Health Administration with compliance of established patient safety protocols, policies and procedures? If so, what are you doing about it?
2. Can you please explain to the Committee how the leadership has held directors and other managers accountable when these written policies and directives are clearly broken?
   a. What specific actions were being taken to investigate and fix the reported issues at the Miami VAMC ?
   b. Why has it taken media reports and a recently released Administrative Board of Investigation to bring these issues to light?
3. Why has this facility been consistently running in a budget deficit—last reported at $30M for FY 11 and Tampa VAMC also running in a reported $27.5M deficit?
   a. What specific action has the leadership at VACO taken to deal with this enormous waste of money that could be spent on our deserving veterans.
4. Where are we today with the external peer review program and how was that used for the Miami VAMC to assess the care provided?
   a. What does the Secretary do with those reports?
   b. The Veterans Integrated Service Network Directors are very senior employees, how do these reports affect them?
5. In your testimony, yo mentioned that the AIB credited the staff for their efforts, but the AIB also recommended "there should be appropriate administrative action regarding the Miami Director and the Chief of Staff for lack of adequate oversight". The Miami Director was removed from her position for several weeks but was reinstated to her position. Your testimony does not match last month's AIB report—please explain?

Department of Veterans Affairs (VISN 8 Director, Nevin Weaver)

1. Why are two facilities under your watch consistently running $27 to $30M in the deficit? If you were running a private company that did this, what do you think would happen?
2. Where are we today with the external peer review program and how was that used for the Miami VAMC to assess the care provided? What do you do with those reports?
3. In May 2010, it was discovered there were 91 additional veterans identified as having endoscopic procedures performed between May 2004 and March 2009, Can you explain how these remaining veterans were identified and why did it take 6 years to discover the additional patients?
4. What specific disciplinary actions have you or will you take regarding the situation with the Miami VAMC?

Department of Veterans Affairs (Miami VAMC Director, Mary Berrocal)

1. Why are there so many issues at your facility? Also, from your perspective, why were you removed from your position and then reinstated?

2. Talk us through step by step the process of the delay in notifying the 79 veterans of possible contamination from Reusable Medical Equipment. Why did it take so long to let these veterans know?
3. Explain why your facility is running $30M in a deficit and what are your doing specifically to fix these metrics?
4. What is your plan to hold your staff accountable and improve this facility so it can provide our deserving veterans the patient safety and care they deserve?
5. Both the Inspector General and the Government Accountability Office have stated in separate reports that patient safety is at risk due to leadership failures and weaknesses in policies and oversight.

   a. What are you doing to improve leadership quality and management training?

Department of Veterans Affairs Final Responses to Hon. Filner's 10–12–11 Post Hearing Questions, Received December 1, 2011

Prepared Statement of Post Hearing Questions for Deputy Under Secretary Schoenhard From the Honorable Bob Filner

1. Mr. Schoenhard, would you agree that there still is a problem within the Veterans Health Administration with compliance of established patient safety protocols, policies, and procedures? If so, what are you doing about it?

Response: Compliance with safety protocols, policies and procedures must be continually monitored and violations quickly and fully addressed. Such compliance monitoring is a fundamental component of quality management, and a responsibility of every leader and employee within the Veterans Health Administration (VHA). VHA has consistently demonstrated a strong commitment to quality management across the Department of Veterans Affairs (VA) health care system—both before and after the shortfalls at the Miami VAMC. We are committed to continuous improvement, strong internal compliance monitoring, and decisive corrective actions at the source of any problem as well as throughout the health care system. Some recent VHA actions that demonstrate our focus on quality management include:

- The May 2010 launch of VA Hospital Compare, www.hospitalcompare.va.gov, a Web site-based dashboard that provides clinical outcome data for Congestive Heart Failure, Heart Attack and Pneumonia (comparing VA with non-VA facilities), and the creation of ASPIRE and LINKS transparency initiatives that are Web site-based dashboards with VHA goals for a wide variety of acute, intensive, and outpatient care process, outcome and safety measures. These sites provide Veterans, their families/significant others and the public with easy access to facility-specific performance data.
- The completion of the February 2011 national conference "Preventing Infection is Everyone's Job" to relay a national sense of urgency, and set an expectation of increased awareness and vigilance for all leaders.
- Veterans Affairs Central Office (VACO), Veterans Integrated Service Network (VISN), and facility SPD staff and experts have been closely re-aligned, and frequent joint communication is now required. In addition, all three levels of staff now conduct routine and emergent inspections and action-oriented evaluations. Further, nine Field Advisory Committees have been charged to provide technical advice related to sterile processing and core facility activities (e.g., construction, environmental services, human resources, etc.).
- Creation of the Office of Clinical Consultation and Compliance (OCCC) in January 2010 to lead a rigorous, proactive, on-site facility assessment of SPD systems, and roll out the International Standards Organization (ISO) 9001 nationally. In addition, OCCC is evaluating informatics software such as the Integrated Quality Management Systems (IQMS) and human-computer process aids such as a recent engineer-created innovation called "Interactive Visual Navigator."
- Each of these initiatives—transparent Web sites, education/awareness, expansion and alignment of SPD resources, and adoption of high reliability organization approaches—focus national, regional, and facility leadership attention on system-level concerns and goals, leading to the development of risk reduction strategies and safer, higher quality care.

2. Why has this facility been consistently running in a budget deficit—last reported at $30M for FY 2011 and Tampa VAMC also running in a reported $27.5M deficit?

Response: The use of the term "deficit" is not accurate in describing the funding situation at the Miami and Tampa medical facilities. The funding adjustments for these two facilities were part of the VISN's fiscally responsible management actions to ensure that medical facilities are funded on a work-performed basis. The funds appropriated by Congress are allocated to the VISNs at the start of each year. Each VISN then allocates those funds to their medical facilities based on projected workload, and the VISN retains a small reserve to make necessary workload-based adjustments as the year progresses. In the case of Miami, the adjustment was related primarily to workload and staff increases and reduced collections. In the case of Tampa, the adjustment for the facility was directly related to workload changes and the activation of the new medical facility at Orlando. The Network was capable and prepared to fund fully both Miami VAHCS and Tampa VAH. As a result, neither the Miami nor Tampa medical facility had a funding "deficit" in FY 2011.

a. What specific action has the leadership at VACO taken to deal with this enormous waste of money that could be spent on our deserving Veterans?

Response: VA is committed to ensuring that funds provided by Congress are executed in a fair and equitable manner to care for our Veterans through all of our medical facilities. The leadership at VACO constantly works to ensure that all Veteran patient needs are addressed, and allocates funds accordingly. Resource allocation is based on the number of Veteran patients served in each network and the complexity of the care required by these patients. This allocation process considers the actual cost of patients including those that are very high cost patients and where they are treated. The process also considers the geographic differences in the cost of care across the country.

3. Where are we today with the external peer review program and how was that used for the Miami VAMC to assess the care provided?

Response: At the end of FY 2009, a national-level VA contract was awarded for external peer review, under which we currently audit over 3,000 records per year and conduct an additional 600 facility-requested peer reviews annually. The audit reviews are secondary to the recurring peer review of episodes of care that are part of VA's internal process. The records are reviewed by contract providers to assess the quality of care using a three level rating system: (Level 1—Most experienced, competent practitioners would have managed the case in a similar manner; Level 2—Most experienced, competent practitioners might have managed the case differently; Level 3—Most experienced, competent practitioners would have managed the case differently).

Once the external reviews are completed by the contractor, a secondary review of the external peer review is completed by staff in the Office of Quality, Safety and Value. Cases that are rated as Level 3 are given special scrutiny for quality of care concerns. Quality of care concerns are brought to the immediate attention of VISN clinical leadership. Teleconferences are then scheduled to discuss the cases with VISN and facility clinical leadership. If the data review suggests a quality of care issue regarding the overall care being provided at the facility, site visits by VACO staff may be initiated.

The external peer review program has been put in place to supplement and validate, not replace the local peer review program. The external peer review program serves the function of validating the effectiveness of local processes. The facility is still required to have a Peer Review Committee chaired by the Chief of Staff and consisting of senior members of key clinical disciplines, such as the Chief of Surgery. The local Peer Review Committee provides the first level of review to address quality of care concerns. Each facility is required to provide a roll-up of its local peer review data for review by VISN staff and VACO/VHA staff in the Office of Quality, Safety and Value.

At the facility level, the Miami VAHCS is required to submit a random sample of 15 records per quarter for external review. The data from Miami is reviewed quarterly at the VACO level and reviewed monthly by the facility and VISN. The data is tracked to ensure there are no trends in specific areas (e.g., missed or incorrect radiologic diagnoses, adverse surgical outcomes, etc.) that would call for a more comprehensive focused review. Local data is also reviewed on a national level to ensure that the facility is assessing information in a timely manner and acts on concerns when appropriate. At the local level, concerns found during the peer review process are addressed through: discussion and recommendations of repeat findings

from the Peer Review Committee; feedback from the clinical leadership to the individual provider; education; and systems changes. At the national level, data from the Miami VAMC is compared with that of other facilities of the same size and complexity level; this serves as another barometer of the quality of the care they provide. These results are discussed at the facility Peer Review Committee for final determination of level of care.

In FY 2011, twelve cases were selected for randomized review by the contracted external peer review program at the Miami VAHCS. Of the twelve cases that were reviewed, nine of the cases were rated at the same level by both Miami and the external reviewer. In the remaining three cases, Miami rated the care more critically (at a higher level), than the external reviewers. This review, as well as local peer review data from the Miami VAHCS, has not identified any systematic or repeat findings that would suggest quality of care concerns.

a. What does the Secretary do with these reports?

Response: The results of the national-level VA contract for external peer review are provided to the VHA Office of Quality, Safety, and Value (OQSV). VA's Under Secretary for Health (USH) has delegated responsibility to OQSV to provide consultation and oversight of this process. The results are reviewed and transmitted by OQSV to VISN clinical leadership to work with the medical centers on the data reconciliation process to address discordant findings. The contractor also provides a quarterly summary of their audit findings to OQSV. This data is shared with the Deputy Under Secretary for Operations and Management (DUSHOM), VISN clinical leadership, and medical center leadership. External peer review reports are managed by local medical center leadership. However, whencritical incidents or concerns are identified, VHA reviews these reports to determine if there is a specific provider or systems issue. Any evidence of quality of care concerns in the data would be shared with the VHA Principal Deputy Under Secretary for Health (PDUSH), the USH, and if needed, the Secretary of VA, along with the plan of action for resolution. Data and reports submitted by the external contractor and reviewed by OQSV and the DUSHOM through Q3FY 2011 have not required PDUSH and USH involvement other than as part of comprehensive quality and safety briefings to assist with VHA strategic decision-making. The data and report findings have not necessitated elevation to the Secretary of VA for intervention.

b. The Veterans Integrated Service Network Directors are very senior employees, how do these reports affect them?

Response: The report summaries from external peer review data are shared with the Chief Medical Officer (CMO) and the Quality Management Officer (QMO) at the VISN. The information is included in quality and safety briefings to assist in VISN level strategic planning decisions. The information provided by peer review data from the facilities in a VISN is just one of several parameters that are considered by the Network Director to ensure that senior officials are providing appropriate oversight of the clinical staff. Data from the peer reviews can be an early indicator to suggest that there may be concerns with leadership, staffing, and clinical competence. Based on feedback provided from data and routine on-site reviews to the facilities in a VISN, the Network Director is given information that is used to assess how the Medical Center Director is managing recommendations and needed improvements, and providing leadership in the facility. At the national level, local and external peer review data and other quality improvement data from each facility are rolled up at the VISN level and discussed in quarterly meetings with VISN leadership. In addition, this is another information source for the DUSHOM to consider in comprehensively assessing the effectiveness of the VISN Director's leadership and determining if consultative site visits and staff assistance are needed from VHA program offices and/or other facilities to provide mentoring to improve the quality of a local peer review program.

Post Hearing Questions for Network Director Nevin Weaver
From the Honorable Bob Filner

1. Why are two facilities under your watch consistently running $27 to $30M in the deficit? If you were running a private company that did this, what do you think would happen?

Response: I want to reemphasize that the use of the word "deficit" is not accurate in this circumstance. Network funding was sufficient to fund fully the shortfalls experienced by Miami VAHCS and Tampa VAH. For a more detailed response, please

see the response to question "2" for Deputy Under Secretary for Health for Operations and Management William Schoenhard. I cannot speculate as to what would happen in a private company.

2. Where are we today with the external peer review program and how was that used for the Miami VAMC to assess the care provided? What do you do with those reports?

Response: Please see response to question "3" for Deputy Under Secretary for Health for Operations and Management William Schoenhard. The results of individual peer reviews are not reported up to the Network. As the Network Director, I ensure that senior leaders at the facility level provide appropriate oversight of the clinical staff. I use feedback provided from data and routine on-site reviews of the facilities to assess how the Medical Center Director is managing recommendations and needed improvements and providing leadership in the facility.

3. In May 2010, it was discovered there were 91 additional Veterans identified as having endoscopic procedures performed between May 2004 and March 2009. Can you explain how these remaining Veterans were identified and why did it take 6 years to discover the additional patients?

Response: The Miami VAHCS did not take 6 years to identify the additional patients. VHA facilities and individual VHA providers have an ethical obligation to disclose to patients adverse events that have occurred in the course of their care, including cases where the adverse event may not be obvious or severe, or where the harm may only be evident in the future. Below is a chronology of what took place from the initial patient safety alert.

VHA issued Patient Safety Alert (AL09–07) across the entire VA system on

December 22, 2008. This alert requested that all facilities determine they were using the correct valve and also stressed that the manufacturers' instructions for all endoscopes were to be exactly followed regardless of the brand. All facilities were directed to determine if manufacturers' instructions were followed in the use or reprocessing of flexible endoscope tubing and accessories and to report any deviations to VA Central Office by January 7, 2009.

On March 4, 2009, Miami VAHCS staff found that the water irrigation tubing was not correctly reprocessed and that it was not consistently primed and flushed prior to the start of the patient examination. While either one of these omissions by themselves would not have resulted in increased risk to patients, both practices together created a slightly increased potential for cross contamination between patients.

In March 2009, Miami VAHCS staff conducted an intensive review of patient medical records for Veterans who were seen between May 1, 2004 and March 12, 2009 and had specific endoscopic procedures with certain types of equipment at the Miami VAHCS. Identification strategies utilized in 2009 included electronic medical record search using procedure codes and note titles pulling up VistA images containing procedure notes and scope numbers. Miami VAHCS staff contacted Veterans identified during this review and offered screening for viruses that were potentially associated with reusable medical equipment (RME) that was not reprocessed according to manufacturer's instructions.

This identification strategy was ultimately refined to a standardized intensive chart review by a team of specially trained nurses and physicians. In 2010 all records originally pulled in 2009 were subjected to a re-review using standardized chart review including capturing dual CPT codes on same day. A series of extended methodologies was also employed, which included looking at additional procedure codes; Delphi Invasive Procedure software list of colonoscopies; pathology codes; additional VistA Imaging titles and consents. The identification process used in 2010 included a validation study that verified all patients identified were found on at least one of the combined methodologies utilized. As a result, Miami VAHCS staff then identified 79 additional patients as a result of a patient concern (who was not previously identified) in May 2010. These additional patients were identified through an extensive manual review of patient records using the methodologies described above (approximately 11,000) in an effort to ensure that no patients were missed.

In August 2010, the U.S. Attorney's office, while gathering information related to patients who had filed tort claims on this issue, asked the Miami VAHCS to review a record source of log books containing information about endoscopic procedures. The review was to identify potential Veterans who may have been affected in the original 2009 look back event. These log books were not reviewed in their entirety as part of the original 2009 look back because the Miami VAHCS was advised by internal and external experts that the log books may be an incomplete source of information.

When reviewing the log books in August 2010, the Miami VAHCS identified a patient who had not been identified in the previous look backs. Miami conducted an exhaustive, manual review of the log book entries for the specific time period in question to ensure all possible patients were identified. As a result, Miami VAHCS staff identified 12 Veterans who underwent endoscopic procedures during the specified time frame who were not previously notified, and offered these Veterans testing.

Post Hearing Questions for Miami VA Health System Director, Mary Berrocal From the Honorable Bob Filner

1. Why are there so many issues at your facility? Also, from your perspective, why were you removed from your position and then reinstated?

Response: Miami VAHCS is a complex Health Care System that provides Veterans a comprehensive array of quality health care services. The facility is staffed with hard-working and competent employees who are very proud of the care and service they provide to Veterans and their families. Despite the tremendous good work that is done here at the Miami VAHCS, there will always be challenges in a system this large and complex. There are thousands of correct decisions and actions taken by compassionate and competent employees every day. On a larger scale, over the past several years, the Miami VAHCS has continued to align resources, leadership, and focused emphasis to realize a better, safer, and more accountable environment for patient care. As is the case with every organization, there is always room for continued improvement. However, there have been many positive accomplishments worth highlighting. These examples of achievement are evidence that the facility is both providing quality care and services to Veterans and engaging in continuous performance improvement to identify and address concerns when they occur:

Since 2009, there has not been a single reusable medical equipment- (RME) related incident where a patient has been placed at a potential risk at the Miami VAHCS. Since 2009, the Miami VAHCS has won awards or has been independently recognized for excellence in stroke care, epilepsy treatment, surgical services, spinal cord injury care, and mammography imaging.

"Get With The Guidelines" Silver plus award on February 10, 2010. Dr. Yolanda Reyes, Chief of Neurology and Stroke Specialist accepted the Silver Plus Award along with Raquel Pastor-Rojas Stroke Coordinator from Dr. Gregg C. Fonarow, Immediate Past Chair Get With The Guidelines® by the American Heart Association/ American Stroke Association.

On July 22, 2009, the Miami Medical Center was selected to be included in the VHA Epilepsy Centers of Excellence Network. This network was established as the VHA response to the section 404 of the Veterans' Mental Health and other care Improvements Act of 2008, Public Law (PL) 110–387. There was a need to enhance epilepsy care to treat existing numbers of veterans with epilepsy and to provide care for veterans who would develop epilepsy as consequence of traumatic brain injury.

Mammography Imaging:

- Miami ACR Inspection—2/23/2011 (every 3 years)
- Miami FDA Inspection—7/22/2011 (yearly)
- Broward ACR Inspection—3/10/2009 (every 3 years)
- Broward FDA Inspection—8/12/2011 (yearly)

- Miami VAHCS leadership chartered a work group on April 13, 2010, to redesign the pharmacy system to reduce wait times to be less than an average of 30 minutes. Following the implementation of the redesign on November 22, 2010, patient satisfaction improved 96 percent, and pharmacy cycle time improved 28 percent.
- Miami VAHCS leadership chartered a work group on October 20, 2010, to reduce the average wait time for compensation and pension (C&P) examinations. Following the implementation of the workgroup's recommended changes in November and December of 2010, Miami VAHCS leadership reduced the average wait time for C&P examinations by more than 30 days to an average of less than 25, improved access to primary care and specialty care clinics, and increased performance in clinical measures such as diabetes care, tobacco cessation, and surgical quality.
- Since 2009, leadership at the Miami VAHCS oversaw the opening of a Fisher House for families of severely ill or injured Veterans, a new medical ward, five state-of-the-art surgical suites, an outpatient clinic in Broward that served over

21,000 Veterans in FY 2011, a new hospice and palliative care service, and general refurbishments to the medical center to ensure the facility will better withstand natural disasters such as hurricanes.

- From 2008 to October 31, 2011, 424 previously homeless Veterans were provided housing through HUD VASH. Of those, 389 were male and 35 were female Veterans. 42 families are included in this number. An additional 200 or more receive services each year as part of the medical center's annual stand down events. Listed below are the events the Miami VAHCS leadership team has coordinated since the homeless effort began:
  - C.H.A.L.E.N.G. Meetings—Miami-Dade and Broward Counties—May 26, 2009, August 3, 2010, August 15, 2011. (A separate meeting was held in Monroe County each year.)
  - Stand Downs—June 27, 2009, September 18, 2010, and November 19, 2011 in Broward County. September 17, 2011 in Miami-Dade County.
  - Homeless Summit—February 2, 2011.
  - Homeless Veterans Outreach Kick-Off Event—October 21, 2011.
  - Coordinated Outreach Team—Miami-Dade County—Identifies chronically homeless Veterans in coordination with non-VA homeless outreach teams.
  - Miami-Dade County Veterans Services Representatives come to the Health Care for Homeless Veterans (HCHV) office every other week to assist Veterans in applying for VA benefits.
  - One Stop Services including:
  - Social Security Administration
  - Florida Department of Motor Vehicles
  - Volunteers of American
  - The ELKS Lodge funds a laundry program for homeless veterans so that they can wash clothes on a weekly basis.
  - The American Veterans Food Assistance Program provides large quantities of food on a monthly basis that are distributed to veterans in the HUD–VA Supportive Housing (HUD–VASH), GPD and homeless walk-in clinic.
  - St. Stephens Episcopal Church provides veterans with funds for birth certificates, I.D.'s.
  - Donations of household goods and furnishings are coordinated through HCHV to assist Veterans in furnishing their HUD–VASH apartments.
  - Supportive Services for Veterans Families grantees provide services to Homeless Veterans daily at the HCHV office.
  - Carrfour Supportive Housing representatives are available weekly at the HCHV office to process applications for subsidized housing.

These improvements, combined with cost saving initiatives begun under my leadership, saved more than $13 million, including one initiative that eliminated the need for a coding contract. Miami's All Employee Survey (AES) has sustained satisfactory levels of employee satisfaction over the last few years. While there were some drops in AES scores on specific questions from 2009 to 2011, they were defined by the National Center for Organizational Development (NCOD) as "significant, but not meaningful." What NCOD meant was that although there were noticeable drops in AES Scores on specific questions from 2009 to 2011, overall, Miami VAMC scored higher than the VHA Average (excluding VA Central Office) in the 2011 survey cycle on the following measures: Job Satisfaction—Coworker, Supervision, Senior Management, Promotion Opportunity and Satisfaction Organizational Assessment—Conflict Resolution, Diversity Acceptance, Customer Service, Innovation, Leadership, Rewards, Employee Development, Job Control and Engagement, Culture—Group, Entrepreneurial, Rational and Enabling.

Finally, it should be noted that Miami VAHCS leaders have expanded relations with the greater Miami community in honoring Veterans, to include such activities as participating in Wounded Warrior "Soldier Rides," rescuing beached whales with the help of Veterans in the community, working with a local restaurant to feed more than 700 Veterans families at Thanksgiving, hosting a Valentines for Veterans concert that provided live entertainment for more than 1,000 attendees, and hosting Yellow Ribbon events for returning troops that resulted in more than 500 new enrollees to the Miami VAHCS.

It is not unusual for a person to be removed from a position during an investigation. This is considered an administrative action. Transfer of leadership away from the facility pending such an investigation is standard practice in the Department; it ensures the integrity of the process. I was detailed to the VISN 8 Network Office while an investigation was conducted to review how the RME incident and subsequent notification of patients at the Miami VAHCS was managed. I returned to my post as Director, Miami VAHCS, after the investigation concluded. The report found

that I should have exercised more effective leadership over the patient notification process. While I was disciplined, the Network Director and VACO leadership did not determine removal from my position as medical center director was warranted at that time. However effective November 17, 2011, I was removed from the position as Director of the Miami VAHCS.

2. Both the IG and GAO have stated in separate reports that patient safety is at risk due to leadership failures and weaknesses in policies and oversight.

Response: The findings and recommendations of the cited OIG and GAO reports were not specific to the Miami VAHCS but reference the importance of the role of leadership and oversight to ensure patient safety. The Miami VAHCS provides Veterans with safe, high quality care. Since we were alerted to the RME issue in 2008, Miami has continued to improve its health care quality performance metrics. The Miami VAHCS met the performance measure for Effective and Safe Clinical Care which requires facilities to continually monitor facility performance on key indicators of quality and safety for both inpatient and outpatient care. The last Joint Commission Survey at the Miami facility occurred in 2010, resulting in full accreditation for the health care system.

The OIG Combined Assessment Program (CAP) reviews are recurring assessments of selected health care facility operations, which focus on patient care administration and Quality Management (QM). The most recent FY 2011 OIG CAP review conducted at Miami VAHCS consisted of a review of the following nine elements:

- Coordination of Care**
- Enteral Nutrition Safety**
- Environment of Care
- Management of Workplace Violence
- Medication Management**
- Physician Credentialing and Privileging**
- QM
- RME
- Registered Nurse Competencies

** no recommendations made in these areas

Recommendations for improvement were noted in five areas. Overall, the types of findings in these areas were similar to the types of findings from CAP reviews at other medical centers. Miami had one (1) repeat finding related to patient privacy, however there were no findings related to leadership or patient safety. All of the recommendations in this report have been addressed and completed except those having to do with construction or physical environment.

GAO visited six VA Medical Centers, including the Miami VAMC, to examine VA reprocessing requirements for reusable medical equipment. At each site, GAO examined the adequacy of the selected reprocessing requirements to help the facilities ensure the safety of Veterans who received care at these facilities. Miami was not specifically identified in the report; however, the overall findings related to weaknesses identified in VA's process for tracking expendable medical supplies and reprocessing RME have been taken very seriously.

The plans for recommended actions have been implemented as directed by the Under Secretary for Health. The National Program Office for Sterile Processing has oversight responsibility for the reprocessing of all critical and semi-critical reusable medical equipment in the VHA. The program office develops and reviews policies and procedures related to sterile processing, tracks and trends data reporting related to sterile processing, and provides subject matter expertise to sterile processing services in VHA facilities.

The National Program Office for Sterile Processing is responsible for reviewing multiple annual inspections of sterile processing functions in VHA facilities. These inspections specifically address compliance with protocols, policies, and procedures that directly impact patient safety. Inspections are conducted by National Program Office staff, VISN leadership, and facility leadership.

Among the areas these inspections address are:

- Staff compliance of sterile processing with nationally established guidelines for the reprocessing of critical and semi-critical reusable medical equipment (use of cleaning agents, length of cycles, temperatures, documentation of sterilization process, etc.).
- Documentation of training and competency of staff performing cleaning, assembly, sterilization or high level disinfection tasks.

- Adherence to VHA policies regarding storage, environmental conditions, use of personal protective equipment (PPE), and the cleaning of sterile processing areas.
- Availability of standard operating procedures and manufacturer's instructions for use for the reprocessing of critical and semi-critical reusable medical equipment.
- Documentation and review of sterilization and high level disinfection records relating to the reprocessing of critical and semi-critical reusable medical equipment performed in the facility.

In addition to regular inspections, the National Program Office for Sterile Processing immediately responds to emergent issues related to the reprocessing of critical and semi-critical reusable medical equipment. Emergent issues may be related to equipment malfunction, environmental service issues, or reprocessing errors. Within 48 hours of an assignment, National Program Office staff review and provide recommendations to VHA leadership on the level of risk an event poses, develops action plans to address the issue, and advises on service disruptions and resumption of services.

The National Program Office for Sterile Processing has convened nine Field Advisory Committees (FACs) chaired by subject matter experts to advise the Program Office on concerns that intersect with sterile processing. These areas include leadership with expertise in construction, logistics, environmental services, biomedical engineering, human resources, education and compliance issues, incident response, as well as clinical end-users of RME. These FACs ensure that all sterile processing-related policies and procedures are developed, implemented, and evaluated with the appropriate subject area expertise.

All VISNs and facility officials have conducted numerous inspections to ensure proper reprocessing of RME and track the results of these inspections. Purchasing guidelines are being adhered to and facilities are being held accountable for the device specific training requirements.

a. What are you doing to improve leadership quality and management training?

Response: Recognizing the importance of leadership in the delivery of patient-centered care, all managers are required to regularly attend leadership training and participate in developmental opportunities.

New supervisors are required to complete approximately 60 hours of training during their first year. In order to complete this requirement, new supervisors complete a pre-test, 14 modules of required training, and a post-test. They are also required to complete approximately 20 hours of elective type training every year offered by Franklin Covey and Booz Allen Hamilton, such as "The Seven Habits of Highly Effective People", crucial conversations coaching, and mentoring. VA's Talent Management System (TMS) offers about 35 courses including Leadership Skills for VA Supervisors and VHA Supervisory Training Evaluation. There are also many training opportunities that address quality and safety. These are in the form of sharing strong practices (that address quality and safety) across the VISN, training through consultants, Quality Council and improvements forums held at the Network level that are attended by senior leaders and quality managers that shares strong practices (presented by facilities) in quality, safety and systems redesign. In addition, the VISN 8 Deputy Network Director, a workforce management expert, is engaged in designing a plan for leadership and management training in FY 2012.

Leadership at the facility continually monitors quality of care and awareness of quality by leadership. As evidence of this, the Miami VAHCS has been recognized consistently by VA's National Center for Patient Safety (NCPS), Annual Cornerstone Recognition Program, since the award was first established in 2008. The Cornerstone Recognition Program enhances the root cause analysis (RCA) process and recognizes the good work done to promote patient safety at the facility level. RCAs are used to identify the most fundamental reason a problem occurred; they are focused on finding vulnerabilities in the system and remedying them to prevent a recurrence.

Patient Safety Culture Surveys occur approximately every 3 years. Results of this Survey for the Miami VAMC are as follows:

- FY 2000: Overall, there were no significant differences in Miami's scores as compared to other facilities.
- FY 2005: Overall, the Miami VAMC was above the Normal VA Range.
- FY 2009: Overall, the Miami VAMC was within the National VA Range.
- FY 2011: This survey was recently conducted in July/August 2011 by the NCOD & NCPS through the Voice of VA Survey process. The final results of this survey are still pending.