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CLEANLINESS AND MANAGEMENT PRACTICES AT THE KANSAS CITY VAMC

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

JUNE 17, 2002

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CLEANLINESS AND MANAGEMENT PRACTICES AT THE KANSAS CITY VAMC

MONDAY, JUNE 17, 2002

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 9 a.m., VA Medical Center, Kansas City, MO, Hon. Jerry Moran (chairman of the subcommittee) presiding.

Present: Representatives Moran, Boozman and Filner.

Also Present: Representative McCarthy of Missouri.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. Good morning, everyone. It is good to be at the Kansas City Veterans Medical Center. This is a facility that as a Kansan, I care very much about. Many veterans from my state utilize this facility, and I am delighted to be here as Chairman of the Health Subcommittee of the House Veterans' Affairs Committee to take a look at a few issues that have surfaced over the last several years, and certainly in the last few months.

My primary desire in having this hearing is to focus on ensuring that the delivery of quality health care in Kansas City at this medical center now and in the future. I want to focus on the quality of health care rather than dwelling on past occurrences. I hope that today's hearing will reassure veterans and their families, the staff, and the employees of this facility that the care our veterans receive at this medical center will be of the highest quality and will be provided in a clean and sanitary environment.

I am certain that since the publication of the article last March describing insect and rodent infestation at the medical center, this topic has been discussed among veterans and their families, and certainly the staff and administration of the hospital, and I have no doubt there was increased concern about this hospital among veterans and their families. The VA both here and in Kansas City and Washington, DC, will have ample opportunity this morning to assure us that the circumstances described in that medical journal are things of the past, and that practices, policies, and personnel are in place to ensure that health care is appropriately delivered to our veterans.

I also believe we can learn lessons from this hearing that will prevent the kind of problems experienced here from occurring elsewhere in the VA health care system. That certainly is our goal, and the veterans of our country deserve nothing less.

I welcome the witnesses and others in attendance today. I appreciate our veterans, the patients, veteran family members, and our VSO officials joining us today. I thank my friend and Ranking Democrat member of the subcommittee, Mr. Bob Filner of California, for his assistance in preparing for this hearing and his presence in Kansas City, MO, today. Also our colleague on the committee, John Boozman of Arkansas, joins us, and he is a member of this subcommittee, and glad to have John with us in Kansas City. My friend and travelling colleague out of Kansas City International every Monday morning and returning every Thursday or Friday afternoon, your local Congresswoman Karen McCarthy is joining us today. This hospital is in her district, and I am very grateful for her interest in this topic and in this hospital. She and I visited the Kansas City Veterans Medical Center together 6, 8 months ago, and I know that she has taken an abiding interest in the quality of health care that is provided here for the veterans of the Kansas City area.

Again, this hearing gives us the opportunity to review recent events at the hospital. The origin of this hearing occurred in March of this year within the publication of an article in the Archives of Internal Medicine. My medical knowledge may limit my understanding of nasal myiasis, but I clearly understand the realities of a mouse infestation. The author of that article is with us today, and his hypotheses seem to me to link the chronic presence of house mice in this medical center, and the effort to rid them, to an infestation of flies and the subsequent discovery of nasal myiasis in two medical intensive care unit patients.

The article reviewed a number of actions to remedy the problems, but left an impression that management did not sufficiently act to eliminate the problem. Also it has been suggested that funds were not sufficient to enable the medical center to cope with this pest infestation while meeting its other responsibilities in delivering patient care to veterans.

Secretary of Veterans Affairs Anthony Principi has been to this hospital on a couple of occasions now since that report. In my opinion, he has acted swiftly to make changes to the medical center and has instigated two investigations by the Office of Inspector General. Those reports were published here just a couple of weeks ago, and we have the inspector general from the VA with us today to discuss the outcome of the inspector general's investigations.

Today's hearings will consider those reports. We will receive testimony from the primary author of the Archives article; the chief VA investigator; the former chief executive of the medical center; representatives of medical center employees; the facility's patient advocate; VA's top health care official, the Under Secretary for Health; and the current chief executive of this facility.

My subcommittee has spent the last 45 minutes with a walking tour of the hospital. We were delighted at we saw this morning and will continue to review circumstances that this hospital faces, all with the goal of making certain that our veterans receive quality health care at this hospital and that this hospital has a future in providing those services to our veterans. We certainly received a good impression this morning during the tour, and we especially enjoyed the opportunity to visit with staff and employees. I can see

significant pride in the accomplishments in their working environment and the job they have performed.

It was my pleasure to take another tour of the hospital and to be here. We are delighted to be able to hear some testimony, to make some conclusions today, and again later this year.

[The prepared statement of Chairman Moran appears on p. 49.]

Mr. MORAN. I would ask Mr. Filner of California if the gentleman has any opening comments he would like to make.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman. Thank you for bringing us here and educating us about this situation. First, I would like to say that with Mr. Moran, who, of course, represents Kansas, and Ms. McCarthy, who represents this district, the people in this area have incredibly good advocates for veterans and for the community in general. They do a great job for you back in Washington, and they work in ways that are very effective, sometimes not always noticed, but they are very effective Congress people.

I know, Mr. Chairman, that we all shared the sense of horror and dismay that must have ripped through the entire VA health care system and through every member of this committee when we first learned about the incidents that you have mentioned. It is the job of this committee and each one of us personally to ensure that our veterans receive the best possible care in a clean and safe environment. Nothing less is acceptable. I know this medical center, like many in our VA, was built half a century ago in another era when health care delivery was very different from the health care model and all the technological advances that we have with us today. The cost to keep a facility of this size and importance up to date, modern and functioning with all the modern advances, is daunting at best.

Now, Mr. Chairman, we know and we have discussed back in Washington at many hearings that our Nation—and this covers both Democratic and Republican administrations—has failed in recent years to allocate the kind of funding needed to maintain VA's health care infrastructure. All across the board, whether it is waiting times that veterans have to suffer through, or lack of clean and well maintained buildings, or lack of new buildings, are problems that we have to deal with every day. And our committee has tried to fight for more funding, although that comes out of a general political decision that is made by the total Congress. We know putting a new face on an old building doesn't seem to have the same emotional appeal or bang for the buck, and yet as we have had to learn the hard way, the costs for failing to do so can have unintended and devastating consequences.

I hope we will all take the lessons provided by the circumstances here and apply them to the bigger picture not only, Mr. Chairman, in the specific situations that we have witnessed and hopefully are being taken care of, but in the whole management structure of this facility and our VA system in general.

Mr. Moran, we thank you for your commitment to veterans health. The leadership within the Department of Veterans Affairs is very strong, I know, and we have worked with the Secretary Mr. Principi very well. He comes from my home town of San Diego, and

he took swift and decisive actions to both investigate and then resolve the longstanding and difficult conditions here. And the new Under Secretary for Health Doctor Roswell is here today, and the whole team of the IG for the investigations that I hope will correct all the problems. The new leadership here at Kansas City Medical Center and, of course, the dedicated, hard-working employees who day in and day out serve the health care needs of the veterans in this community are the strength and fortification that will make this old building continue to be a quality health care system.

We have looked at the building. We have looked at some of the improvements, but we are interested to make sure that the community understands that progress is being made, and that management improvements are also being made throughout the system. So I look forward, Mr. Chairman, to hear the testimony and make sure that we learn from this situation.

Mr. MORAN. Mr. Filner, thank you very much. Thank you very much for making your way from California to Kansas City and participating today.

Mr. Boozman, welcome to Kansas City. I would welcome any opening remarks that you might have.

OPENING STATEMENT OF HON. JOHN BOOZMAN

Mr. BOOZMAN. I would like to thank you, Mr. Chairman, for convening the meeting, and I know you and Congresswoman McCarthy have been very concerned about this. We have just got through doing a tour of the facility, and I was impressed. I think the hospital is well on the way to—is getting there in the sense of well on the way of getting where it should be. It is better now than it was a year ago, and I know in the future it is going to get even better.

What I would like for the outcome of this hearing to be is such that we identify some of the systemic problems that allowed it to get in this condition or in the condition it got into, and perhaps be able to carry that over to existing VAs and again try and figure out some resources that perhaps we can provide to help with those other facilities.

Thank you very much.

Mr. MORAN. Thank you very much, Mr. Boozman.

Karen, I don't need to welcome you to Kansas City. It is good to be with you. Any opening remarks?

OPENING STATEMENT OF HON. KAREN MCCARTHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Ms. MCCARTHY. I am truly honored to be a part of this subcommittee's effort. I appreciate you adopting me for the occasion, and it is truly a bipartisan, collaborative effort for all of our veterans.

This is a flagship institution. It is known for its quality care, and I am—I commend the subcommittee for its ongoing efforts year after year to try and provide more funds for our veterans. I am usually out there on the floor championing your efforts as we go through that process, in the appropriations and authorization, and I think that that is at the core what may be needed to resolve both the situation here and in other hospitals of the same age.

But I want to commend the staff here for what we saw this morning and the efforts that have been taken in the recent months. As the report was published just in April and brought to the attention to all of us the need for more continuing efforts, I find that from our tour this morning, there have been aggressive responses to many of the problems, and we have seen some of the improvements. And I think what we will need to do, Mr. Chairman, as we hear the witnesses and as we get our questions answered, is strategize on the way back to Washington today about what our proper role will be to see that this institution can return to the greatest—the greatness physically that it has in its reputation of patient care.

So I thank you for letting me be a part of this field hearing. I appreciate all that has gone on to improve the supervision, the training and the hiring of new staff to address the problem, and I know that the Veterans' Administration and the new management of the medical center will eliminate these environmental and sanitary problems in order to continue to provide quality care to the patients they serve.

Thank you, Mr. Chairman.

Mr. MORAN. Thank you very much, Congresswoman McCarthy. We are delighted to be in your community and at this hospital. I look forward to working with you to see that only good things happen here.

Mr. MORAN. I don't know that there is a Representative from any other congressional offices. I know Senator Bond has submitted written testimony, and if there is no objection, his testimony will be placed in the record. No objection, so ordered.

[The statement of Senator Bond appears on p. 51.]

Mr. MORAN. I am told that a representative from Representative Moore's office is here. If you would like to stand up. Anyone who has veteran problems may see Congressman Moore's staff. We are delighted to have you, and we appreciate Congressman Moore's interest in this topic.

We will call our first panel. Our first panel consists of Dr. Stephen Klotz, professor of medicine, and also a practicing physician at the University of Arizona School of Medicine and at the VA Medical Center at Tucson, AZ, and this medical center's former chairman of the infection control committee. He is accompanied by Ms. Teola Tillman, a retired VA nurse and former infection control nurse at this medical center. Also Mr. Michael Slachta, Assistant Inspector General for Auditing, from the VA Central Office in Washington, DC. Mr. Slachta was the chief investigator who responded to the Secretary's decision to investigate the occurrences mentioned earlier.

Thank you for attending, Dr. Klotz, and without any additional delay, we will begin our hearing. We will hear from Mr. Slachta.

STATEMENT OF MICHAEL SLACHTA, JR., ASSISTANT INSPECTOR GENERAL FOR AUDITING, DEPARTMENT OF VETERANS AFFAIRS

Mr. SLACHTA. Mr. Chairman, members of the subcommittee, I am here today to report on the results of our review of the Kansas City Medical Center. At the request of the Secretary of Veterans

Affairs, we conducted a review to determine if, one, significant deficiencies existed in the sanitary conditions at the medical center; two, whether any deficiencies found had an effect on the quality and outcomes of medical care for patients treated; and three, what corrective actions were taken to implement the recommendations made in our report of the combined assessment program review of this facility dated in January 2002.

We conducted our on site review from April 1 through April 10, 2002, and our report presents our analysis of the medical center's environment of care and the progress made by the medical center in implementing four prior CAP recommendations. The medical center's management did not maintain the medical center at appropriate levels of cleanliness or rid the medical center of pests. The unclean conditions date back to at least October 1997; were discussed among medical center management, staff and patients and were well documented in medical center records. Management of the Heartland Veterans Integrated Service Network, VISN 15, was also aware of the poor sanitary conditions and pest control problems.

Medical center e-mail shows that management was aware of insect and rodent infestations dating back to July 1993. E-mail messages describe incidents involving rodents and insects in the surgical intensive care unit, operating room and patient ward areas in 1993, 1994 and 1995. However, reports of filthy clinical areas, fruit flies, gnats, flies, wasps and rodents began appearing in e-mail messages and committee minutes with more frequency in 1998. These records document discussions of these problems from calendar years 1998 through January 2002 involving the former medical center director, key clinical managers and providers, environmental and infection control managers and patients.

We also found that the clinicians had a program for ongoing surveillance for pathogens of medical importance, took specific effective actions to address infestation issues and outbreaks of disease, and conducted ongoing training directed toward general and specific infectious disease topics.

Medical center clinical management also implemented effective controls to monitor the quality of care provided to patients as the controls related to infectious diseases and infection control. We found that the care provided to the two patients discussed in an article entitled Nasal Myiasis in an Intensive Care Unit Linked to Hospital-Wide Mouse Infestation was adequate, and that the incidents described occurred because of a recurring pest control problem at the facility. We concluded that the maggots found on two ICU patients was unacceptable and closely associated with an overall unclean patient care environment.

We determined that management did not maintain the medical center at appropriate levels of cleanliness or rid the medical center of insects and pests. Management of the Heartland Veterans Integrated Service Network was aware of the poor sanitary conditions and pest control issues at the Kansas City Medical Center. These conditions existed because network and medical center management had not acted aggressively to respond to numerous warnings and instances brought to their attention for years. We believe top managers were able to avoid major illnesses at the medical center

only because of dedicated efforts of the health care team who compensated for the lack of aggressive pest management actions and institutional housekeeping support.

In response to our report, the Secretary concurred with our recommendations to ensure that managers are held accountable for the sanitation of the medical center. He indicated that the Under Secretary for Health closely monitor and provide his office reports on implementation of the plan, corrective action developed by the acting network director and medical center director.

This concludes my testimony. I would be pleased to answer any questions that you or the subcommittee would have.

Mr. MORAN. Thank you very much.

[The prepared statement of Mr. Slachta appears on p. 52.]

Mr. MORAN. Dr. Klotz, we are delighted to have you with us today. Perhaps your report is what starts this story, at least from the perception of the public and our awareness. So we appreciate hearing from you and Ms. Tillman, if she has remarks as well.

STATEMENT OF STEPHEN A. KLOTZ, M.D., PROFESSOR OF MEDICINE, UNIVERSITY OF ARIZONA, SECTION OF INFECTIOUS DISEASES, AND STAFF PHYSICIAN, SOUTHERN ARIZONA VA HEALTH CARE SYSTEM, VA MEDICAL CENTER, TUCSON, AZ, ACCOMPANIED BY TEOLA TILLMAN, FORMER INFECTION CONTROL NURSE, VA MEDICAL CENTER, KANSAS CITY, MO

Dr. KLOTZ. Thank you. I am pleased to be here this morning to testify before this committee. The issue of the mice and maggots as reported in a recent article is a matter of public record. It is accurate, and I hope we will not waste time rehashing the contents of the publication. I was led to believe that this committee wanted to address weightier problems; for example, what events or decisions brought about such a dismal state of affairs. Hence, my interest in appearing.

All of my adult life has been spent in Federal service, first as a battery commander in the Army Artillery with nuclear weapons, later as a physician with the Indian Health Service, and now as an infectious disease physician with the Veterans' Affairs for the past 17 years. I mention this to point out that I have experienced a variety of bureaucratic organizations.

There was a cataclysmic change in the managerial structure in this organization now half a decade ago that has entirely changed the landscape of patient care with the unfortunate result that there has been a loss of focus on the veteran patient. Some of the decisions and their consequences were not self-evident at the time of change. Important knowledge on how to run an effective and safe hospital was sacrificed in no small degree at that juncture. Difficulties are only now apparent as we gaze at beleaguered VA hospitals with increasing numbers of patients, fewer doctors and nurses, an increasing need for expensive and effective medications, and a need for timely consultations and operations.

The structural changes that occurred brought a measure of fiscal responsibility to the VA. That is a good thing. However, I would like to focus our attention on some matters that still require change to bring about more improvement. I have limited time in

this statement and so will restrict myself to briefly mention five major ongoing problems in the VA system, most a consequence of the change in the management style some years ago. What I have to say is applicable to all VAs, not just Kansas City. It is exceedingly difficult to uncover where trouble begins in an organization of this size, but I believe I can disclose some areas where changes were made leading to major deficiencies eventually impacting on patient care.

The five major problems are as follows: 1.) The addition of an entire cadre of middle managers who embrace a business model of management. These managers have fiscal oversight in the clinical side of the organization and are neither sufficiently knowledgeable nor trained in the areas they supervise.

2.) The hospital director has more real power than the chief of staff. There is no equal partnership.

3.) A sundering of any meaningful relationship with local medical schools.

4.) Individuals in the organization with direct patient care, for example, physicians and nurses, have no meaningful influence in the organization of patient care.

5.) Supervisory positions are all too frequently held until retirement.

Let us look in detail at problem 1, that is, the insertion of a business style of middle management and how this relates to current problems. Former departmental structures were eliminated in 1996, and entirely new positions were created with supervisory and fiscal control. I direct your attention to table 1. The real numbers of physicians and dentists, registered nurses, licensed practical nurses and nurses aides have declined since 1995. You will not be surprised to hear me tell you that the numbers of support personnel has actually risen during the same time frame.

Contrast the data in table 1 with table 2, where it is evident that the number of patients, visits and expenditures by the VA have all risen from 1995 to the present. When all of this was occurring, it appeared as if the possession of real credentials for a job position was grounds for immediate disqualification. For example, we had the unenviable experience at the Kansas City VA of witnessing the promotion of a very fine engineer to direct line authority over the pharmacy and housekeeping, disciplines of which he had only superficial knowledge. Internists were placed in direct charge of subspecialty surgeons whose specific requirements often went unmet. Another fine man, in this case not a physician, was placed in charge of pathology and radiology, disciplines that even trained specialists in these fields struggle to direct in the VA. We were told that the position of Chief of Staff was obsolete, and the individual in the position was summarily dismissed, only to have the position reinvented months later. If fiscal responsibility were the desired goal, it would have been cheaper to hire accountants.

The entire personnel structure of hospitals was reformed around a business model with the primary emphasis on fiscal soundness, something we have learned to our regret doesn't always perform well even in the private sector, much less in the VA. In the VA system, changes like those I have described translate into process, that is, paperwork and meetings, rather than into any actual doing,

that is taking care of patients. The end result following all of these changes: it was still left to the nurses and physicians to figure out how to deliver care in spite of the managerial impediments.

Problem 2 deals with the accumulation of power, real or perceived, in the hospital director's office and is separate from the middle management problem. Prior to recent changes, the Chief of Staff representing the clinical arm of each hospital had meaningful supervisory control of the professionals and influence on the use of fiscal and real resources. In bureaucracies, there is always a tendency to seize more power in order to influence one's own agenda. In an organization such as the VA, established to provide professional services essential to patients, this can be disastrous when the equation is tilted toward nonclinical management.

In the present setup, the Chief of Staff is literally in the pocket of the director. He or she is incapable of instituting the best system of medical care composed of nurses and physicians representing the needed disciplines in order to meet hospital needs. Hence, we see a system embracing primary care at the expense of all else. There is disdain for specialists at the very time that HMOs are realizing the hazards of such an approach. Specialty consultations cannot be met in a timely fashion, and many subspecialties are inadequately represented in the system.

Problem 3, a sundering of any meaningful relationship with local medical schools. The VA is an important partner in the training of physicians, pharmacists, psychologists and nurses in the United States. One of the major reasons many professionals join the VA is to participate in a collegial fashion with the local university medical school. Individuals may enjoy regular faculty status with their respective schools because of their own accomplishments.

In these Dean's Committee VAs, the control of education establishing who would teach trainees was exercised, rightfully, by the universities. This productive working relationship is no longer extant. The medical schools are in fiscal distress, and the VA has the money to spend on cheap workers, i.e., the resident and the interns, and a willingness to employ them. The power in this equation is enjoyed solely by VISN headquarters throughout the country. According to the new rules, residents and interns will perform direct patient services when at the VA regardless of the increasing number of patient encounters scheduled or the quality of the interactions. Individuals supervising such trainees are not necessarily established as competent or even interested in medical education.

Problem 4, individuals in the organization with direct patient care, for example, physicians and nurses, have no meaningful influence on the conduct of patient care. Diminished in numbers and treating an increasing number of patients, the professional employees, that is the physicians, dentists, pharmacists and nurses, are increasingly unhappy and unfulfilled. It is alarming when one hears the best of physicians stating, "I can't always do what is right for the patient," or, "my time is spent doing computer entry." Caretakers in this organization are trapped behind computers entering data of little or no immediate clinical relevance that consumes half of the patient encounter time. Consultations, depending upon the service requested, are often not performed in a timely fashion. Patients are forced to utilize the private sector to obtain

these services, only to return to the VA for their medications, which cost them less in the Federal system.

Contemplate the following scenario, which is the VA's idea of a meaningful patient encounter. Following clinic visits, patients were asked questions mandated by VA Central Office such as, "Did your doctor smile?" "Did your doctor look you in the eye?" "Are you happy with your care?" All cosmesis, no substance.

There is no process by which to determine if your doctor is even competent in the VA, which is an important question, since there is no meaningful professional development for physicians in the VA, and the distancing from the medical schools contributes in no small way to a deterioration of the faculty. I suspect the demoralization of the professional staff will be the ultimate undoing of this organization.

Problem 5, supervisory positions are all too frequently held for a professional lifetime. This statement is self-explanatory. The genius of the democratic system is not that we can vote in whom we want, but more importantly that we can vote out individuals whom we do not want. Such is not the case in the VA.

In conclusion, changes are needed now, but they are not necessarily large ones. All of the foregoing, the good and the bad, was accomplished by the appointment of one individual with the authority and mandate to affect change. Laws are not required, but the reestablishment and embracing of a professional culture of sound clinical practice is required.

Mr. MORAN. Dr. Klotz, thank you very much for your testimony and your analysis. Look forward to asking you a few questions.

[The prepared statement of Dr. Klotz appears on p. 58.]

Mr. MORAN. Ms. Tillman, is there anything you would like to say?

Ms. TILLMAN. I do not have a prepared statement. As you well know, I am retired, but I would like to add in my experience, and I am still somehow connected with the medical profession, a good program, especially for good nurses.

Now many of our hospitals have gone to depend upon agencies. There is nothing wrong with agency nurses, but they are here one day and gone the next. So if we can prepare a good program—because nurses will stay when they are happy.

Mr. MORAN. Thank you very much.

Let me first ask Mr. Slachta if he has any response to Doctor Klotz's analysis? I know that the IG has looked at management of the VA hospitals in a number of instances. Do you have items that you agree or disagree with Dr. Klotz?

Mr. SLACHTA. That is a difficult question to respond to.

Mr. MORAN. Thank you.

Mr. SLACHTA. There are several points in there that I do agree with, and there are other issues we need more information on before I give an IG position. I would like to do a lot more exploration.

Mr. MORAN. That is understandable.

Dr. Klotz, have you visited the hospital and visited with staff and physicians currently on your visit, I assume, here to Kansas City?

Dr. KLOTZ. No.

Mr. MORAN. So you don't have any sense whether things have changed since you were here at the hospital?

Dr. KLOTZ. I am sure they have changed.

Mr. MORAN. Have they changed in a systematic way? Are they more than cosmetic changes?

Dr. KLOTZ. Well, those type of changes were definitely needed. And to be fair, the individuals who were in charge at that time made every attempt to do so given their budget and their decisions. But what concerns me is that just as I pointed out, we are going to have, we are going to be left with the same system unless we do something about it. That is the problem. And if I could, I would like to, as someone pointed out, connect the dots so to speak. How did we get from mice to the management style? May I take a few minutes?

Mr. MORAN. Please do.

Dr. KLOTZ. Well, in 1995, or prior to, the changes that as I said, were cataclysmic, we had a functioning housekeeping service at this hospital directed by a fine employee. It did well. It kept the hospital clean. We then had the mandate from Washington to change, and everything was in turmoil. We ended up with an individual, as I stated, who was the hospital engineer, who is now suddenly in charge of a whole pyramid of agencies or departments of which he is no more familiar with than I am. The housekeeping supervisor was either retired or dismissed. I don't recall.

And so his approach to the problem was, well, let us get a consultant firm. I think over $100,000 was paid this firm to come in and tell us how to clean a hospital. And what they provided was a computer printout that told you, you, Joe, you go clean this room on Tuesday, and you go clean that room on Wednesday. Unfortunately no one inputed into the computer the room next to the cafeteria where food was stored. It wasn't cleaned for over 1 year. And there was no supervision—no knowledge; it was all lost with this change. What to do or even how to identify that there was a problem was lost. And then once it became apparent there was a problem, management did everything it could to control it and to improve it. They weren't in any way creating the problem. Don't misunderstand what I said. But therein lies the sort of things that can happen when you just remove an entire culture of knowledge. And I suspect there are lots of incidents like this in many VAs.

Mr. MORAN. If I understand the point that you are making about management, it was not that they were indifferent to the circumstances, it was that the management system did not provide them with the information with which they could pursue the problem?

Dr. KLOTZ. Right. And they had no knowledge or any training in what they were supervising. This is rampant in the VA at the current time.

Mr. MORAN. Do you or have you practiced medicine outside the VA system?

Dr. KLOTZ. Yes now currently I do. I am the chairman of the Infectious Disease fellowship program at the University of Arizona, and I am also at the VA, which turns out to be a problem.

Mr. MORAN. Is the management critique that you provided us this morning applicable to other hospitals outside the VA system?

Dr. KLOTZ. Well, in more ways than you want to hear. I no sooner had this paper published, and I had other Infectious Disease

people call me and say, "hey, these are not only VAs, we've got flies in our place, we have maggots in wounds." It is just not something you are going to report to the press. And that wasn't the point of my report. It was this novel finding of the relationship between the flies and the mouse infestation, and it was my duty to write this article.

Mr. MORAN. When did the change—assuming there was a change—occur in the role that the medical centers play in the VA health care system? At an earlier time in your career, was the medical center much more actively engaged in this hospital and other VA hospitals?

Dr. KLOTZ. Well, ask that question again, please.

Mr. MORAN. One of your critiques is that the roles that the medical centers play in supervision and medical education have deteriorated, if I understand your testimony.

Dr. KLOTZ. There is no doubt. I don't think you will find a physician in the system who would deny that.

Mr. MORAN. It seems to me that that is one of the most critical components. We need to retie the medical education and our universities together with the VA in a stronger way. Is that true?

Dr. KLOTZ. Yes. It is critical.

Mr. MORAN. What precipitated the demise of that relationship?

Dr. KLOTZ. Well, it happened concurrently, and perhaps because of the establishment of the current management model, which involved at that time VISN's. Suddenly VISNs had all the power in this relationship. Now simultaneous with this was all the fiscal distress that the universities in the country underwent. They no longer have any control in a meaningful way over what happens to their trainees because the VAs have the salary money. They have the money. When the trainee comes here, or any VA, the trainees will do what the VA tells them, which is their agenda, not medical education. So this whole thing has been skewed just a little bit, but enough to really portend problems in the future.

Mr. MORAN. Mr. Slachta, you indicated an awareness on the part of the VISN as well as the hospital director of filthy conditions and rodent population. What about the knowledge or awareness of the VA about the VISN, evidence that this information was known and, if known, not acted on in Washington?

Mr. SLACHTA. There were no reports going to Washington about the general cleanliness of the facility itself. There were reports going to Washington on the maggot infestation that occurred. Reports went into the Assistant Under Secretary of Health's office, but they were considered incidents, and that the proper response was taken by the hospital clinical staff to the issue.

Mr. MORAN. And any evidence that the VA in Washington attempted to correct the problem?

Mr. SLACHTA. No, sir, because they were told the problem was corrected.

Mr. MORAN. It was just one incident.

Mr. SLACHTA. Just an incident.

Mr. MORAN. I will conclude my questions with this. I thought one of the most significant statements in your report, which I think is really in agreement with Dr. Klotz, is actions taken by management through March 2002 were concentrated on addressing specific

cleaning and pest conditions and not on organizational failures that permitted the problems to exist or to persist. I think that is the message I took from the report—that we can solve problems, we can make things okay for the day, we can correct an incident, but do we have the practices in place that prevent this from either happening in the first place or happening again.

Dr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. We could spend a long time on both of your testimonies, but first, Mr. Slachta. Is that pronounced right?

Mr. SLACHTA. Yes.

Mr. FILNER. It seems that the recommendations that were made to address these problems—I mean, this is not rocket science.

Mr. SLACHTA. No, sir, it is not.

Mr. FILNER. I don't understand why all these things weren't done continuously. But have we looked at the other hospitals in our VA system? Do they have these same controls that you would recommend here? Do I have to go to my hospital in San Diego and find out if they have all this in place?

Mr. SLACHTA. The Office of the Inspector General has a program of CAP visits in process right now. The current Inspector General, Mr. Richard Griffin, started the visits. We are making CAP visits to all facilities. We are currently on a 5-year cycle, so we will be getting to the facilities once every 5 years. We would like to move to a 3-year cycle; but are there other facilities like this with these kinds of conditions? I don't know. I can't answer that at this point.

Mr. FILNER. I wondered if anybody can answer that, which would lead me to believe there is a real problem.

Dr. Klotz, I didn't get the biography. How long have you worked for the system here?

Dr. KLOTZ. Seventeen years.

Mr. FILNER. And you were here for also——

Dr. KLOTZ. I was here for 10 years.

Mr. FILNER. Given all these problems that occurred, why do you stay here in the VA system?

Dr. KLOTZ. You mean in the VA?

Mr. FILNER. Yes.

Dr. KLOTZ. Well, it has offered me a lot. I have enjoyed years of funding for my basic science research, and I enjoyed taking care of the veteran patients. It is just like the individuals here, everyone really cares what they are doing, but you can't do it if you are not given the resources to do it. And then you have these impediments, management above you. It makes life difficult. And I would like to interpose that it is not that these individuals are bad people. They are all fine men and women, and I have enjoyed working with them. But it is a philosophy. It is an understanding of what medicine is about.

Mr. FILNER. Have you brought this critique before to Washington? Do people there understand what you are saying, and have they responded to you?

Dr. KLOTZ. No. I would be glad to now because I was driven to this extremity by the actions of the VISN here. Even prior to the article coming out, I had phone calls in Tucson from the Acting Director at the VA there that "you are not to talk to anyone." And

shortly after the article came out, the VISN headquarters here closed a lab that I formerly had six individuals working in. I wasn't even the principal investigator anymore. But anything that had to do with my name was off limits. They keyed the employees out of the lab.

Mr. FILNER. Someone told you not to talk, did you say?

Dr. KLOTZ. Yes.

Mr. FILNER. Can you tell me who told you that?

Dr. KLOTZ. I can tell you that what came right out of VISN office is the following, verbatim: "Klotz ain't gonna work for the VA anymore." And once you are faced with this kind of problem, well, then you end up coming up with a sort of critique of the whole system.

Mr. FILNER. This critique was not published yet. This critique, this is not in the article that you had written. But have you communicated this before, this testimony, to Washington, to the Secretary?

Dr. KLOTZ. Well, the VA always sends out surveys to physicians, nurses, everyone, and provides its own data and interpretation of such surveys.

Mr. FILNER. I mean, is it the logical conclusion of what you are saying that no matter what we saw that was good happening here, improvements made, that it won't in the long run make a difference.

Dr. KLOTZ. Well, I am not so sure it will be sustained. If we keep saying——

Mr. FILNER. The mice will return.

Dr. KLOTZ. The mice will roar again.

Mr. FILNER. You know, the testimony of both of you seems to say, and tell me if I am wrong on this, and clearly we don't have sufficient monetary resources for this system. But it seems to me you are saying that that is not the chief problem anyway. Is that a fair——

Dr. KLOTZ. Lack of money.

Mr. FILNER. Yes. Lack of money. That is not the major problem.

Dr. KLOTZ. No. It is the way these resources are utilized.

I would agree. The utilization of the resources, because we have a $25 billion system here. That is a lot of money, and as this committee knows, I have been one that is trying to take the lead to provide more resources. But if what you are saying is true, then we will have some debate about that through the rest of the morning. We should be focusing attention on other things than just lack of money.

Mr. FILNER. Yes, I would believe so.

Thank you, Mr. Chairman.

Mr. MORAN. I thank Mr. Filner. Mr. Boozman.

Mr. BOOZMAN. Yes, Mr. Slachta, I bet I am not the first one that has messed that up. I am Boozman instead of Boozman, so I get confused all the time.

Mr. MORAN. He only changed his name when he became a Congressman.

Mr. BOOZMAN. Not my name, my habits.

In reading the OIG report, there are three or four things that I guess just kind of bothered me, that not only I think pertained to this institution, maybe the rest of the country. One of them was

that it seemed like one of the problems here was that there is a finite amount of money, and in an effort to expand other programs, housekeeping was basically put on hold. Is that basically what your report said?

Mr. SLACHTA. Yes, sir. I think that is a fairly accurate picture. There is a finite pot. Management decisions were made that the money was going to be used in other areas than housekeeping. In fact, housekeeping was frozen, no staffing. I would say, as we said in the report, from about 1996 to about 2001, 2002, there was no increase in housekeeping staff, and, in fact, there was a decline.

Mr. BOOZMAN. Okay. And so I guess there is really no mechanism to prevent that in other areas of the country, or, I mean, is that a potential problem for other hospitals also or——

Mr. SLACHTA. It is a management decision on how the resources are going to be used in the VISN and in the medical centers. The only mechanisms that would bring this to the attention of Washington would be a failure on the part of a facility on a joint commission visit, an article from the doctors; something special would have to occur before Washington would be aware of it.

Mr. BOOZMAN. So really you almost have a situation where you are expanding, and you don't have the money to take care of what you have got.

Mr. SLACHTA. Yes, sir.

Mr. BOOZMAN. Okay. The other—there were a couple of other things. The hospital again in the report seemed to receive good reviews, you know, consistently, even though in your report, you use the world "filthy" in some areas. How did that happen?

Mr. SLACHTA. For those of us who are veterans, when you had an IG inspection or a performance, you put your resources into preparing for that inspection. This hospital did that as well. The deputy director of the VISN in his white paper stated that the hospital was substandard when he came in. He was faced with a joint commission visit. The way he accomplished a good rating from the joint commission was he hired a private contracting company to come in to do some cleaning and had his staff concentrate on high visible areas. So you beef up for the inspection. Once the inspection is over, you go back to normal.

Mr. BOOZMAN. So to prevent that, then, I mean, you actually need to reform the inspection system. I mean, evidently it is not working if you—you know, if you have a situation where, to quote you, filthy, and then to have a high and then to return to that.

The other thing is that also, it seemed like, again, from your report there are individuals that hierarchy was obviously upset with, and yet they continued to receive merit bonuses.

Mr. SLACHTA. Yes, sir, that is true. The former director did receive a merit bonus after a year. The rating for this former director was extremely good for 3 years, then he received 1 year with a very poor rating, and then the following year he got an extremely good rating and a good bonus.

Mr. BOOZMAN. Okay. And then I guess the last pattern that I saw was that you seem to allude to was that there didn't really seem to be a lot of responsibility taken by anybody as to—you know, when we had a problem, it seemed like throughout your report it was kind of somebody else's fault.

Mr. SLACHTA. I don't want to leave the impression that the clinical staff didn't try to fix the problem. They did. We say in the report that high-quality medical care was given at this facility. We believe that. The medical staff here took, I would say, extraordinary measures to keep up, and, in fact, when I was doing my reviews, it was not unusual to see clinical staff doing cleaning.

Mr. BOOZMAN. Right. No, I was speaking more of the hierarchy not taking responsibility that it was—they didn't want to interfere with management style or—you have alluded to that in some of the report.

Mr. SLACHTA. Yes, sir. The hospital director was in charge, and his decisions were not challenged by the staff.

Mr. BOOZMAN. Okay. Can I ask you, Dr. Klotz, a quick question? You mentioned in your testimony to the effect that some of your colleagues said that they were not always doing what was right for the patient?

Dr. KLOTZ. I said that they were prevented from doing what was right.

Mr. BOOZMAN. Can you give an example? Let me let you think about it.

The other thing that you alluded to was that a lot—half of the patient encounter time was done doing recordkeeping. Is that higher in the VA than we experience in—I was an optometrist before I came here, and literally I spent more time filling out the paperwork for Medicare than I did, you know, seeing the patient. I know it is a problem elsewhere. Is it more of a problem in the VA than it is in the private sector dealing with insurance.

Dr. KLOTZ. It is a big problem. You are using resources to increase the computerization of the VA. There isn't any data to demonstrate anywhere that this is going to be effective, or will affect outcomes. But I can tell you it takes at least 10 minutes per patient to sit in front of the computer to input the information that the computer requires for each encounter. In some institutions there are as many as 81 questions you have to strike off before you can get on to your next patient. Patients are scheduled every 20 minutes.

Mr. BOOZMAN. Right.

Mr. KLOTZ. So, it is a problem.

Mr. BOOZMAN. Okay. Thank you.

Mr. MORAN. Ms. McCarthy.

Ms. MCCARTHY. Thank you, Mr. Chairman, and thank you to all the panelists here today sharing this wisdom with us.

Nurse Tillman, I was struck very much by the comments that you made, and I would like to explore those with you, if you don't mind. We have been listening this morning to the deteriorating conditions and the—we know that the cost of prescription drugs and increase in Medicare patients, all of the fiscal strain that is occurring to this hospital is occurring to other veterans hospitals and other hospitals in our region and our community and in our Nation. So I doubt that many of the situations that keep nurses from being happy—and you mentioned nurses stay when they are happy, and that is not unique to this institution. I find that in my visits with nurses all over my district. But many of the situations

that keep them from being happy are not necessarily unique to here.

But I wondered if we could, you know, just reflect on this whole utilization of resources, because it seems to me this morning we are hearing that that has been at the core of some of the trouble. How are the resources utilized in your mind? How would you best utilize them for the benefit of those nurses to keep them happy and to keep them here? They are—is there any flexibility in the allocation of these resources, what kind of—when you were here and you were the control nurse in this whole setting, did you have authority and input in order to help to reallocate resources so that nurses stayed happy, or if you could, tell us what you would like to see as sort of the perfect plan, because without nurses, they are the front line in patient care.

Ms. TILLMAN. Well, that is why I made the statement that I did. Anyplace nurses work anymore is going to be difficult because patients are sicker now. Patients are living longer, we have more procedures, and as far as other institutions, I have also worked at private hospitals prior to coming here, and I, as an infection control nurse, did not have input in the budget or allocation of funds. But I am coming from experience in that the hours, that is important for nurses. The average nurse, and I will stick myself out on the line to say 80 to 99 percent of nurses, if you go into nursing, you go into it because you care. You want to do a good job. I can hardly note any nurse who is not about wanting to take good care of patients. But long hours are sometimes a problem. A lot of overtime. Patient care is difficult. They get worn out and sometimes maybe burned out.

So flexibility in the hours. Few nurses really work for the money, very few. We all have to make a living, but if it comes to patient care, we will work overtime whether we are paid or no because we enjoy what we are doing. But anyone gets worn out, so I think look to have comparable salaries. There has not been a lot wrong with salaries here from an infection control nurse's standpoint. I made a very good salary. I was very pleased with it, and I don't think any of the nurses are complaining about that. But more resources for them; allow them to get out of the building, to go for educational reasons, especially those of us in Kansas, we have to have continuing education units, 30 of them, in order to get our license renewed. Make that available, because those CEU credits are very expensive.

So these are things. It is not hard to make nurses happy, but you cannot overwork them.

Ms. MCCARTHY. In the structure you experienced here at this institution, what means did you have to raise these issues and try to get them implemented? What was the chain of command or procedure you would use?

Ms. TILLMAN. If I had the opportunity, I would set forth a program especially for staff nurses, a lot in continuing education, input from them. Nurses know how things should—how a hospital should run. I venture to say not one nurse here doesn't. I mean, you may not always take everything we recommend because it is always going to be for the patient, but nurses should have input in structure.

I go back to before, there were temporary housekeepers here. They were let go, and I know in hindsight perhaps that wasn't the right thing to do, but with those temporaries they kept the house pretty clean. They were let go. And then the mistake was we were building—we were repairing, remodeling, and then to dismiss the temporary housekeepers put a burden on other staff members, and they just could not keep it up, so, therefore, some things deteriorated.

But nurses will take on the burden. They will take on the cleaning of the beds, and that takes them away from patient care. I would say input from your nurses, your staff nurses especially, because those are the ones that are at the bedside. They visit with the patient, and they are the ones that's really giving the patient care.

Ms. MCCARTHY. Thank you.

Mr. Slachta, would you comment on that flexibility, that idea of having——

Mr. SLACHTA The Department has a position of nurse executive. It is a means of bringing the information upward. To be honest, when we go into a hospital, we want to find out what is going on, the first thing we do is we talk to the nurses. And I believe that most management structures listen to their nurses. They need to listen to the nurses. They are an integral part of most of the clinical committees. And it is through the committee structure and their own supervisory relationships that they get you up to the medical center director level and even to the VISN level. There is a representative in the Central Office, nurse executive that sets the program goals.

Ms. MCCARTHY. I am pleased to hear that last comment. How do we get there? How do we get them to use it? How do we empower them.

Mr. SLACHTA. I haven't found VA nurses to be reluctant to speak. I think their message comes forward.

Ms. MCCARTHY. Who listens then when they speak? Because I get the feeling that just based on Nurse Tillman's remarks this morning that the dismissal of the temporary help to keep the place clean, especially under construction, was of concern. It was done anyway, and there didn't seem to be any flexibility or any clear channel to turn to to undo that until, of course, the paper came out and the public was made known of it.

Mr. SLACHTA. In this facility I saw no evidence that information was passed beyond the medical center director. I saw no evidence that information went from here to Central Office, here to the nurse executive. I saw the information went up to the medical centers through the committee structure, but I didn't see anything beyond that. And I don't know whether there was a thought given to doing it, or was—we reported it, we are going to get on with the job.

I saw a great deal of concern for the patient, a great deal of concern for the environment. In fact, I saw in some of the infectious control committee minutes where the nurses were actually trying to take on supervisory roles for the housekeeping staff, but I didn't see that information leaving the hospital.

Ms. MCCARTHY. When you saw that, why, then, wasn't there an intercession to bring about corrective action? Or were you reading these reports after the fact? Perhaps I should have——

Mr. SLACHTA. The only thing that I can say, is that there was a perceived or real, I don't know, budgetary shortfall in the facility.

Ms. MCCARTHY. I think it was real, but I think that in—that that is what the Central Office is designed to cope with, either by coming to get more funds or by realigning those priorities. Yes, I know we are short of money, and we will remain so for the foreseeable future, but this institution has a great reputation for patient care.

But when these issues were raised, I think, you know, some conversations should have been held about—what can we reprioritize here so that we can address this before it becomes a crisis, because I really believe we need to keep nurses happy. It is a challenge for all of us in America. And I would like to see it—a renewed commitment on the part of the Central Office to listen better to the nurses and to intercede if possible when they raise these serious concerns for patients and have those conversations and not wait for a crisis.

And thank you, Mr. Chairman. I know I have carried on a bit long.

Ms. TILLMAN. Congressman McCarthy, I have one more comment especially for our staff nurses. I am a strong proponent of staff nurses because, again, they are the ones in the trenches. And I would like to say for the professional standards board, look closer at those nurses as far as promotions are concerned or bonuses and not just always to individuals in management. I think the staff nurses should be considered on every—and other employees, but I am speaking for nurses because right now that is what we are talking about. But that should be looked at very closely.

Mr. MORAN. Committee, I am going to allow us a very brief second round of questions, in large part because I have one.

But, Ms. Tillman, first of all, just briefly, do you still have friends who work here at the VA Medical Center?

Ms. TILLMAN. Yes.

Mr. MORAN. In your conversations with them, are things different today at this medical center than they were in the past?

Ms. TILLMAN. As far as?

Mr. MORAN. As far as cleanliness, management, the things that you think or your colleagues here would think make a good hospital?

Ms. TILLMAN. There is improvement, and the management, of course, is listening to many of the recommendations. And many of the employees, although no longer here, still have greater respect for Dr. Klotz and his outspokenness. And, yes, much has—improvement is being done.

Mr. MORAN. Thank you very much. My real concern here is that there is always a scapegoat. Often to me as a Member of Congress it is we don't have the dollars. We have significantly increased the amount of money available for VA health care. The budget passed by the House of Representatives is certainly the largest increase in VA health care dollars since World War II. There is always going to be a need for additional resources. We can find ways to spend money.

There are things that we ought not overlook, and, again, I am not defending the fact that all the dollars that need to be there are there, but that can't always be the excuse for everything that goes wrong. People have to be responsible for what occurs.

We all work in certain circumstances that affect the outcome. And today the excuse is something different than resources. In fact, you admitted, Dr. Klotz, that it is something more than lack of dollars, it is management. I don't know that I have a question, but my concern is that no individual is ever responsible, it is the management system. So when we try to resolve problems and no one can step forward and say, what happens here is my fault, it is a consequence of a bad decision that was made. It is always: we don't have a management system in place to solve the problems. Maybe that is just the reality of the way life is; that no one is responsible because the system is responsible.

From my point of view, I guess we need to work on fixing the system, but I refuse to give up the belief that individuals matter, that decisions made by people, that leadership skills they have or don't have—all of this affects the consequences of the outcome.

Whether or not our nurses are happy is not just a matter of whether there is dollars. In fact, Ms. Tillman indicated that she was adequately compensated. It can't always be just that the management system doesn't work. It has to be that I as an individual, I as a manager, I as a nurse, I as an employee were to make good things happen at this hospital. And as we hear from employee representatives, maybe we will hear a little more about that.

But I only raise this issue because I am troubled by the fact that whenever everyone is responsible, no one is responsible.

Dr. KLOTZ. Can I address that?

Mr. MORAN. Yes, sir.

Dr. KLOTZ. Briefly. You are right. If I were in my house, and we had mice all over the place, I would conclude that maybe my mother was a bad housekeeper, or I was. And in this case you can point to individuals; individuals do matter. Every choice we make matters. As we look at this globally, there are patterns, and we talk of systems, and they are a problem. And what was the problem? Well, as I tried to point out, you take individuals, and you put them in charge of something they know nothing about, no training in or credentials to perform the duty, and you have mistakes like this occur. And so you can point to them and say: you did it, or your decision, by not doing A or B, ended up in this way.

We could find individuals responsble. I think in the long run the solution comes at looking at what we have instituted here, what we have layered in to this organization.

Mr. MORAN. Doctor, thank you.

Mr. Filner. Dr. Filner.

Mr. FILNER. Just to follow up on something that the Chairman just said and Mr. Boozman alluded to, and that is we can't institute individual evaluations. Can you tell me about the evaluation system that exists now in the VA? Everybody has testified these problems were long-standing. Everybody knew about them. We talked to staff members today, and they said they knew about all this for years.

You said in your statement that everybody stays forever. What is the evaluation system? The director of the hospital, the VISN director—are they evaluated, and why aren't these conditions included in their evaluation, and why did they stay if these conditions were so bad?

Mr. SLACHTA. They are evaluated. There is a system of evaluation. The hospital director has performance standards, just as all VA employees have performance standards.

Mr. BOOZMAN. Well, what—Mr. Chairman, I am sorry for interrupting because it is not—I was once on the school board, and you asked if there was supervision, if there were evaluations of the principals, and he said, certainly. And it is the exact same answer you give. And I made the stupid follow-up, asked can I see them. And I looked at—we had 168 schools in our school system, and they gave me the evaluations, and every one of the 168 principals they had checked satisfactory or unsatisfactory; satisfactory, satisfactory needs improvement or unsatisfactory. And everybody was satisfactory. I mean, that was the extent of the evaluation system. I managed to fire the superintendent, by the way. So he got his evaluation.

I want the evaluation meaningful, and should people who have bad evaluations be fired, or, you know, moved onward or demoted, or has that ever—no principal in that system I was talking about was ever demoted. Is any of that management personnel ever demoted in this system?

Mr. SLACHTA. I can't speak to that.

Mr. FILNER. Dr. Klotz is smiling, so I think the answer is no.

Dr. KLOTZ. Everyone knows in the VA it is impossible to fire an employee. I mean, you have to go to great lengths. You have to be careful. First of all, you have got to go get counsel and, figure out how to attack the problem. So that is a problem. But the evaluations are not very meaningful.

Mr. FILNER. Well, at some point, Mr. Chairman, I want to have Mr. Roswell give us some evaluation forms. But it sounds to me that we don't do that at all in a very effective fashion—not just based on your testimony, but my own knowledge of the system.

Mr. SLACHTA. Excuse me, Mr. Filner. I am going to disagree with Dr. Klotz. I have fired employees. I have fired management employees. I have removed management employees. We can do it. It is a lot of work, but you can do it. And when you have somebody who is not doing the job as a supervisor, you are responsible for doing that. That is your job.

Now, the Department does have a performance evaluation system, and I do know that from time to time they put in there certain factors. They stress certain issues that they want their managers to concentrate on. It wasn't too many years ago that medical care cost funding was a major concern. It still is a major concern, and I know it was added to the directors' performance evaluations, and they were measured. Now, the problem comes in the measurement because there are ways to game the measurement, and you see those kinds of things going on. But you can hold people responsible and should be holding them responsible.

Mr. FILNER. I wish, Mr. Chairman, we would have each panel in series. I hope you will stay because maybe the management is

going to have a different point of view. Maybe the best thing would be to have a debate between them instead of on separate panels. But if you stay, I may ask you for comment on what is going on.

Mr. MORAN. Dr. Boozman.

Mr. BOOZMAN. Yes. Dr. Klotz, Congresswoman McCarthy was concerned about the information from the nurses, you know, getting out things. In your testimony you mention that now the chiefs of staff, you know, don't seem to have any authority. Is that correct?

Dr. KLOTZ. This is my perspective, yes.

Mr. BOOZMAN. Is that true just here, or is that true throughout the VA system or——

Dr. KLOTZ. No, it is fairly true throughout the VA system. Of course, when you talk about the VA, you need to be careful. There are some flagship VAs which still retain very good working relationships with there respective medical schools. But they are the exception, rather than the rule.

Mr. BOOZMAN. But in the past, a strong chief of staff, you know, that did have discretion over budgetary matters and patient care, just things in general, that was a mechanism of getting everybody in on the patient care side of it, that is how—that was your—the way that you expressed your viewpoint and got things done, wasn't it? I mean, that is how the nurses in the past would.

Dr. KLOTZ. Right. You had to have a strong chief of staff.

If I may, a short little vignette. The first VA I was a faculty member at, the director and chief of staff couldn't agree. They came to a fistfight, blows in the office. What did management do? They moved them both up to Washington, DC. My point? It was a draw. But you have equality.

Mr. BOOZMAN. So that balances out the patient's side of it with the business side.

Dr. KLOTZ. Right.

Mr. BOOZMAN. Okay. Thank you.

Mr. MORAN. Ms. McCarthy.

Ms. MCCARTHY. Mr. Chairman, I am glad you pursued this whole issue on the system and policy and management because what prompted my questioning to Nurse Tillman was that on July 22, 1998, a nurse, a nurse, first noticed maggots from a 45-year-old patient admitted on July 12. On September 30, maggots were noticed on another patient. And it wasn't until October 5 that a program was released, Program Guide 1850.2, Integrated Pest Management, IPM, and she talked about nurses having more input, having—you know, into the organization.

So I think as we go through the other panels today, I would like to pursue this, the line of thinking that you raised in the second round, to figure out where in the organization, management or otherwise, we could probably address a little bit better and that might benefit all the veterans hospitals in our country.

Mr. MORAN. That certainly ought to be our goal, and I appreciate this panel's testimony in helping us reach that goal. I thank you, all three, very much.

Mr. MORAN. Our second panel consists of Ms. Linda McEwen, the president of Union Local 910, American Federation of Government Employees; Mr. Bryan Baldwin, president of Local 2663, AFGE;

and Ms. Shari Grewe, patient advocate at this VA Medical Center; and Mr. Hugh Doran, former director of the VA Medical Center here in Kansas City. We welcome you.

Ms. McEwen, if you would like to begin, we would be glad to hear from you. We are going to try to be better about our timing. I am sorry.

STATEMENTS OF LINDA McEWEN, PRESIDENT, UNION LOCAL 910, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, VA MEDICAL CENTER, KANSAS CITY, MO; BRYAN BALDWIN, PRESIDENT, UNION LOCAL 2663, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, VA MEDICAL CENTER, KANSAS CITY, MO; SHARI GREWE PATIENT ADVOCATE, VA MEDICAL CENTER, KANSAS CITY, MO; AND HUGH DORAN, FORMER DIRECTOR, VA MEDICAL CENTER, KANSAS CITY, MO

STATEMENT OF LINDA McEWEN

Ms. MCEWEN. Chairman Moran and Ranking Member Filner, thank you. My name is Linda McEwen. I am the president of Local 910 from AFGE, which is the American Federation of Government Employees. My union represents the professionals, approximately 400, in this building, and that is the nurses, the doctors, the pharmacists and those people that give direct hands-on care to the patients in this facility.

I have about 30 years in nursing. The last 18 years have been with the VA. I have a bachelor of science in nursing, I have a master's in health service management, I am certified in gerontology, and I was one of the charter members of this union in 1999.

I am here now to tell you that the professional staff here at this facility were appalled. We are very frustrated. We were very dissatisfied with the way the problems never got resolved. We did bring them forward. We did talk, and they were not acknowledged, and they were not done. We watched our brother union of the nonprofessionals try relentlessly to get more housekeepers, but they never came. When we came up with the second infestation of filth and mice and stuff in the canteen, we argued to have the VA—the canteen closed, and it wasn't. We tried and tried through a lot of our internal processes to make what was happening here known, and it simply didn't go anywhere.

As a nurse, and as a union officer, I would like to ask Congress what you guys can do to help us. And I think to start with, your congressional investigation and your staff certainly having initiated a lot of activity, and that is good. And to his credit, Secretary Principi has responded and has really done some stuff to help solve the underlying problems. And, of course, we have a new director, and that is excellent. He is really trying to focus us on the direct patient care issues rather than surveys about patient satisfaction and joint commission scores, and that is good.

But I would also say to you that I am still very concerned for our future because directors come and go, and it seems to me that we need to do a bit more than field hearings to solve this problem so that it doesn't happen again, not only here, but in other VAs.

I guess, as you said before, funding is always an issue because we need appropriate numbers of professional and support staff to

give the care. That is the truth. But money alone is not the answer, and we feel there clearly needs to be some systematic checks and balances to prevent such an awful thing from happening anywhere else.

Part of that, we believe, is from the VISN and from Washington. There are routine reports that are given to Washington from the VISN. The problem about that, ladies and gentlemen, is that they are too distant, they aren't about the front line, and some managers do try to manipulate them. I would share with you that none of the front-line staff have any opportunity to review those reports or make any comments on them. So, for example, there are programs—there are surveys to patient satisfaction. Well, as a union member, if management would have asked the union about those numbers, we would have objected, and we would have objected to them because we felt like that they were being manipulated.

You can gloss over the problems in reports to Washington, but what you cannot do is show the doctors and the nurses and the other professionals that are doing hands-on care. We know. We know what is happening. I am an advocate for the patient because I am a nurse. But as the union president for the professionals, I really feel that it is important we have a real voice in the workplace; that we tell management what the problems are; that we discuss the working conditions, even if it is kind of an ugly picture, which it has been lately. It is important that we do that. It is also important that we stand ready to help management in terms of solving these issues.

My thoughts on these issues are you do need a robust, a robust, labor/management relationship. It is absolutely required if you hope to have quality of care. It is absolutely required. Information from the professionals that give the care, who know the systems, should not be dismissed and should not be ignored. Especially with the VA, as it tries to become more market-based, we run like a business. Sometimes when you get down to the bottom line, it takes away the compassion, and it can divert your attention from the quality of care. That is where we were, and that cost a lot of money.

As Dr. Klotz alluded to in his testimony, we were under a "do more with less" type of management philosophy, and if there is a good management relationship, it is the individuals who can sit down with management and say, you know what, less is less. That is it. It just is.

I recognize that you can't legislate respect, we understand that, but you do write the laws that decide what we can say and what we can do as the representatives of the professionals, and we would like to urge you to do three things. One is that we would like for you to require that management should get union information on reports and be able to comment on the key recommendations or the content of the report. I think you and Secretary Principi deserve the rest of the story, and it is the union that can help give you that.

I think that there has to be strong union partnerships. What we are asking from Congress, is for your support, to be an advocate for that and to monitor it, because it is our opinion if you find the hospital where there is poor or nonexistent labor management, you

will find a hospital with problems, and they aren't just with labor management. There is actually a very strong underlying basis for that, and you should look at that. We are asking that you would.

Secondly, we would—or third, we would like for you to know that as the professionals, we are the ones that play the vital role in delivering the patient care. We know the issues. We know the challenges. But the truth is, ladies and gentlemen, I can't bring those up at the bargaining table, because in the VA the law prohibits me from bringing up any issue that has to do with direct care. So if you really want to help and you really want to see all of the VAs better, and you want to be able to monitor that, you need to really look at 38 US Code 7422. It prevents the professionals who are the ones who are doing the care from actually talking to management about the care, and that is a big problem. That is a big problem. We need a voice in the workplace. We need a strong voice, and we would hope that you would support strong labor relations; that you encourage management to hear from us about getting the rest of the story; and that you look at that law and how you are preventing the very professionals who give the care from bringing up concerns about that care.

Thank you for the opportunity to——

Mr. MORAN. Thank you, Ms. McEwen.

[The prepared statement of Ms. McEwen appears on p. 62.]

Mr. MORAN. Mr. Baldwin.

STATEMENT OF BRYAN BALDWIN

Mr. BALDWIN. Well, Ladies and Gentlemen, my name is Bryan Baldwin, and I am president of the AFGE Local 2663 here, and that is basically the LPNs, the health techs, the trades and all the construction trades, electricians, carpenters, plumbers and the people that do a lot of the front-line work. I am also a life member of the DAV. I am a life member of the VFW, past commander of my VFW post.

I was elected in 1997 as president of this local, and right off the bat there was some concerns about the staffing levels. There had been a reorganization that went through in 1996 and 1997. There were a lot of changes that have come about. As a result of these changes, it seemed like there were certain numbers were going to be put on exactly how many personnel were allowed in a section. And right off in just a short period of time, we started experiencing problems and complaints.

I know there were doctors and nurses in this hospital, sir, that were sending photographs down to the VISN of what was going on behind the walls and stuff. I know Ms. Crosetti was aware of those situations, and evidently she had supposedly discussed them with Mr. Doran. So, it seemed like next time, we will have to find out what was wrong.

And I would like to correct the figure that Mr. Klotz mentioned there. It was $54,000 that was spent on a consultant survey in 1997, and right off the bat they said, you are at least 16 people short at a minimum to maintain this facility in an acceptable level. Well, I thought this is all we were going to need. We have got this survey here. You know, a consultant's report, and—16 more people

are going to show up. And, ladies and gentlemen, that just didn't happen.

And I want to tell you, it is my opinion, that the veteran population of Kansas City in this area around here is just about one of the most fortunate group of veterans anywhere in this country, because I know that the front-line staff around here, the nurses and the LPNs, the doctors and the people that actually were doing the hands-on care were doing outstanding job, because I think of the adverse situation and conditions they had to function under, they went the extra mile for this veteran population.

Well, I know, conditions just, in my opinion, kept getting worse, and I kept addressing them. I did everything a labor leader can do. I tried to negotiate. There was not going to be any negotiations. I had to file 76 unfair labor practices just to force the management at this facility to come to the bargaining table, and then it was a slow process of stall it, stall it, stall it. And I get the one part to the end—we will just cut to the chase here.

It comes to this canteen situation, and I believe that is in your report there, that an employee coming in said, have you been up there in the back? And I said, no. He said, it is deplorable. He said, it is unbelievable. So I called Mr. Doran, and we got Mr. John Howard, who was the program facilities manager of this area, and I took my safety officer, Mr. Bob Cheatham, and we went on a tour in the back of that canteen. And sir, I—it just—it was unbelievable. Mr. Doran seen it. We left the area. He said he would take care of it.

I informed Ms. McEwen here what we saw. She sent an e-mail out, asking her people not to use the canteen until it was cleaned up and taken care of. As a result of that e-mail, Mr. Doran had some rather harsh comments to me about even informing somebody of something like this. He said he would take care of it. I was told—by e-mail through the program manager that that weekend that they had went in and done a real thorough job, and on Tuesday, their own people, the infection control nurse, the safety officer, the health—employee health nurse here, we (AFGE) weren't invited to go back again.

Anyway, they went back in, and the first thing they found was mouse manure in the coffee and the cocoa powder that people drank that morning. And, ladies and gentlemen, you don't allow a condition to exist like that. Feeding people mouse manure is not right. And, I mean, it was bad. I mean, I see people out here laughing, but it is not funny. It really isn't.

Well, nothing happened. Nothing was done. A week went by, and I took these e-mails and I put them in an envelope and put a cover letter on it, and I said, would you please do something about this? And I sent it certified mail to Ms. Pat Crosetti's office. I thought maybe if she knew, something would be done. It just went on.

I took it to a—every 3 months stakeholders meeting up in the director's conference room. That is where they invite the service officers and people like that to come in. And I held these e-mail documents up and these consultants reports, and I thought maybe if I could catch them in a—you know, a situation where the constituents would see it, and Mr. Doran said, well, that was a Cadillac; 16 more people, and I didn't have money, so I bought the Buick.

Some old vet made a crack back there, says, it sounds to me like you got a Ford Escort, and everybody laughed, and it went on, but nothing got done.

The thing, as a labor management person I would go to Mr. Doran and would say, this is mandated to me by the VISN. I would call Ms. Crosetti, and she would say, well, that is a local issue. You deal with it. And they just played ping-pong with me. I couldn't get anything done.

And what was really sad, I guess, in the outcome of this investigation, and I think you people should know this, I am the individual that provided the documentation to Senator Bond when this broke, because the documents that I have—and he shared them with Mr. Principi, and, yes, things immediately started happening, but it shouldn't be that way. I watched on television that night after the story broke, and they had the news media here, and they said, oh, this was an isolated incident; this happened 4 years ago, and we took care of it. Ladies and gentlemen, the bug zappers and the plastic was put up 15 minutes before the news media took that tour. The employees had to hustle to get up there that morning and get it done before the media got here. That is just like I call hide, conceal and cover up, and it went on at this facility.

So I don't know. Like Ms. McEwen said, I think that if we—if nothing else, that these reports and so forth that go to Washington that is sent out by the managers, it can be very easily manipulated. I don't know the answer. I think that in this situation we could all use more money, but it is like you say, just throwing money at a situation when it is mismanaged at that extent or level, here I don't know.

I feel sorry for the employees. They worked hard. Can you imagine every day, sir, that you would come into your job and you are going to be doing something different that was forced by our management? They were at one time down to 32 housekeepers, and they were supposed to have 46 plus an additional 16, and they were down to 32. These people, they were paid like 19,000 hours overtime. They were burning these people up. Instead of an 80-hour pay period in 2 weeks, there were employees here working 120 and 130 hours every 2 weeks, and they couldn't get ahead.

Mr. MORAN. Thank you.

Mr. BALDWIN. Thank you.

Mr. MORAN. Thank you, sir, very much. Ms. Grewe.

STATEMENT OF SHARI GREWE

Ms. GREWE. Hi. Mr. Chairman, members of the subcommittee, and the members of the congressional delegation, for the Kansas City VAMC my name is Shari Grewe, and I have been a veterans supporter all my life, but in 1997 I was selected as the patient advocate for the veterans at this facility. Thank you for the opportunity to share the voices of many thousands of veterans that I have dealings with all the time. They have one common goal. That goal is to receive the best quality care in a clean, sanitary environment, with leading top-quality care of anywhere in the Nation. They deserve it. They have provided many years of their lives to protect our liberties. They deserve nothing less than the best.

Their focus is not on the cleanliness of this facility at the time this occurred. They came in preoccupied. Their perceptions were overshadowed because of the high-quality, excellent care provided to them by the nurses and physicians and other staff of this facility. They have been overlooking the conditions of the cleanliness for a long time, but let me assure you they will not overlook continued areas of uncleanliness.

I am summarizing my report, and the reason I am is because I look out among this crowd, and I see so many ex-prisoner of war veterans, I see the dedicated, committed patient population of this facility, and I feel that they deserve the very best. Their concerns are focused on timely access to care. They shouldn't have to wait 6 months to get into primary care for the very first time. They shouldn't have to wait hours for an unscheduled appointment or wait for a scheduled appointment. They are ill. They want to be seen.

But the first primary concern that the veterans are having is that they don't even know how they are going to get here for at appointment half the time. They live out in the community, out in the remote area. Thank goodness we have DAV, Disabled American Veterans, who have devoted millions of hours in transporting these veterans that are scared to death to drive from their home to our facility, or they don't have a car to drive to Kansas City for their appointment. That is their first problem, and we have got to try and solve that.

The second problem is that they are worried about their medications. They don't believe that they should be billed for their medication. They believe that Congress promised them a long time ago that their health care services would be provided to them at no charge. They are angry. They believe that the government has lied to them. They come into our facility angry with that concept.

They believe their mileage reimbursement isn't enough. It is 11 cents a mile for them to come. Many veterans are driving 3 hours to get here for their care. They are sick. They are worried about their health care. They are making tough choices. Should they buy their medication? Should they buy food to put on their table instead? Or should they purchase their wife's medication? So those are the tough questions that are facing our veteran population today.

They are worried because their service-connected claim has taken years to be processed. They are worried because they can't work, but they can't get VA un-employability because they have to be unemployed for a while before they can apply for this benefit. During that time when they aren't working, what are they going to use to put food on the table? Those are the concerns of our veteran population.

We owe a great thank you to the committed service of the nurses and the physician staff taking care of our veterans here. For that reason there was not that many complaints that came through regarding the cleanliness of the facility. But let me share with you, those that did come forward and speak with me were outraged. They don't deserve it. They deserve the highest degree of respect. That respect should begin as those veterans are coming up that drive. It should follow them through the facility to each encounter

they have. They deserve that. They deserve the dignity that they have earned. They deserve the care at this facility because they have earned it, not as a gift, but they deserve it. Thank you.

Mr. MORAN. Thank you very much for that reminder.

[The prepared statement of Ms. Grewe appears on p. 66.]

Mr. MORAN. Mr. Doran, welcome, we look forward to your testimony.

STATEMENT OF HUGH DORAN

Mr. DORAN. Thank you for the opportunity to appear before you today. I consider this a distinct honor and privilege. I am further gratified that I will have the opportunity to present my position on this unfortunate chain of events.

On March 5, 1995, I became the director of the VA Medical Center here. My first day I toured the hospital, and I was appalled at the medieval conditions our veterans were hospitalized in. Nurses had difficulty getting monitoring equipment to the patients bedside in the intensive care units. The patients were in poor bedrooms where they could reach over and touch each other. It was antiquated and outdated. We were in a 45-year-old building that had very little upgrading other than air conditioning.

Our veterans indeed deserve better. My administration was centered on two areas, quality of patient care and patient satisfaction. All of my decisions were based on this. I immediately conveyed my priorities to our employees and the management staff. I also told everyone that, the veteran service organizations, my board of directors. I told all concerned that we were going to become a patient-focused hospital.

The unfortunate incident involving the maggots was handled expeditiously and appropriately by our staff, including monitoring and follow-up by our medical staff. I took immediate action to insure our adjacent construction site was secure, informed my superiors, and discussed the incident with the families involved.

There is absolutely no evidence to establish a relationship between the two nasal myiasis cases and the alleged mouse problem. You have an obviously disgruntled former employee's opinion who managed to get the article published. There are many others who disagree. Mice were never trapped or observed at any time in the intensive care units. No mice were ever noted to have larvae or flies associated with them. The blowfly is extremely common in the Kansas City area. No one can prove the fly did not come in the front door.

I hope you don't think that this is the only case of a maggot being discovered in a hospitalized patient. Unfortunately, it is not uncommon; certainly underreported, but not unusual. There were three incidents of flying insects that invaded the operating room in 1999. Immediate action was taken to protect the patient and clean the area. This situation was closely monitored by the operating room supervisor and to my knowledge was an isolated incident in November of that year.

In a 50-year-old building you are going to have an ongoing rodent problem. The key thing is what does one do about it? There were various rodent-control initiatives over the years, including our own employee as a pest controller, followed by contracts with private

companies. No one can absolutely rid a hospital this old of mice and rodents. They will always be there. We tried to control this problem as best we could in this antiquated building in a neighborhood full of vacant lots and vacant buildings.

There was an occasion when both local union presidents brought to my attention evidence of mice in the canteen area. I immediately examined the area, asked the canteen officer and our facilities program director to clean up the grease area of the stove in question, and relocated the store room. I asked our infection control nurse to conduct daily inspections and report back to me her observations. I personally inspected the area several times following this incident and was satisfied the problem was addressed. I did not have the money to do anything to this area at this time, as I was in the process of building a new cafeteria in the basement, which was scheduled to be opened in several months.

Regarding the budget, ladies and gentlemen, each year as the director of this hospital, I started the fiscal year in the red, each year $4 million to $10 million in the red. Each year this deficit was brought to the attention of my superiors without relief. Despite a meager increase each year in my total budget, I faced each year with a daunting task. I funded our supply allocation, for example, pharmacy, supplies, et cetera, and what was left was devoted to salaries. For this reason, I went from 1,400 employees in 1995 to 980 employees in 2001. Each year was a struggle. Our only alternative was really to reduce employment. Physicians' and nurses' positions were not reduced.

The budget allocation process in VISN 15 discriminated against the tertiary care hospitals, Kansas City, Columbia and St. Louis. Tertiary care is very expensive, and we received many referrals for needed care from other hospitals in VISN 15. The transfer pricing scheme was woefully inadequate in paying us for the expensive care we gave, further diminishing our meager allotment. For example, the total hip patient referred from Leavenworth resulted in a $4,000 allocation in transfer pricing. I had to buy the hip joint for $4,000. So I was losing money before the patient was ever admitted.

The pharmacy budget increased from $8 million to 18 million during my tenure. Medical supply inflation runs took 10 to 15 percent each year. We received less than a 3 percent increase in our budget. Do you get the feeling now for the challenges I faced each day in trying to remain fiscally solvent?

Construction, it is important to note that 10 to 15 years ago there was a $45 million renovation project requested by the VA for the Kansas City VA Medical Center. Congress did not fund this project, despite it being requested each year for several years. I can assure you that if this project was supported at that time, we probably would not be here today.

When I arrived in 1995, I decided that the $45 million project would never be funded, and we had to go in a different direction. With the support of the VISN, we designed several $3 million to $4 million projects that we could do each year and completely rebuild the important patient care areas of the hospital in 6 to 7 years. We started with the new state-of-the-art 13-bed medical intensive care unit followed by a 13-bed surgical intensive care unit.

In addition to these very important initiatives, we completed several local projects that included a new endoscopy clinic, a new primary care clinic, the new ambulatory surgery suite and rooms, new ENT and ophthalmology clinics, a new cafeteria, renovated this room, the front lobby, opened the only learning center in the VA or private sector for patients and employees, and relocated the administrative areas from prime patient care space on the first floor up to the fifth floor. We are nearing completion on the new laboratory, which is being completely reconstructed to support tests sent to us from other VISN hospitals.

The 70-bed medical ward was completed in the spring of 2001 providing rooms which were as nice as any in the city. Our veterans deserve nothing less.

At this time we began construction on the new operating room suite to be completed in the fall of 2002. This was our crowning achievement, a much-needed facility for the veterans of Missouri and Kansas. This was a major accomplishment, and my appreciation to our local Representatives and Senators in both States.

For the past 6 years I had two $3 million projects to renovate the halls and the walls. I made the decision that the patient-care-related projects were far more important than the cosmetic changes in the halls and walls. We definitely need this project, and it was my plan to do it after the operating room was completed, along with the project to renovate the fifth floor to accommodate surgery beds and our new SPD.

The SPD area has been the subject of attention. I also had a roof project that we all knew was needed. The SPD problems were directly related to the leaking roof. At no time was patient care compromised because of anything in SPD. Upon completion of the two projects, we would have a wonderful state-of-the-art facility second to none.

Workload. During my tenure our workload dramatically increased. Patients treated went from 12,000 to 32,000, and outpatient visits went from 130,000 to over 200,000. Our hospital became a popular place for patients we served. A significant number of veterans came to us from the State of Kansas. I believe this dramatic increase in patients was a result of our patient-focused health care environment initiatives. There is nothing more important than quality of care and service. The Kansas City VA and dedicated employees were the best, and the veterans came to us.

Sanitation. It is interesting to note the most—that the most vocal individuals regarding sanitation at the hospital are well-known malcontents and/or disgruntled employees or former employees. I can honestly say the housekeeping staff was not reduced any more or any less than other areas. In fact, in late 1997, early 1998, I added eight positions to the housekeeping staff and purchased $200,000 worth of equipment. The decision was the subject of our presentation to the joint commission identifying a problem and our solution to it.

At this period of time several decisions impacted the quality of our sanitation efforts. Our local union objected to our compensated work therapy program, wherein we were able to use housekeeping job assignments in the rehabilitation program for veteran patients. At any time there may have been 10 patients in various assign-

ments. We were forced to stop this very worthwhile program, patient care program, while other hospitals in the VA benefited tremendously from it.

Supervisory positions were reduced throughout the hospital. Housekeeping was no exception. In fact, we allowed the night housekeeping staff to function with a work leader. I agreed to this organization after meeting with the union and employees and granting their request for individual promotions for these individuals versus a supervisory position. This did not work out as well as we had thought, and when we involved a supervisor in determining work in that area, that is when we were hit with the 72 unfair labor practices that was referred to earlier.

More importantly, joint commission reviewed the hospital in the fall of 1998, reviewing sanitation with everything else; gave us compliments on the cleanliness of the hospital and a score of 97. In the fall of 2001, another joint commission review—and the joint commission, like it or not, is the gold standard for hospitals—in 2001 they gave a score of 99, the highest in the VA system, and probably the highest in the country. Several service organizations conducted cyclic reviews and did not report any significant problems with housekeeping during this time frame. We had many visitors, and I talked to many patients and families. Housekeeping or the lack of it was not a major topic of conversation.

Much has been written about the consultants' report. In the 1998 time frame, I contracted with a firm to tell us what was needed in housekeeping. I was mainly interested in his plan for cleaning the respective areas and frequency needed. The consultant and I discussed his recommendations and agreed that my present staff in housekeeping was equivalent to the Ford Escort. An additional 14 positions would give me the Cadillac, the difference being frequency of cleaning. We discussed what I needed for a Pontiac, and he said around eight positions, and that is what we ended up increasing the staff.

During this 1998 time frame, the VISN director Ms. Crosetti called me and told me that she had been at a service organization picnic, and one of the members had told her that he noticed a slippage in the housekeeping efforts. She said that she had noticed it also. I told her that was true and that I was taking the necessary steps to address the problem. I further explained that I had the consultants' report and was hiring positions that I had lost, and that I had lost the services of the CWT program. Everything happened in a short period of time, and we were turning things around.

I would have liked to have a cleaner hospital. Unfortunately, I did not have the resources to support housekeeping as I would have preferred. I can assure everyone that patient care did not suffer because of the lack of housekeeping. We must not lose sight of the purpose we are all here for, and that is to provide the highest quality of care, and no one can argue with our success.

IG report on the relationship with Crosetti. It was disturbing to read Ms. Crosetti's comments concerning my performance in the inspector general report. She never told me that she thought I was unsatisfactory. I did receive a low evaluation in 1999 because of a personal issue, and I was accused of lobbying Congress for the op-

erating room project. Guilty as charged for the lobbying effort. It is hard to believe that she would give me a minimal successful rating in 1999 and an outstanding rating in 2000, about 10 months later. She even gave me a bonus, as was mentioned before.

Suffice it to say my relationship can be measured in outcomes. Ms. Crosetti took great pride in VISN 15 being the best in the country for several years in a row in performance measures and patient satisfaction. Kansas City was the best hospital in VISN 15 for 5 years in a row in these areas. I always used to say Kansas City is the engine that pulls the VISN 15 train.

Summary. I have dedicated 38 years of my life in service to the veterans in 16 hospitals throughout this wonderful country. While the recent publicity has been terribly biased and one-sided, I have been heartened by the many calls and cards from patients' families employees and volunteers. This episode has been a terrible disservice to me and to the many dedicated and compassionate employees at this medical center. Our employees are the finest in the country.

The accomplishments in the past 6 years cannot be overlooked: Joint commission scores of 97 and 99, number 1 in performance measures, et cetera; morbidity and mortality rates are in the top 5 percent of all hospitals; dramatic increases in satisfied patients using our hospital; and the many construction projects mentioned earlier. We have achieved a true patient-focused environment, my goal in 1995.

Due to budget constraints, I had to make choices, and I chose patient care. I provided the highest quality of care to the veterans of Missouri and Kansas, and I am damn proud of it. Our judge and jury is the patient that we serve, and our patients are saying, we are glad you made the decisions you did. The Kansas Department of Disabled American Veterans organization presented me with their achievement award in the year 2000, the only director of a VA hospital ever honored in this manner. Secretary Principi completely vindicated me as the director when he ordered the hospital to receive $10 million 2 months ago for the halls and walls project and for additional employees. I ask you, what could I have done with $10 million?

Thank you for this opportunity to appear. We do need to move on. Our employees need to keep—to get on with keeping the promises to our Nation's veterans. I will address any and all questions.

Mr. MORAN. Mr. Doran, thank you very much.

[The prepared statement of Mr. Doran appears on p. 69.]

Mr. MORAN. Committee, we are going to have to be very precise in our comments and remarks if we are going to have any semblance of staying on schedule.

Mr. Baldwin and Ms. McEwen, I asked the director today during our tour if there was any place in the hospital that they would not want me to see, I would like to see it. They indicated I could see any place, and that there wasn't any place that they would not want to have observed. Any place that I should see today before I leave the hospital? Everything in good shape?

Mr. Baldwin.

Mr. BALDWIN. I think, sir, that we have put on a new face, but this is an old building. My safety officer is very astute to construction, has informed me that as soon as this kind of dies down, he

would like to take the director on a tour and show him some things behind the walls dealing basically with some of the plumbing issues, the electrical issues that basically need upgrades. And I think in time those will be corrected, but it is dealing with the hard core type of construction that we have.

We put in some new equipment for which we do not have enough electrical power to run all of it at the same time. I have been informed our new OR project that is going on out here, it is on schedule, and it is doing good, but the cooling system that was designed to put into it in a really hot situation in the summer may not be able to take care of it all, and we are going to investigate that and look into it.

Mr. MORAN. Thank you very much.

The hospital administration indicated to me this morning that Mr. Doran is right, ten million additional dollars can make a difference. He indicated that while a significant amount of that money has been contracted to be spent, very little of the work has actually been done, a lot of work yet to come. I understand the importance of cosmetics and changes that have been made. I think we need to reassure our veterans and their families about the quality of care, the cleanliness, and sanitation.

We do want to make sure that there are changes. We heard some things from earlier panels and from your testimony that indicated that we need to continue to work with you and make sure good things happen at this hospital.

Ms. Grewe, I noticed in your written testimony that there are rumors that this discussion is nothing more than an opportunity to close the hospital. I can't imagine that being the case, and we will try to get the reassurance from our VA officials from Washington to let you and the veteran patients know that there is a long-term commitment to the Kansas City VA Medical Center.

Mr. MORAN. Dr. Filner.

Mr. FILNER. Thank you, Mr. Chairman, and thank you all for your candid discussions.

Ms. McEwen and Mr. Baldwin, I take to heart very much your testimony. You made some very clear recommendations that we should look at, and I promise you we will look at them. I found them very compelling. Your testimony, both Ms. Grewe and Mr. Doran, I just find very distressing, or ununderstandable. You separated, you very clearly separated, patient care from cleanliness. I don't understand how you can separate those two. One says something about the other, and to make that distinct thing, I think, is completely unsupportable. There is no way if everything is dirty that you are going to have good patient care. I just can't see it. I will give you a chance to comment later, but I just don't understand that demarcation.

Ms. GREWE. I think as far as the patients go, what the patient did is because of the satisfaction and the excellent care that they had received, they overlooked the uncleanliness situation.

Mr. FILNER. Well, maybe. It only means that they are not as informed as they ought to be about the situation in which they found themselves. I would find that that is not informed consent here in terms of what is happening. But, be that as it may, that is just my layman's approach to things.

Ms. GREWE. That doesn't make it right, and that doesn't make it acceptable. That just means the patient is saying, I like the nursing care. I like the physician's care. I like the facility.

Mr. FILNER. Right, but that doesn't mean that any manager could say, well, that makes my management fine because the patient said it was——

Mr. DORAN. Well, if I could respond now. Obviously you can't separate patient care from sanitation. It is all connected together. In the end result, the patient care is the overriding factor.

The sanitation was a problem. I admit that it was a problem. I have never denied that it was a problem. But with the resources that was given—that were given to me, we addressed the problem as best we could and maintained the problem—on top of the problem as best we could. That is my point.

Mr. FILNER. Maybe.

Mr. Doran, I believe you asked to be here and I guess you want to justify your management at the time.

Mr. DORAN. I really did not ask to be here to justify anything. I asked to be here because I couldn't fathom a hearing concerning the hospital and happened at the hospital for the last 5 or 6 years without the director of the hospital being here.

Mr. FILNER. I am glad you are here. But I will tell you, I have been a member, as I said, of a school board, a city council, and have been in Congress for a decade. I will tell you, out of my experience of dealing with management justifications, that any manager who justifies what he or she is doing by mentioning disgruntled former employees as malcontents, any person who does that is automatically suspect in my mind. That is, we have heard again and again from employees from this institution over a long period of time of problems. To say that there is one malcontent is completely dismissive and not understanding of the problem and, in my mind, is, a prime example of bad management. If you are not taking your employees seriously, if you are blaming somebody's objections on somebody's personality or their problems, you are not a good manager. In fact, you left out, by the way, in your oral testimony your justification on the canteen that you don't have any supervisor direction. That is not what people have told me your powers are as a medical director. You have direct control over the canteen, as every other place in the institution.

Mr. DORAN. I don't know who said that, but I don't have direct control over the canteen.

Mr. FILNER. You cannot, if you wanted changes in there, you could not order them?

Mr. DORAN. No, I could not.

Mr. FILNER. Well, I find that at odds——

Mr. DORAN. That is true in any VA hospital you are in.

Mr. FILNER. Well, we will hear other testimony about that. I have asked people, and nobody, nobody agrees with your assessment of your own power there.

In any case, you don't need to respond. The vocabulary used and the tone you use to defend yourself makes your testimony suspect in my eyes and it is contradictory to everything that we have heard over the years about problems here. So I will tell you if you had to have me vote on who I was going to believe here, I would vote

for the employees on the first line and I would have to say, you, sir, are the weakest link.

Mr. MORAN. Mr. Boozman.

Mr. BOOZMAN. I really don't have any questions except that, Ms. Grewe, I also was a little bit concerned in reading your testimony about perhaps some people think this was a ploy to find a reason to shut down the—again the VA here. Again, I would like also, as Chairman Moran indicated, to say that the purpose of my visit here is to, you know, to help the situation, and I am totally committed to the, you know, the Kansas City VA and its continuance, and just want to make it get better. Hopefully we can, you know, ascertain some useful material that would not only help this hospital, but the rest of the others in the rest of the country.

Mr. MORAN. Ms. McCarthy.

Ms. MCCARTHY. I will be very brief. Ms. Grewe, I want to visit with you a little bit more about the 11-cent-a-mile reimbursement, find out historically why it is trapped at that level for our veterans. I would like to visit with you on the 7422 collective bargaining statute and find out why that is unique to the VHA.

And Director Doran, I had the pleasure of getting to know you while I got to know the Congress, and I think you have done a terrific job at this institution, and I think that what we are trying to get about is how to prevent such things in the future in any veterans' hospital. So I just wanted my colleagues to know that as we toured today and saw some of the new improvements and things that it was under your leadership that much of that was instituted, and I was honored to work with you to get the funding from the Federal Government to make some of that possible.

I want to thank the whole panel because have you really enlightened us, and we are pressed on our time, so I will visit with you individually when we break on those other matters.

Thank you, Mr. Chairman.

Mr. MORAN. Thank you all very much. I thank the panel for your time. We are glad to be with you and appreciate you taking the time to educate us today.

Our third and final panel consists of Dr. Robert Roswell, who is the Under Secretary for Health at the VA Central Office in our Nation's capital, along with Mr. Kent Hill, the current, relatively new director of this medical center, and we are delighted to have the Under Secretary with us. He follows in the footsteps of his boss who was here not too long ago and we appreciate the attention that the Central Office is playing in Kansas City. Dr. Roswell, you may begin.

STATEMENTS OF ROBERT H. ROSWELL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS, AND KENT HILL, DIRECTOR, VA MEDICAL CENTER, KANSAS CITY, MO

STATEMENT OF ROBERT H. ROSWELL, M.D.

Dr. ROSWELL. Thank you, Mr. Chairman. Let me begin by thanking all of the members, Dr. Filner, Dr. Boozman, Ms. McCarthy, for being here. This is a unique field hearing in my personal experience to see it so well attended by members who clearly have a very

strong desire for the welfare of veterans. And as I have had the opportunity to sit in this hearing room this morning and listen to the witnesses, I think to a person each witness and each member in their own way shares a burning and compassionate desire for the same thing and that is to better serve our veterans. And to that extent, it is rewarding, it is gratifying, it is reassuring to me to see that level of commitment to America's veterans.

Certainly it is a commitment I share. I have spent 20 years in the VA. I have been a chief of staff in three medical centers. I have been on the faculty of four medical schools. I have spent the overwhelming majority of my career in direct patient care and working with medical schools, working in the field. And I think I know some of the frustrations that occur in the field.

It was only about 2-and-a-half months ago that I was privileged to be confirmed as the Under Secretary for Health. But I wanted to deviate there from my testimony for just a moment and share with you some of the issues that are being addressed.

We heard Ms. Tillman speak of nursing, and I share her concern for nursing. One of the things I have already done is to realign the nursing service in the VA Central Office so that it reports not through the patient care services but directly to my office to make sure that our commitment to nursing, to expanding the nursing profession and the practice opportunities in VA continues to expand. We have just completed a very extensive call for action that addresses a large number of initiatives to expand the nursing professional practice in VA as well as recruitment, improving and enhancing pay and benefits. And many of the things you spoke of, Ms. Tillman, are included, including the tuition reimbursement and benefits.

Someone spoke of a strained relationship with America's medical schools. There clearly are problems with America's medical schools that in many respects are similar to VA's, and at a time when challenges are great, I have reached out to renew our commitment to America's medical schools. I have met with Dr. Jordan Cohen, the President of the Association of American Medical Colleges, on several occasions since my confirmation. I have re-established a meeting with the Council of Deans of America's medical schools and am working aggressively with them to make sure that those relationships, which in large measure are responsible for the quality of health care in the VA are still continued and enhanced.

We heard about our medical record documentation. The computerized patient record system, Dr. Boozman, in fact requires less documentation and it is actually designed to enhance the documentation effort by automating it. It is a unique application which has been cited by the Smithsonian Institute and others as an outstanding records system and at the very cutting edge. But not only——

Mr. FILNER. Could you tell us how many minutes would be required by a doctor for each visit with that system?

Dr. ROSWELL. Unfortunately, Dr. Filner, I can't do that because it depends upon the type of encounter. The lengthy type of things we heard about are typically with the new patient registration. It also depends upon how clinical reminders are applied in that. But the computerized patient record system allows us to capture docu-

mentation and share it at virtually all locations of care in our medical system and do that expediently. And while I have worked personally and directly with many clinicians, many nursing staff who have opposed the implementation of the computerized patient records system, almost to a person after they have had an opportunity to experience it, they have said that it really has enhanced their ability to provide high quality care.

Many of our performance measures are captured through the computerized patient record system. While the format we use for evaluation of senior executives is a simple "check the box," that is because that is the standardized government format for senior executives. However, behind that we have an extensive performance measurement system with literally dozens of measures, all of which are verifiable and documentable. We have quarterly performance measures reviews for every VISN director who in turn passes that on to each medical center director across a whole array of performance issues. And it will be my pleasure after this hearing to share with you that performance measurement system. In fact, I would be delighted to send you a complete quarterly report four times a year showing how the performance is being measured throughout the system.

There was some talk about labor management. And I would point out with all due respect to Ms. McEwen that you are correct, that section 7421 of title 38, which is the professional employment statute for VA, not the title 5, does preclude that, but it never, ever precludes nursing leadership talking with clinical leadership, talking with medical center leadership. And while I deeply regard and respect your advocacy for the professional members of your union you represent, I would still strongly encourage you to make sure that your communication with Mr. Hill is open, as I know it will be. Thank you.

Mr. Baldwin talked about some issues behind the walls. There is no question that we have extensive problems. We have made available $10 million for this medical center and it may not be sufficient to meet all the needs. Just last week I had authorized the expenditure of an additional $5.7 million to do an engineering evaluation of 18 VA medical centers around the country who share similar electrical distribution problems and infrastructure problems with plumbing because of their advanced age, and this medical center is one of those 18. So there are some significant issues. But it is, as I said, it is rewarding for me to see the almost universal commitment to serving veterans. And while we may not all agree upon the specifics or the facts of the testimony, it is hard to refute the fact that we are all committed to providing that care.

I would like to share with you several actions that the Secretary and my office have taken to assure that this situation that occurred in this medical center does not occur elsewhere in the VA health care system.

First, we have asked all facilities to review their physical plants, the cleanliness of their facilities, and their pest control programs, and certify in writing that they are being properly maintained. The certification has been concurred on in writing by each network director or each of the VISN directors.

I have asked all facilities to assure that their senior leaders are conducting regular weekly environmental rounds and that they have mechanisms in place for rapidly addressing issues and environmental deficiencies when they are noted.

I have also asked network directors to conduct environmental rounds at each facility when they visit to assure that local managers are indeed attending to these issues.

Further, I am incorporating the expectation of maintaining facilities into the performance measures that I spoke of for network and facility directors this coming year.

Finally, I have asked the VHA Office of Performance to closely monitor and trend all reports from accrediting bodies, review groups, including our own inspector general, and others to track what actions are taken to correct deficiencies.

The senior staff in my office will review these reports frequently and provide appropriate counseling and follow-up with managers having accountability for remedial activities.

Secretary Principi, in a personal discussion with all VHA network managers and through follow-up correspondence, has made it clear that managers will be held personally accountable for correcting deficiencies in their facilities when they are noted and where they are under their control.

I also feel it is important to hold managers accountable for maintaining their facilities. In recognition of the gravity of this situation and the potential for the new information to arise during today's hearing, the department has deferred initiating action regarding top management officials until the hearing proceedings are completed.

In summary, the cleanliness environment for care was allowed to deteriorate unacceptably at the Kansas City VA Medical Center over the past several years. An aggressive action plan has been developed and I am convinced that this plan will bring the facility back to a superior level of cleanliness. I have full confidence in the leadership Mr. Hill brings to the facility and know that he and his team will work tirelessly to complete corrective actions and maintain the cleanliness of this facility in the future. I am particularly pleased that the quality of care has been high at the Kansas City VA Medical Center and I am confident that it will remain high.

It is my honor to serve the veterans in this community. They deserve nothing less than a facility that provides the highest quality of care.

And in closing, I appreciate your commitment to veterans by your presence here today.

[The prepared statement of Dr. Roswell appears on p. 76.]

Mr. MORAN. Mr. Secretary, thank you very much. I appreciate your testimony. We will have a few questions for you.

The next witness is Kent Hill. Congresswoman McCarthy indicated her knowledge and good working relationship with Mr. Doran. I don't know Mr. Doran, but I do know Mr. Hill. He comes to Kansas City from Wichita. I appreciate the strong working relationship that I had with you and I wish you well in your assignment here. And I am grateful that you are here to testify and to tell us what has transpired since your arrival.

STATEMENT OF KENT HILL

Mr. HILL. Thank you, Mr. Chairman and members of the subcommittee, and Congresswoman McCarthy. Thank you for the opportunity to bring you up to date on some of the specific accomplishments that we have had to date, and plans for further corrections of the deficiencies at the medical center. I will provide you with some information on immediate actions taken on items identified by the inspector general's office and on some of the long-range goals for maintaining the facility into the future.

Although the Kansas City Medical Center leadership had in the weeks just before the Archives of Internal Medicine article begun to review and slowly phase in measures to correct housekeeping and maintenance deficiencies, the articles and the subsequent inspector general audit brought national attention to the environmental problems and required the medical center to expedite its plans on corrective actions.

Indeed, as the 21-member inspector general team conducted its environment-of-care audit and provide almost daily feedback on its findings, medical center personnel promptly corrected those that it could, while formulating written plans to accelerate the rebuilding of a housekeeping and maintenance infrastructure.

Most of the environmental problems reported by the IG fell into one of several categories: First, an overall lack of cleanliness, 2.) failure to maintain equipment, furniture, utilities, hospital services, and lastly, inadequate pest control.

The correction of these problems with so many facets required expertise and a thoughtfully designed plan. However, until the plan could be completed, interim steps were taken. Specifically, we worked a lot of overtime using medical center personnel. We also detailed housekeeping personnel from the eastern Kansas facility to help us. A very seasoned environmental care manager was also detailed from eastern Kansas. He brought the expertise we needed to direct the additional personnel and to help us begin developing a long-range plan. Additional housekeeping equipment was purchased immediately. Recruitment of our temporary housekeeping personnel was initiated until we could get the permanent staff on board.

The environmental care manager initiated a systematic training effort to increase the existing staff skills. The pest control contract wasn't adequate, and action to acquire a more effective contract had already been done. The medical center accelerated efforts to hire a nationally recognized company that would respond to us immediately. The new contract also required the contractor to keep and report performance data to monitor the effectiveness of his treatments. The policy was changed to require more participation of facility management to include the union representatives and provide for a mechanism for following up on deficiencies. Employee food storage policies have been redeveloped and implemented, and confusion between the medical center and canteen personnel over responsibilities for housekeeping duties has been eliminated by the development of a memorandum of understanding between the canteen and the hospital. This memo clearly delineates the lines of responsibility. It calls for regular inspection of all canteen areas and establishes penalties for noncompliance. The supply and processing

distribution area, SPD, where many of the medical center's supplies and instruments are sterilized, was cited by the IG for poor maintenance, cleanliness, and inadequate support and space. While a long-range solution to this problem is a new SPD, a contract for which we are currently negotiating, immediate corrective actions had been taken and cleanable surfaces have been installed, ceilings repaired, and professional duct work cleaning initiated.

The inspector general audit reported that the wall covering located throughout the facility was poorly maintained, it was dark, it had a potential for harboring dust and dirt particles. The medical center had already recognized this problem and had begun a systematic removal of the material and upgraded treatment areas over a period of years through its recurring maintenance program. Nevertheless, the IG findings elevated the urgency of this work and immediate steps were taken to finish upgrading treatment areas. Non-recurring maintenance contracts to remove the material and repair and upgrade ceilings and floors will be awarded this and next calendar year. Until then, a DOD contract for labor was utilized to remove sisal in several clinics and wards and install bright wall surfaces and adjust hall lighting. The results are very remarkable and give some indication of what the facility will look like when the contracts are completed.

The medical center has had no interior design plan to help select appropriate clinical furniture, wall coverings or wall services. An interior designer was brought from Eastern Kansas Medical Center to help us assess and correct the most acute problems. Replacement furniture for many of the waiting areas has been ordered. Floor coverings designed for high traffic use are now in place. The contract to replace insect screens on all exterior stairwells has been awarded and a window-washing project has begun.

Other contracting activities have been initiated to renovate some of the public restrooms, seal the building exterior, replace leaking roofs, correct and find deficiencies in the emergency room involving patient privacy, and upgrade or replace worn floors and cabinetry.

The corrections I have mentioned so far will, when completed, bring the facility and its environment up to an exceptional level of cleanliness and maintenance. However, we are establishing an organizational structure that will sustain these improvements over time. Our plans call for re-establishing an appropriate number of permanent personnel in housekeeping and engineering, providing a supervisory structure operating under a formal environmental management program. This will include communication of expectations and training and monitoring and feedback. Open communication with our union partners and employees at all levels is critical to the ongoing success of this plan.

In summary, the Kansas City Medical Center is in the middle of an environmental improvement plan that will bring the facility back to a high level of cleanliness and maintenance. You have heard about the quality of care offered and the superior efforts of those who provide it. It is an honor for me to work with the outstanding staff here and to serve the veterans of our community.

Thank you.

[The prepared statement of Mr. Hill appears on p. 80.]

Mr. MORAN. Mr. Hill, thank you very much.

Mr. Secretary, let me first give you the opportunity to belie any fears that anyone may have about the future of the Kansas City Medical Center. Would you describe the VA's commitment to the hospital here?

Dr. ROSWELL. There is no question that the VA has a strong commitment to making sure that the health care needs of veterans of the Kansas City area are met both now and in the future. The department is going through a capital asset realignment process to evaluate all of our infrastructure to identify the best utilization of that infrastructure, both today and to meet the veterans' needs into the next several decades. And that process will evaluate the physical infrastructure of all facilities and determine their best utilization. But I think it is safe to say, given the large number of veterans who are served throughout the Greater Metropolitan area and the long and distinguished track record of outstanding quality care delivery at this facility, that the future outlook for this medical center is very, very positive.

Mr. FILNER. Dr. Roswell, I had a conversation when you first took over and I said you are known as a straight-talking, clear-thinking person. I hope that the bureaucracy doesn't incorporate you into its thinking, and I just want to you review the comments from the transcript of what you just said.

Dr. ROSWELL. Let me——

Mr. FILNER. That is exactly what I feared. So please read it.

Dr. ROSWELL. Let me display the candor that Bob Roswell would like to display. Secretary Principi has asked that departmental officials not make any pronouncements about the outcome of the CARES process. The CARES process will examine every single facility in our inventory, and because it will be examining hospitals that could be closed or more likely be converted to outpatient facilities, Secretary Principi has asked all members of the department, including myself, not to publicly speculate on the outcomes of the CARES process. So respecting the Secretary's wishes, I was admittedly a bit evasive, but I hope you understand why.

If you ask me, clearly this is a medical center. It is a tertiary medical center that serves a very large number of patients. It would be difficult for me to even imagine a CARES process that would recommend closing this facility.

Mr. FILNER. But this whole problem that was raised, you will agree with all of us, is not a ploy to close this system.

Dr. ROSWELL. No, it is really not, Dr. Filner. I mean,as I said, I am trying to honor the Secretary's guidance. You know, this is an unfortunate situation. It is something that we can learn from, that we have learned from. And I appreciate the committee's interest in it. But there is no intent in any form or fashion to use this as justification to close a medical center. In fact, just the opposite, this is an opportunity to allow us to expedite the renovation and enhancements of the environment of care of this very important medical center.

Mr. MORAN. Dr. Roswell, why does it take the publication of the circumstances about the sanitation of this hospital to get the attention that this facility needs to improve its circumstances? One of the things that Mr. Doran said that struck me: "if I only had $10

million." What is it about a system that requires a publication of a significant problem to direct the resources where they need to go?

Dr. ROSWELL. It is a very complex answer, Mr. Chairman. I think what we are dealing with is a situation where there were competing priorities, limited resources, ineffectual communication between various levels of management, and less than ideal monitoring. And I think in each of those areas, we are looking at this situation to make improvements.

Mr. MORAN. What was the awareness at the central VA office about the problems of sanitation and cleanliness here at the hospital over the last several years, say from 1996, 1997, on?

Dr. ROSWELL. And please understand I can't speak prior to April of this year when I was confirmed, but to my knowledge, there was not ongoing communication from the field that there were significant problems with sanitation.

Mr. MORAN. As you look at your files, there are no reports coming from this hospital, from this VISN to the Central Office, saying we have got a serious problem here?

Dr. ROSWELL. Not from the hospital, not from the VISN. There were, in fairness, deficiencies identified through the Office of Inspector General's combined assessment program or CAP survey. In fairness, they were pointed out. But there was also a follow-up action plan which appeared to have indicated that those problems had or were being resolved.

Mr. MORAN. Mr. Hill, I read earlier from the inspector general's report that actions taken by management were concentrated on addressing specific cleaning and pest conditions, and not on organizational failures that permitted the problems to exist. Please tell me that we are not simply addressing specific instances, but we are putting in place a process by which these instances don't reoccur. We are not just crisis-managing. Is that true?

Mr. HILL. That is true.

Mr. MORAN. Anything else? Actually you are helping me conclude this meeting on time, so I ought to take advantage of your brevity.

Mr. HILL. As I was saying, we really think that in the short term we want to get some things done, and we went ahead and we are fixing some of those specific things, but we really feel the long-term solution is in re-establishing an organizational structure which will support the maintenance of the facility over time.

Mr. MORAN. Dr. Roswell, Dr. Klotz' testimony mentioned five recommendations. I don't expect you to respond to those today, but I would welcome the department's response to each one of those five suggestions. Your thoughts about what the VA is and isn't doing to address those areas.

Mr. MORAN. You mentioned the university relationships. I think there is a number of things that this subcommittee ought to be paying attention to as outlined by Dr. Klotz, and I would like to have the department's response to his suggestions.

Dr. ROSWELL. We will certainly do that. It is distressing to me that Dr. Klotz spoke of the need to share the information, and, yet, despite repeated requests he was not willing to share his testimony prior to the hearing today. So I had no opportunity to review his testimony. As all, of course, as you know, executive branch employees, our testimonies are required to be cleared before they are sub-

mitted. But I found it confusing. I mean table one in his testimony, as I looked at it, shows that in fact the level of direct patient care employees is virtually identical to where it was in 1996. So I don't know the interpretation. We have actually improved the number of the percentage of employees in direct patient care results or roles as a result of performance measurement system.

Mr. MORAN. Well, despite the fact that you hadn't seen the doctor's testimony before today, you and I will be around for a while longer, and we can spend some time working our way through those recommendations. I would look forward to that opportunity.

Mr. Filner has already utilized most of my time, so we will go to Mr. Boozman.

Mr. BOOZMAN. I have just got a couple things. I kind of see a thing that goes through this a little bit with a few things. One thing I am concerned about, it was started with Mr. Slachta's testimony, was that the hospital received really good ratings despite the fact that I think everybody that has testified agreed that, you know, statements were made it was filthy, others said it wasn't clean. So everybody has agreed. How do you go about designing a system where the ratings really do reflect the total picture? Evidently if you get almost a perfect rating, you know, how do you fix it where you can't go in and do these things when the investigators get here and then leave? Some of the major food chains and things, with theirs, they will do unexpected things. It is almost like we could learn from some of these other agencies that do a good job. But I would like to see that, you know, if the patients, if Congress, if you see a rating that there should be some correlation——

Dr. ROSWELL. The point is an excellent one. The Joint Commission on Accreditation of Health Care Organization visits each of our medical centers every 3 years and, as has been pointed out very convincingly in this hearing today, you can prepare for that triennial visit, throw resources at a cleanliness problem and achieve very good results. What wasn't made clear is that the joint commission also has unannounced visits periodically throughout the 3-year interim between visits. And that is another opportunity for a condition of what we call the standard for environment of care to come to light through the joint commission process.

Mr. BOOZMAN. Are those published?

Dr. ROSWELL. They are available, yes, they are discoverable. I know the joint commission maintains a web site. They are available, yes. As I pointed out, we have not actually put environment of care per se as a performance measure in the director's performance measurement system, but that is a change that we will be making, as I have indicated.

Mr. BOOZMAN. The other concern I had was that again there doesn't seem to be any real sense of responsibility. Even Mr. Baldwin, you know, he said that he went to his supervisor, he said it is the VISN's fault, the VISN said it is the local issue. And the inspector general's report, you know, the VISN didn't want to take responsibility, saying this was a day-to-day thing, that they didn't have jurisdiction over that. It seems like that needs to get sorted out, that, you know, who is responsible for what. Again, I don't know that argument at all to be honest.

Dr. ROSWELL. I found it a bit circular myself. Again, as I said, the opportunity to be here and listen has been extremely helpful for me this morning. I would go back to the labor management relations that were alluded to. Strong labor management relations, in my opinion, through a management assistant council or a partnership council are an absolutely essential way to make sure that we have effective communication. And that is something that we will be looking into. Because that seems to have broken down here.

Mr. BOOZMAN. The last thing, as Chairman Moran indicated, I also would be interested especially about the role of the chiefs of staff, you know, if you would comment at some point in written whatever, you know, if the role of the chief of staff is broken down in this. Perhaps we have gone too far the other way where we don't have a good advocate for the doctors and nurses.

Dr. ROSWELL. I found that puzzling. I don't know that the doctor has served as a chief of staff. I have actually served as a chief of staff at three facilities. The chief of staff does report to the medical center director. It is not a co-equal relationship. The chief of staff is employed and responsible to the director of the medical center. That is the way it is. That is the way it is organized. But as the chief of staff, you have the accountability, you have the responsibilities to relay the status of clinical care, the support of clinical care to the medical center director. I have never ever in three different institutions where I have served in that role found that difficult. It is not to say that I didn't have disagreements, but I was able to air those disagreements. That is a responsibility of that office. I don't see that it is broken.

Mr. BOOZMAN. I guess that is my question, as time has evolved over the last few years if that has changed any. And is that more—is that the individual hospital, do they determine the role of the chief of staff?

Dr. ROSWELL. It is possible that there is some variation in how the chief of staff office is utilized or functions. But I think in reality the most significant variable is the personality of the individual who serves in that role.

Mr. BOOZMAN. Thank you.

Mr. MORAN. Because I have to ride on a plane with you, Dr. Filner, we will allow you to ask additional questions. Dr. Filner.

Mr. FILNER. Thank you, Mr. Chairman. I think we all agreed and are impressed with the specific changes that have occurred here. We can all assure the patients in this area that they are going to get quality care in a sanitary facility. We all can agree with that. What I hope that we can talk about in the future is some of the systemic problems that seem to be evident. And I hope, Mr. Hill, that when you have heard the employees feel that they have not been heard, and you have indicated in your testimony that you have already institutionalized ways that they can be heard, I hope you continue down that path and institutionalize the methods. If people perceive they are not heard, then they are not heard. And you have to figure out a way that there are no disgruntled malcontents in the system. You have to listen. They may not always be right. You may not have the resources to do it. But a dialogue and communication deals with those things. So it seems to me that you are moving in that direction.

I think Dr. Roswell has bigger systemic things to think about. In your written testimony you pointed out a number of deficiencies here. It seems to me you need to be looking at how we didn't know about this earlier. You said just a minute ago the communication seems to have broken down here. I think you better think that the communication is broken down everywhere, just assume that for a minute, and begin to take the steps to make sure that that is not the case.

You talk about the IG's investigations. It seems to me this is potentially everywhere the same situation. And we have to institutionalize those kinds of evaluations of our facilities.

Dr. ROSWELL. You are absolutely right, Dr. Filner. I agree with you. We have actually made changes to include those types of measures in the performance measurement system. We are restructuring the governance of the 21 VISNs in a way that will provide a broader oversight and more detailed day-to-day communication facilities. And I would be happy to discuss those at some point.

Mr. FILNER. I hope Dr. Klotz' testimony is not overlooked. I don't want to compare it to Ms. Rowley's cry for help from the Minneapolis division of the FBI to the Central Office that was not heard. It was not heard. And we had tragedy that may have resulted from the lack of being heard. I think you ought to take these kinds of things very seriously. I sensed in your tone of voice you may not have, but I hope you do. I hope that the systemic issues here are addressed. The chairman had asked for a response. I don't necessarily want a response because I would like to see some dialogue. I would like to see some debate. I said I would like to see them on the same panel. Maybe in Washington we could do that. We ask questions, you give us back answers. I find that very unfulfilling. You already have convinced me you are a master at the bureaucratic language. I would like to hear it, you know, in English, us talking together.

Again, we are not trying to prosecute anybody, we are trying to come to an understanding of the issues here. Maybe we could have a dialogue in private or public about these kinds of issues.

I have received communications from other doctors and other union people and other employees about similar issues. I have found that Dr. Klotz' way of putting it synthesized a whole lot of things that I had heard, which leads me to think it has some merit. Because rather than take an individual thing in Kansas City or in San Diego or Chicago, he seems to be talking about a whole pattern. I hope we take it seriously and look at them. He could be wrong, but he may be right. And I think you ought to sponsor a nationwide dialogue about this, put his thing on your Internet, on your web, and see what other people say. I think it is worth a systemwide discussion maybe in the way we haven't done before. And all the specific problems at Kansas City may help us make the whole system better for our veterans.

Mr. MORAN. Under the theory that no member of Congress ever has the last word, the potential last word is the local Congresswoman, Ms. McCarthy.

Ms. MCCARTHY. I will be brief, Mr. Chairman. I want to thank you for inspiring this session and thank your committee staff for the efforts to put together terrific panels and experts for us. While

I am not on the subcommittee, I would like to work with the subcommittee as you do the follow-up on the issues raised here today. And, in particular, you know, there are other VA facilities 50 years old, like this one. They are going to need maintenance funds to upgrade. We have heard from the witnesses that it is possible these kinds of things could happen there. Given the current fiscal situation, Mr. Secretary, I hope we can—I am very happy for that $10 million. This is great. It will help a great deal. But I think we ought to all be very realistic, too, about the other needs out there in our country and just come to grips with how to do some of the upgrading and wonderful things that Mr. Hill is accomplishing right here in Kansas City. I would like to work with you on that.

Mr. Hill, I am very heartened by what I learned here today in this conversation. I very much appreciate your emphasis on sustaining these changes, these improvements over time. I look forward to working with you and to come back as often as I can to visit with you and see what more I can be doing in my role.

Thank you, Mr. Chairman, for including me in this very, very informative session.

Mr. MORAN. Thank you so much for joining us. Proving the theory is correct, Mr. Filner has asked for an additional moment.

Mr. FILNER. I want to ask for some reassurance, Dr. Roswell. I hope it is not the same answer that you gave to the Chairman when he asked for reassurance about the medical center here.

There was a statement made earlier that—I may have this wrong, Dr. Klotz, that someone in the VISN said Klotz ain't going anywhere. Could you assure us that there will be no retaliation, for his testimony here or any testimony that we have had today?

Dr. ROSWELL. No.

Mr. FILNER. You are not going to assure us?

Dr. ROSWELL. I said no, there will be no retaliation. I don't know where that statement came from, but it certainly is not the kind of behavior nor the kind of statement that any of us could condone. I can assure you that you won't see retaliation.

Mr. MORAN. It is my understanding that Dr. Klotz is not here as an employee of the VA, he is a part-time physician with the VA in Arizona. He is here as a private citizen, as a university professor, and we are delighted that you took the time to join us in Kansas City. I don't think the article that you published ever mentioned the hospital. In fact, I know it didn't ever focus the attention upon Kansas City or the VA. So the committee and I really appreciate the opportunity we have had to be together this morning to garner some information, gain an understanding, hopefully reassure our veterans and citizens in the Kansas City area about the importance of this hospital, our care and concern for its staff, its employees, its administration management, and that we have the opportunity to do things as Members of Congress, as policymakers, that make good things happen for our veterans and for this community. I have just become the Chairman recently of this subcommittee and look forward to continued efforts.

Again I appreciate the relationship that I have developed with Mr. Hill and wish him well here in Kansas City. Patricia Crosetti and Matt Kelly, I had a good working relationship with them in their roles in covering the State of Kansas, and I appreciate the

chance to get acquainted with people who care a lot about our veterans. This is a great committee assignment, a great opportunity to try to do something good for other people. We are particularly grateful to the VISN Director Norby and Ms. Greer and their staffs for all of the arrangements that were made today for our committee to be here and help us prepare for this hearing.

There are a number of people who have submitted written testimony. Without objection, their written testimony will be made a part of our record. This record will remain open for 5 days. If anyone else would like to submit written testimony to the committee, they may do so.

Our record will remain open for written testimony and I just encourage people that have concerns here at the hospital to talk to their elected officials and others. And we try to take these comments and concerns very seriously. Again, this is about the future. And we look forward to doing the things necessary to provide a bright future for Kansas City VA Medical Center, and this hearing has gone a long way toward educating us in that regard. And I very much appreciate the time and attention you provided, and our subcommittee meeting is adjourned.

[Whereupon, the subcommittee was adjourned.]

APPENDIX

Honorable Jerry Moran - Chairman, Subcommittee on Health
Committee on Veterans' Affairs
Hearing on Cleanliness and Management Practices at the Kansas City VA Medical Center
June 17, 2002

This Committee is the jurisdictional committee in the Congress for the Department of Veterans Affairs (VA) health care system, a nationwide system of 1,200 clinics, hospitals, nursing homes and other health care facilities that provide care for nearly 6 million veterans, with 185,000 employees and a budget of $22 billion in 2002.

This Committee authorizes programs and facilities with legislation, holds public hearings and meetings and carries out other activities, including investigations. This work is done to ensure that the Department of Veterans Affairs fulfills its mission of providing appropriate, safe and decent health care to eligible veterans of service in our armed forces. The Committee holds an important responsibility, and let me assure all present today that it is a serious and sobering responsibility for all our Members.

My primary interest in holding this hearing at the Kansas City Veterans Medical Center is to focus on veterans and ensuring quality care in the future, rather than on any event in the past. The desire of this Subcommittee is to reassure veterans and others involved at the Medical Center that this Subcommittee of Congress is monitoring this situation to see that the care that veterans receive is not compromised.

I also believe we can learn lessons from this hearing that will prevent any recurrence of these problems at this Medical Center, and may well avoid this kind of problem from occurring elsewhere in the VA health care system. This is our goal and the veterans of our Nation deserve no less.

Congressman Jerry Moran
Hearing on Cleanliness and Management Practices
at the Kansas City VA Medical Center June 17, 2002

We welcome the witnesses and others in attendance today. I thank Subcommittee Ranking Democrat Member Bob Filner of California for his assistance and presence today. Also, our colleague, the Honorable John Boozman of Arkansas. I'd also like to welcome my friend and local Congresswoman, the Honorable Karen McCarthy of Missouri for attending this hearing. The presence of my colleagues enable this Committee to review a series of recent events at the Kansas City Veterans Medical Center.

The origin of this hearing occurred in late March of this year on publication of an article in the Archives of Internal Medicine, entitled: "Nasal Myiasis in an Intensive Care Unit Linked to Hospital-Wide Mouse Infestation." While my medical knowledge may limit my understanding of "nasal myiasis," I clearly understand the realities of a mouse infestation.

The author's hypothesis linked the chronic presence of house mice in this Medical Center, and efforts to rid them, to an infestation of flies, and the subsequent discovery of nasal myiasis in two medical intensive care unit patients. The article reviewed a number of actions taken to remedy these problems, but left an impression that management did not sufficiently act to eliminate them. Also, it has been suggested that funds were not sufficient to enable the Medical Center to cope with this pest infestation while meeting all its other responsibilities in delivering patient care to veterans.

The Secretary of Veterans Affairs, Anthony Principi, has acted swiftly to make changes at the Medical Center and the network level. The Secretary initiated two investigations in response to VA's realization that some of these conditions existed for years prior to publication of the article and reassigned management pending the outcome of these investigations.

The investigations were completed and reports compiled earlier this month. Today's hearing will consider these investigative reports. We will receive testimony from the primary author of the Archives article; the chief VA investigator; the former chief executive of this Medical Center; representatives of Medical Center employees; the facility's patient advocate; VA's top health care official; and the current chief executive of this facility.

I look forward to hearing their testimony, to asking questions of those involved, and to working together to ensure that quality medical care is provided to our veterans.

STATEMENT FOR THE RECORD
SUBMITTED BY SENATOR CHRISTOPHER S. BOND
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
HEARING ON KANSAS CITY VAMC
JUNE 17, 2002

Thank you, Chairman Moran for holding this important hearing at the Kansas City Veterans Affairs Medical Center. I personally applaud you for your leadership on veterans issues and for your dedication and hard work in addressing the important needs of our veterans in Kansas and Missouri. I am especially thankful for your work in resolving the terrible problems identified at the Kansas City VA Medical Center. As you know, I have been following the problems surrounding this facility and appreciate your efforts in ensuring that these problems do not happen again in Kansas City or any other VA facility across our Nation.

As the former Chairman and now, Ranking Member of the Senate VA-HUD Appropriations Subcommittee, it has been one of my top priorities to improve the quality of health care received by our nation's veterans.

That is why in the wake of the disturbing reports of the conditions at the Kansas City Veterans Hospital, I formally requested a thorough review by the VA Inspector General. Unsanitary conditions at any VA facility are simply unacceptable.

When the Archives of Internal Medicine medical journal report was made public, some within the VA said the sanitary conditions that led to the situation where resolved. We now know that those statements were not accurate! Not only where those statements inaccurate, they were not in the best interest of the patients this hospital serves.

Secretary Anthony Principi is taking action and I applaud his responsiveness. His leadership and decisiveness is sending the right message: our veterans deserve the highest quality care.

On a recent visit to the hospital, I witnessed first-hand the upgrades being made to assure our veterans received the highest quality of care, in a clean, well maintained hospital. The Kansas City VA leadership outlined the new sanitation procedures, and the new canteen agreement. Additionally, I personally spoke to the quality control director, who now has the authority to shut down any part of the hospital if it does not meet sanitary requirements.

It is clear that we have some serious work to do, but we must do this together. Under the hospital's new leadership of Mr. Norby and Mr. Hill, the VA has made great strides in a short period of time. We are working with veterans, the staff of the hospital, and Secretary Principi and his able staff at the Department of Veterans Affairs to restore the confidence of our veteran population in our VA facilities and to ensure that safeguards are in place to guarantee that our veterans receive the highest standard of care. Our veterans deserve nothing less.

VA MEDICAL CENTER KANSAS CITY

TESTIMONY OF

Michael Slachta, Jr.

ASSISTANT INSPECTOR GENERAL
FOR AUDITING
OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

June 17, 2002

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to report on the results of our review of the Kansas City VA Medical Center (KCVAMC). At the request of the Secretary of Veterans Affairs, the Office of Inspector General (OIG) conducted a review to determine if: (i) significant deficiencies existed in the sanitary conditions at the medical center, (ii) any deficiencies found had an effect on the quality and outcomes of medical care for patients treated, and (iii) corrective actions were taken to implement the recommendations made in our report of the Combined Assessment Program (CAP) Review of the Kansas City VA Medical Center, dated January 2, 2002.

We conducted our onsite review from April 1st through April 10, 2002 and our report (Report on Medical Center Sanitation and Follow-up of the Combined Assessment Program Review, Kansas City VA Medical Center) presents our analysis of the medical center's Environment of Care and the progress made by the medical center in implementing our prior CAP recommendations. The appendices to the report, provide further explanation of the internal and external reviews performed at the medical center over the past 5 years, an analysis of the quality of care as it relates to the reported pest infestations and infection control, pictures of some of the unsanitary and unsafe conditions found during our review, and finally VA's management's responses to our recommendations. A Report of Administrative Investigation, (Leadership Issues Relating To Cleanliness and Sanitation Conditions, Kansas City VA Medical Center and VISN 15, Kansas City, Missouri) was also completed and presents our finding that the housekeeping deficiencies at the medical center were a result of the prior Director's decision to give funding priority to construction projects and staffing needs that more directly related to quality of care and patient satisfaction rather than to housekeeping.

Environment of Care

KCVAMC management did not maintain the medical center at appropriate levels of cleanliness or rid the medical center of pests. The unclean conditions date back to at least October 1997; were discussed among medical center management, staff, and patients; and, were well documented in medical center records. Management of the Heartland Veterans Integrated Service Network (VISN 15) was also aware of the poor sanitary conditions and pest control problems at the KCVAMC.

Medical center electronic messages (e-mail) show that KCVAMC management was aware of some insect and rodent infestations dating back to July 1993. E-mail messages describe incidents involving rodents and insects in the Surgical Intensive Care Unit (SICU), operating room (OR), and patient ward areas in 1993, 1994, and 1995. However, reports of filthy clinical areas, fruit flies, gnats, flies, wasps, and rodents began appearing in e-mail messages and committee minutes with more frequency in 1998. These records document discussions of these problems from calendar years 1998 through January 2002 involving the former Medical Center Director, key clinical managers and providers, environmental and infection control managers, and patients.

In October 1997, the medical center received a consultant's report, requested by the Chief of Facilities, that stated the Housekeeping Department was understaffed, needed training for managers and staff, and was not organized to deliver quality service. The consultant found a staffing shortage of approximately 16 Full Time Equivalent Employees (FTEE) existed based upon the number of square feet that needed to be maintained. At the time the consultant's performed the study, medical center records indicated that Housekeeping had 42 FTEE. The consultant's report also recommended that management:

- Restructure job descriptions to meet the staffing objectives of the medical center.
- Establish a Housekeeping equipment preventive maintenance program.
- Hire intermittent employees to provide relief for permanent staff on leave.
- Establish a comprehensive project or periodic program, which provides for preventive maintenance of floors and walls.
- Develop a quality assurance program.
- Provide specific supervisory and staff training on proper cleaning techniques and chemical use.

- Establish supervisory responsibility for functional activities like training and cleaning geographical areas of the medical center.

The consultant's recommendations were not implemented. In fact, staffing in Housekeeping ranged from 42 full-time in April 1997; to a high of 45 full-time, 3 part-time, and 13 intermittent in March 1999; and to a low of 36 full-time, 1 part-time, and 6 intermittent in June 2000. At the time of our review, Housekeeping staffing was reported for March 2002 as 44 full-time, 1 part-time, and 2 intermittent.

In addition, senior managers were advised of cleanliness and pest infestation problems over a number of years. Some examples include:

- July 16, 1998 – The Infection Control Nurse reported that the entire Canteen needed to be "terminally cleaned." The report stated that a complete shut down was needed until all areas of the Canteen were entirely clean. "The dirt build up has been permitted for too long."

- October 16, 1998 – A Quality Improvement Team report identified cleanliness problems in the intensive care units (ICUs), recommended that the responsibilities of Environmental Management Service (EMS) workers and ICU staff regarding the "cleanliness and orderliness" of the units be identified, and noted the need for an ongoing monitoring program to maintain cleanliness and orderliness of the units on a daily basis.

- November 3, 1998 – An Infection Control Committee (ICC) memorandum to the Environment of Care Committee stated that it was evident the EMS was not thoroughly cleaning rooms. In addition, there was an apparent lack of knowledge on the part of EMS staff as to what needed to be cleaned and how. A lack of overall supervision contributed to the confusion on the part of housekeepers as to proper cleaning procedures and there was inadequate staffing of EMS personnel for the ICUs.

- November 9, 1998 – ICC minutes noted the following actions were recommended to the KCVAMC top management: (i) reevaluate/readjust staffing patterns in EMS to include adequate levels, as well as unit-dedicated personnel, to ensure thoroughness and consistency in cleaning of assigned areas; (ii) identify an experienced EMS manager to supervise all housekeeping activities; (iii) establish a detailed schedule of daily, weekly, monthly, quarterly, yearly, etc. cleaning functions; and (iv) provide orientation and recurring training to EMS personnel including training on infection control and other relevant matters.

- January 11, 1999 – The ICC minutes document that the committee recommended that the Nurse Managers be made solely responsible for determining whether a patient room is clean. The committee

recommended training for employees and supervisors as to what "clean" is and proper cleaning procedures.

- August 16, 1999 – ICC minutes reported that the OR just recently had a new infestation of "meat-eating flies."

- August 22, 2001 – A consultation was requested by the Acting Director in order to prepare the medical center for its upcoming JCAHO inspection. A memorandum to the Acting Director from the Manager, Environmental Programs, Salt Lake City VAMC stated that: staffing and equipment shortages prevent their ability to maintain an aesthetically pleasing environment for patients, visitors, and medical personnel. Cleaning procedures and directives were outdated and staff did not understand their duties. Work assignments should be documented, an inventory (of supplies and equipment) should be made, and procedures describing how to perform tasks should be readily available in each work area for staff reference.

- March 28, 2002 – A white paper (for the record, explaining actions taken to pass JCAHO inspection) from the Deputy Network Director, VISN 15 reported, "...The environmental management staff had a number of vacancies which had been frozen for recruitment. I immediately ordered the full recruitment of those positions as a priority for the medical center. It was immediately clear that even with these positions filled it wouldn't be possible to get the medical center up to standard in the time available. I authorized a contract with a cleaning service to concentrate on the large public areas that didn't require special healthcare cleaning techniques for a one time major overhaul. The existing staff was then able to concentrate on those areas requiring special skills and training." In reference to the August 22, 2001, memorandum, the Deputy Network Director stated: "The experienced manager did find that the EMS portion of Facilities was understaffed for a physical plant the size of Kansas City. However, he found that the lack of front line leadership and misallocation of staff by shifts were larger problems than actual numbers of staff."

As the above chronology demonstrates, the actions that the outside consultant recommended in October 1997 continued to be raised for the next 5 years. However, actions taken by management through March 2002 were concentrated on addressing specific cleaning and pest conditions, and not on the organizational failures that permitted the problems to persist.

Infection Control

We found that KCVAMC management had a program for ongoing surveillance for pathogens of medical importance, took specific effective actions to address

infestation issues and outbreaks of disease, and conducted ongoing training directed toward general and specific infectious disease topics. [1]

As a result of ongoing surveillance, two peaks (outbreaks) in the incidence of Methcillin-Resistant *Staphylococcus aureus* (MRSA), Vancomycin-resistant *Enterococcus* (VRE) and *Clostridium difficile* were noted.

The first outbreak of an increase in infectious disease was identified in May and June of 2000 in the SICU and operating suite, as a result of poor aseptic technique. A re-education program on the maintenance of sterile technique for the relevant health care staff brought an end to the outbreak. The second outbreak in March 2001, on a medical ward, was determined to be the result of a breakdown in housekeeping protocol.[2] This outbreak was controlled by a re-education effort aimed at the housekeeping staff and all who came in contact with patients who were on isolation precautions.[3] To further reduce nosocomial infections (diseases contracted in the hospital), in February of 2001, an antiseptic agent was added to soap used in the medical center.[4] In spite of management's actions to improve hand washing, our review found that many soap dispensers were empty.

Quality of Care

KCVAMC clinical management implemented effective controls to monitor the quality of care provided to patients as the controls related to infectious diseases and infection control. We also found that the care provided to the two patients discussed in an article entitled, "Nasal Myiasis in an Intensive Care Unit Linked to Hospital-Wide Mouse Infestation" was adequate, but that the incidents described occurred because of a recurring pest control problem at the facility.

Follow-Up of the
Combined Assessment Program Review

During the review we evaluated management actions taken in response to 13 recommendations made in our January 2002 CAP report. We found that medical center management had implemented recommendations made concerning pharmacy security and contracting for angioplasty procedures. For the remaining 11 areas that were reviewed, we reaffirmed our original recommendation or provided more detailed recommended corrective actions.

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[1] Ongoing surveillance for Methcillin Resistant Staphylococcus Aureus, Clostridium Difficile, Vancomycin-Resistant Enterococcus, and other nosocomial infections is demonstrated in the ICC minutes.
[2] Housekeepers were not changing water and cleaning mop heads before moving on to clean the next patient's room which was under isolation precautions, among other shortcomings in isolation procedures.
[3] Data from the ICC committee and medial staff interviews.
[4] Chlorhexidine Gluconate in the ICUs and soap with Triclosan for other clinical areas

In each case, medical center management and the Assistant Deputy Under Secretary for Health agreed with the recommended action and provided acceptable implementation plans.

Conclusion

We determined that management did not maintain the medical center at appropriate levels of cleanliness or rid the medical center of insects and pests. The unclean conditions date back to at least October 1997; were discussed among medical center management, staff, and patients; and were well documented in medical center records. Management of the Heartland Veterans Integrated Service Network (VISN 15) was also aware of the poor sanitary conditions and pest control at the KCVAMC. These conditions existed because Network and KCVAMC management had not acted aggressively to respond to numerous warnings and incidents brought to their attention for years.

We believe top managers were able to avoid major illnesses at KCVAMC only because of the dedicated efforts of the healthcare team who compensated for the lack of aggressive pest management actions and institutional housekeeping support.

In response to our report the Secretary concurred with our recommendation to ensure that managers are held accountable for the sanitation of the VA Medical Center Kansas City. The Under Secretary for Health has stated that he will closely monitor the implementation of the plan of corrective action developed by the Acting Network Director and Medical Center Director.

This concludes my testimony. I would be pleased to answer any questions that you and the members of the subcommittee may have.

Testimony of Dr. Stephen Klotz

I am pleased to be here this morning to testify before this committee. The issue of the mice and maggots as reported in a recent article is a matter of public record. It is accurate and I hope we will not waste time rehashing the contents of the publication. I was led to believe that this committee wanted to address weightier problems, for example, what events or decisions brought about such a dismal state of affairs. Hence, my interest in appearing.

All of my adult life has been spent in Federal service, first as Battery Commander in the Army Artillery with nuclear weapons, later as a physician with the Indian Health Service and now as an Infectious Disease physician with Veterans Affairs (VA) for the past 17 years. I mention this to point out that I have experienced a variety of bureaucratic organizations.

There was a cataclysmic change in the managerial structure in this organization, now half a decade ago, that has entirely changed the landscape of patient care, with the unfortunate result that there has been a loss of focus on the veteran patient. Some of the decisions and their consequences were not self evident at the time of change. Important knowledge on how to run an effective and safe hospital was sacrificed in no small degree at that juncture. Difficulties are only apparent now as we gaze at beleaguered VA hospitals with increasing numbers of patients, fewer doctors and nurses, an increasing need for expensive and effective medications, and timely consultations and operations.

The structural changes that occurred brought a measure of fiscal responsibility to the VA, which is good thing. However, I would like to focus our attention on some matters that still require change to bring about more improvement.

I have limited time in this statement and so will restrict myself to brief mention of five major ongoing problems in the VA system, most a consequence of the change in management style some years ago. What I have to say is applicable to all VAs. It is exceedingly difficult to uncover where trouble begins in an organization of this size but I believe I can disclose some areas where changes were made leading to major deficiencies, eventually impacting on patient care.

The five major problems are as follows:

1. **The addition of entire cadre of middle managers who embrace a business model of management. These managers have fiscal oversight in the clinical side of the organization and are neither sufficiently knowledgeable nor trained in areas they supervise.**
2. **The hospital Director has more real power than the Chief of Staff: there is no equal partnership.**
3. **A sundering of any meaningful relationship with local medical schools.**
4. **Individuals in the organization with direct patient care, for example, physicians and nurses, have no meaningful influence in the organization of patient care.**
5. **Supervisory positions are all too frequently held until retirement.**

Let us look in detail at problem 1, that is, the insertion of a business style of middle management and how this relates to current problems. Former departmental structures were eliminated in 1996 and entirely new positions were created with

supervisory and fiscal control. I direct your attention to Table 1. The real numbers of physicians, dentists, RNs, LPNs, and Nurses Aids have declined since 1995. You will not be surprised to hear me tell you that the numbers of support personnel has actually risen during the same time frame. Contrast the data in Table 1 with Table 2 where it is evident the number of patients, visits and expenditures by the VA have all risen from 1995 to present. When all of this was occurring, it appeared as if the possession of real credentials for any job position was grounds for immediate disqualification. For example, we had the unenviable experience at the Kansas City VA of witnessing the promotion of a very fine engineer to direct line authority over the pharmacy and housekeeping—disciplines of which he had only superficial knowledge. Internists were placed in direct charge of subspecialty surgeons whose specific requirements often went unmet. Similarly, another fine man, in this case not a physician, was placed in charge of pathology and radiology, disciplines that even trained specialists in these fields struggle to direct in the VA. We were told that the position of Chief of Staff was obsolete and the individual in the position was summarily dismissed, only to have the position reinvented months later. If fiscal responsibility were the desired goal, it would have been cheaper to hire accountants.

The entire personnel structure of hospitals was reformed around a business model with the primary emphasis on fiscal soundness, something we have learned to our regret doesn't always perform well even in the private sector, much less in the VA. In the VA system the changes like those described before translate into more "process", i.e., paperwork and meetings, than into any actual doing, that is taking care of patients. The end result following all of these changes, it was still left to nurses and physicians to figure out how to deliver care in spite of all the managerial impediments.

Problem 2 deals with the accumulation of power, real or perceived, in the Hospital Director's office and is separate from the middle management problem. Prior to recent changes, the Chief of Staff (representing the clinical arm of each hospital) had meaningful supervisory control of the professionals and influence on the use of fiscal and real resources. In bureaucracies, there is always a tendency to seize more power in order to influence one's own agenda. In an organization such as the VA, established to provide professional services to patients, this can be disastrous when the equation is tilted toward non-clinical management. In the present setup, the Chief of Staff is veritably in the pocket of the Director—he or she is incapable of instituting the best system of medical care composed of nurses and physicians representing the needed disciplines in order to meet hospital needs. Hence, we see a system embracing Primary Care at the expense of all else. There is disdain for specialists at the very time HMOs are realizing the hazards of such an approach. Specialty consultations can not be met in a timely fashion, and many subspecialties are inadequately represented in the system.

Problem 3. A sundering of any meaningful relationship with local medical schools. The VA is an important partner in the training of physicians, pharmacists, psychologists and nurses in the United States. One of the major reasons many professionals join the VA is to participate in a collegial fashion with the local university medical school. Individuals may enjoy regular faculty status with their respective schools because of their own accomplishments. In these Dean's Committee VAs the control of education establishing who would teach trainees was exercised, rightfully, by the universities. This productive working relationship is no longer extant.

The medical schools are in fiscal distress and the VA has the money to spend on cheap workers (the resident and intern trainees) and a willingness to employ them. The power in this equation is enjoyed solely by VISN headquarters throughout the country. According to the new rules, residents and interns will perform direct patient services when at the VA regardless of the increasing number of patient encounter scheduled or the quality of the interactions. Individuals supervising such trainees are not necessarily established as competent or even interested in medical education.

Problem 4. Individuals in the organization with direct patient care, for example, physicians and nurses, have no meaningful influence on the conduct of patient care. Diminished in numbers and treating an increasing number of patients, the professional employees (physicians, dentists, pharmacists and nurses) are increasingly unhappy and unfulfilled. It is alarming when one hears the best of physicians stating: "I can't always do what is right for the patient" or "My time is spent doing computer entry". Caretakers in this organization are trapped behind computers entering data of little or no immediate clinical relevance that consumes half of the patient encounter time. Consultations, depending upon the service requested, are often not performed in a timely fashion—patients are forced to utilize the private sector to obtain these services only to return to the VA for their medications which cost them less in the federal system. Contemplate the following scenario, which is VA's idea of a meaningful patient encounter. Following clinic visits patients were asked questions (mandated by VA Central Office) such as: "Did your doctor smile?" "Did your doctor look you in the eye?" "Are you happy with your care?" All cosmesis, no substance. There is no process by which to determine if your doctor is even competent in the VA which is an important question since there is no meaningful professional development for physicians in the VA and the distancing from the medical schools contributes in no small way to a deterioration of the faculty. I suspect the demoralization of the professional staff will be the ultimate undoing of this organization.

Problem 5. Supervisory positions are all too frequently held for a professional lifetime. This statement is self explanatory. The genius of the democratic system is not that we can vote in whom we want but more importantly, that we can vote out individuals whom we do not want. Such is not the case in the VA.

In conclusion, changes are needed now but they are not necessarily large ones—all of the foregoing, the good and the bad, was accomplished by the appointment of one individual with the authority and mandate to affect change. Laws are not required but the re-establishment and embracing of a professional culture of sound clinical practice is required.

Table 1. Employment at the Department of Veterans Affairs

Year	Total FTEs	Physicians	Dentists	RNs	LPN/LVN/NA	Support + Other
1995	200,448	12,053 (6.0)	930 (0.5)	37, 731 (18.8)	23,196 (11.6)	29,769 (14.9)
1996	195,193	11,891 (6.1)	906 (0.5)	34,187 (19.1)	22,033 (11.3)	28,878 (14.9)
1997	186,185	11,507 (6.2)	867 (0.5)	35,190 (18.9)	20,184 (10.8)	27,853 (14.8)
1998	184,768	11,258 (6.1)	826 (0.4)	34,397 (18.6)	19,448 (10.5)	29,976 (15.0)
1999	182,661	11,241 (6.2)	814 (0.4)	34,071 (18.7)	18,646 (10.2)	31,167 (16.2)

Table 2. Veteran population, treatments and costs.

Year	Patients	Inpatients Av. daily	Acute care Av. daily	Outpatient visits (X1000)	Expenditures (X1000)
1995	2,858,582	81,071	16,028	26,501	$15,981,948
1996	2,937,000	74,764	13,948	29,850	$16,372,856
1997	3,142,065	67,353	10,461	31,919	$17,149,463
1998	3,431,393	63,969	9,030	34,972	$17,441,079
1999	3,610,030	60,036	8,371	36,928	$17,875,584

STATEMENT OF

OF

LINDA McEWEN, RN, BSN, MA
LOCAL PRESIDENT
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
LOCAL 910

BEFORE

THE HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

KANSAS CITY, MISSOURI, FIELD HEARING
ON

PATIENT CARE AT THE KANSAS CITY VETERANS AFFAIRS MEDICAL CENTR:
INVESTIGATING INFESTATIONS AND MANAGEMENT PRACTICES

JUNE 17, 2002

Chairman Moran and Ranking Member Filner, my name is Linda McEwen. I am President of Local 910 of the American Federation of Government Employees (AFGE). My union represents some 400 Registered Nurses (RNS), physicians, pharmacists and other health care professionals at the Kansas City VA Medical Center. I come from a family of veterans.

Of my 30 years practicing nursing, I have proudly cared for veterans at the VA for the past 18 years. I have an advanced degree in Health Service Management and I am certified in Gerontology. I also served as the Chief Nurse at this facility from 1989 through 1997. In 1997, the administration and Congress started to place the VA on a flat-line starvation budget. During this time the Director, Mr. Doran, and I had significant differences in our approach to the management of staff to provide high quality of care given limited resources. In 1999, I was one of the health care professionals who chartered this local AFGE union.

Much has been publicized about the grotesque and horrible safety problems at this facility. Nurses, doctors and other staff at this facility have been frustrated and dissatisfied with how the problems never seemed to be rectified no matter how loudly or how persistently we called attention to the obvious problem of vermin infestation.

My AFGE Local regularly spoke up to the management of Quality Assurance. We regularly reported the problems to infection control staff and facility housekeeping management. Our brother union, AFGE Local 2663, representing the non-professional staff at this VA medical center, was relentless in their efforts to negotiate with management for more housekeeping staff because it was clear that our facility was dirty and needed more cleaning staff. Unfortunately, even when our brother union persuaded the Federal Impasse Panel of the merits of their negotiating position, VA management at this facility delayed hiring new housekeeping staff and failed to replace housekeepers as they left.

When it was clear that the problem was a repeated infestation in the Canteen, I urged that the Mr. Doran shut down the Canteen to no avail.

We tried and tried through internal processes to prompt management to make changes.

As nurse, as a concerned citizen, as the daughter of a WWII veteran and as a union officer, I ask what can Congress do to help make sure this never happens again?

Your congressional investigations and your staff have certainly been effective in prompting much needed action. And to his credit, Secretary Prinicipi has responded to correct some of the underlying problems of this medical facility.

We have a new Director at our facility. He is one in ten. He is trying to make a difference and restore our focus back on patient care not just survey results from patient satisfaction forms. The replacement of top management is an important first step towards improving patient safety. But I fear for the future. Directors come and go.

Chairman Moran and Ranking Member Filner, Congress must do more than field hearings to prevent the multiple problems that led to filth at our facility.

The VA must be fully funded. Additional funds are essential to rebuild our staffing levels. We need professionals and support staff, like housekeepers, to get the job done. But money alone is not enough if management will not use it to hire staff or focus resources to improve patient care.

It is clear that we need systemic checks and balances to prevent such egregious problems from ever developing again, here or elsewhere. We need additional accountability for how management runs a facility. Part of that accountability occurs through the reports to the VISN and monitoring done by central office in Washington, DC. However, surveys and reports are too distant from the frontlines of health care and can be manipulated. With 172 medical facilities, real accountability can only occur at the facility level, where health care is delivered. You can gloss over a problem in a report to headquarters but you can't snow the nurses and doctors on the ward.

As a nurse, I am first and foremost a patient advocate. Because my union represents nurses and physicians my role as President of AFGE Local 910 is to ensure that health care providers have a real voice at the workplace. It is my job as a union leader to speak truth to power. It is my role to tell management what they need to hear about our working conditions and about the delivery of care at our facility – even when the truth is ugly.

Robust labor-management relations are key to providing quality care for veterans. The information and concerns expressed by federal employee unions on behalf of the health care providers we represent should not be ignored or dismissed. This is especially true as the VA tries to be more market-based and run like a business. The focus on the bottom-line can divert attention away from quality care and the needs of the patient, which may be costly. Under a "do more with less" management philosophy it is the frontline employees who can remind VA management that "less is less." It is the nurse at the bedside, and the physical therapist helping a veteran, and the doctor with a calming explanation who keep the VA focused on our mission. These health care providers on the frontlines need to have a real voice at the workplace and that is through their union.

I recognize that Congress cannot legislate that management respect its staff. But you do write the laws that decide the topics for which we can ask management to discuss with us at the bargaining table.

The other AFGE Local at my facility was able to at least prod Mr. Doran to the bargaining table to discuss the need to hire more housekeeping staff. The negotiations took place because under an then existing, but now rescinded, Presidential Executive Order, VA management was required to negotiate over permissible bargaining topics, including the number and types of employees.

I urge you to help provide the staff at this and other VA facilities with the tools to hold management more accountable. As nurses and doctors we have a significant and vital role in patient care yet we cannot prod management to the bargaining table over important issues the affect our ability to provide high quality care. Because infection control and quality assurance are areas involved in direct patient care, the law prohibited me from raising them at the bargaining table.

To prevent future safety problems at this or other VA facilities, I urge you to rewrite 38 U.S.C. 7422 to allow unions that represent Title 38 employees to negotiate over issues of direct patient care. Give us a real voice at the workplace, and we will help you hold the VA accountable for providing safe and high quality care for veterans.

Thank you for giving me this opportunity to share our concerns with you.

Statement of
Sharon A. Grewe, Patient Advocate, Kansas City VA Medical Center
Veterans Health Administration
Department of Veterans Affairs
Before the
Subcommittee on Health
House Committee on Veterans Affairs
June 17, 2002

Mr. Chairman, members of the subcommittee and other members of the Congressional delegation for the Kansas City VAMC, my name is Sharon Grewe and I have been a veterans advocate all my life, but in January 1997 I had the honor of being selected as the Patient Advocate at the Kansas City VA Medical Center.

Thank you for the opportunity to share the voices and concerns of many veterans. Their voices are strong with determination and hold the highest quality of patriotism to this country, with honor and respect for their fellow man. They are dedicated and fully committed to this facility, which they consider their home. Many are fearful that the long-standing negative publicity will result in the closure of this medical center.

Certainly, we have complaints at this medical center by some of the patients and families, some complaints have been about the cleanliness of this facility, but most are about other administrative or communication issues. The reporting of the 1998 events has brought comments in support of the VA's action by the majority of the veterans. What is of greater concern to our veterans is the fact that this issue is such a high profile issue now, when the incident occurred some four years earlier. Certainly this was a serious situation, but some veterans fear that this is a "ploy" to close this facility.

Some veterans ask "how often does this sort of thing happen and does it happen at other health care facilities." The publicity and journal article attempt to link overall cleanliness issues to the separate issue of nasal myiasis. This gives patients the perception that the cleanliness of the facility directly links to poor quality health care. The **QUALITY OF CARE** here has **never** been an issue. In fact, the majority of our veterans are extremely pleased with the overall quality of care they receive. The veterans tended to overlook the lack of cleanliness because of their satisfaction with the overall quality of care. Numerous veterans

have come to me in support of the facility. Their comments range from "I have never once seen a mouse in this place...or a maggot.....or a fly....and I was in the ICU then or had surgery, etc. As a matter of fact, I haven't seen anything like what is being reported in the news."

The fact remains that the overall appearance of our facility had deteriorated over the years. But through the efforts of our dedicated staff these issues did not impact the quality of care the patients received, nor did the patients notice any decline in their care.

I don't mean to imply that every patient we treat is 100% satisfied. Complaints are brought forward on many different aspects of the services patients receive. However, the majority of issues brought to me are not of cleanliness, but of timely access to care, delays for a scheduled appointment, billing, phones not being answered, and getting prescriptions filled from their private doctor. These are national concerns across the country, both VA and non-VA.

It is important that the 1998 ICU situation regarding nasal myiasis and the overall cleanliness of the facility be addressed as two separate situations and shared as two separate situations with the veteran population.

One of my greatest concerns is that some veterans are expressing fear of even entering our facility because of the many adverse media reports that attempt to link the overall cleanliness issues to the quality of care our patients receive. Sadly this seems to affect our most vulnerable patients. In order to re-establish that trust, I often offer to meet patients and their families at the door and walk them through the facility so that they can look around for themselves. Patients and families can immediately see that our facility is clean and improvements are ongoing. As recently as Thursday of last week a veteran stated, "I was really concerned about coming to the KCVA yesterday because of the news of the dirty facility and the maggots, but I want to tell you the news has blown this way out of proportion. I've been coming here for a long time and have never seen what they are talking about. Yesterday when I got here, I noticed this place is really clean, I just want to tell you that and let you know the news is frightening me and other vets too."

The veterans are a very proud and unique group of individuals and we at the Kansas City VA Medical Center are honored to serve them. Sometimes our contact is the only personal interaction a veteran may have. We provide much more to veterans than health care. A common example is....one veteran

experiencing a very bad day, got a hug from me and with tears in his eyes and a shaky voice, he said, "That feels so good to have someone just hug me, it's been many many years since anybody did that to me." Many are estranged from family and friends, have no home, and are living on the street, some by choice and other by circumstance. One veteran visiting my office relayed that he had been estranged from his family for 20 years. I was able to assist in reestablishing the connection with family by listening and placing three phone calls. I am not unique in these acts, as many of the dedicated staff at the KCVAMC perform the same sorts of things - day in and day out.

At this time, dramatic improvements are ongoing and immediately identifiable as you enter and walk through this facility. The veterans and our staff express pride and are quick to remark on the cleanliness and improvements being made. They especially appreciate the new location of the canteen, now located in the basement. Secondly, they are happy that the sisal wall covering is being removed and replaced with an open and brighter appearance. They are pleased with the noticeable improvements in routine cleaning and monitoring of public and patient care areas. However, they want to be assured that is not a "quick fix" and that we will never again allow this facility to fall in disrepair. Our patients and our medical staff will not tolerate a dirty facility, and will demand that we secure enough resources to maintain this facility at the level that our patients deserve.

Our veterans and staff are proud of this facility and are extremely satisfied with the healthcare provided. Patients and employees are frustrated and even angry that the positive things that are being done receive little or no attention, but the negative issues are always on the surface. Veterans and staff want to see more emphasis placed on the improvements made and the excellent services we routinely provide. This has been an upsetting time for our patients and the dedicated staff at this facility. Both patients and staff want to move forward.

The Department of Veterans Affairs has a responsibility to each and every one of our Nation's veterans to offer them a leg up - not a hand out. Our patients and our staff are very proud. Patients want the things they were promised and not feel like they are a welfare recipient. The staff wishes to provide the highest level of quality health care available, in a timely fashion. However, they need the resources to accomplish that goal.

Again I want to thank you for the opportunity to share the concerns of many of the veterans we serve.

June 17, 2002

House Committee on Veterans' Affairs
Subcommittee on Health

Testimony of Hugh Doran, former Director of the VA Medical Center, Kansas City, Mo. From March 1995 to June 2001.

Thanks you for the opportunity to appear before you today. I consider this a distinct honor and privilege. I am further gratified that I will have the opportunity to present my position on this unfortunate chain of events.

On March 5, 1995, I became the Director of the VA Medical Center in Kansas City, Mo. My first day, I toured the hospital and was appalled at the midieval conditions our Veterans were hospitalized in. Nurses had difficulty getting monitoring equipment to the patient's bedside in the Intensive Care Units. Patients were in 4 bed rooms where they could reach over and touch the other. It was antiquated and outdated. We were in a 45- year -old building that had very little upgrading other then air-conditioning. Our Veterans deserved better!

My administration was centered on 2 areas---Quality of Patient Care and Patient Satisfaction. All of my decisions were based on this. I immediately conveyed my priorities to our employees and management staff. I also told everyone that the Veterans Service Organizations were my "Board of Directors". I told all concerned that we were going to become a "patient focused hospital".

Maggot/Rodents

This unfortunate incident was handled expeditiously and appropriately by our staff, including monitoring and follow up by our Medical Staff. I took immediate action to insure our adjacent construction site was secure, informed my superiors and discussed the incident with the families involved. There is absolutely no evidence to establish a relationship between the two nasal myiasis cases and the alleged mouse problem. You have a disgruntled former employee's opinion, who managed to get this article published. There are many other respected physicians who differ. Mice were never trapped or observed at any time in the Intensive Care Unit. No mice were ever noted to have larvae or flies associated

with them. The blowfly is extremely common in the Kansas City area. No one can prove the fly did not come in the front door! I hope you don't think this is the only case of a maggot being discovered in a hospitalized patient. Unfortunately, it is not uncommon, certainly under reported but not unusual.

There were 3 incidents of flying insects that invaded the operating room in 1999. Immediate action was taken to protect the patient and clean the area. As I remember we were not able to identify the entrance path of the insect. This situation was closely monitored by the Operating Room Supervisor and to my knowledge this was an isolated incident in November.

In a 50 -year -old building, you will have an ongoing rodent problem. The key thing is what does one do about it? There were various rodent control initiatives over the years, including our own employee devoted to pest control, followed by contracts with private companies. No one can completely rid the hospital of mice. They will always be there. We tried to control this problem as best we could in this antiquated building in a neighborhood full of vacant lots and vacant buildings.

There was an occasion when both local Union Presidents brought to my attention evidence of mice in the canteen area. I immediately examined the area, asked the Canteen Officer and our Facilities Program Director to clean up the grease area of the stove in question and relocated the storeroom. I asked our Infection Control Nurse to conduct daily inspections and report back to me her observations. I, personally, inspected the area several times following this incident and was satisfied the problem was addressed. I did not have the money to do anything to this area at this time as I was in the process of building a new cafeteria in the basement, which was scheduled to be open in several months. The reason I constructed a new cafeteria is to provide our patients and employees a 'state of the art' facility in conjunction with our own VA kitchen staff. Remember, the Canteen is not under the supervision of the facility Director.

Budget

Ladies and Gentlemen, each year as Director, I started the fiscal year 4 to 10 million dollars in the RED. Each year this deficit was brought to the attention of my superiors without relief. Despite a meager increase each year in my total budget, I faced each year with a daunting task. I funded our supply allocation, ie. Pharmacy et. Al. and what was left was devoted to salaries. For this reason, I went from 1400 employees in 1995 to 980

employees in 2001. Each year was a struggle. We were not very good at collecting insurance reimbursement in those days, this being the only way to attack the deficit. In 2001 we collected approximately 5 million dollars. Our only alternative was to reduce employment.

The budget allocation process in VISN 15 discriminated against the tertiary care hospitals, Kansas City, Columbia and St. Louis. Tertiary Care is very expensive and we received many referrals for needed care from the other hospitals in VISN 15. The 'transfer pricing scheme' was woefully inadequate in paying us for the expensive care we gave, further diminishing our meager allotment. The total hip patient referred from Leavenworth resulted in a 4 thousand dollar allocation in transfer pricing. I had to buy the hip joint for 4 thousand dollars, so I was losing money before the patient was admitted..
The pharmacy budget increased from 8 million dollars to 18 million dollars during my tenure. Medical supply inflation runs 10 to 15 % each year. We received less than a 3% increase each year. Do you get a feeling now for the challenges I faced each day in trying to remain fiscally solvent? This was a critical element in my performance requirements each year!

Construction

It is important to note that 10 to 15 years ago there was a 45 million dollar renovation project requested by the VA for the Kansas City VA medical center. Congress did not fund this project despite it being requested each year for several years. I can assure you that if this project was supported at that time, we would not be here today. When I arrived in 1995, I decided that the 45 million dollar project would never be funded and we had to go in a different direction. With the support of the VISN, we designed several 3 to 4 million dollar projects that we could do each year and completely rebuild the important patient care areas of the hospital in 6 to 7 years. We started with a new state of the art 13 bed Medical Intensive Care, followed by a 13 bed Surgical Intensive Care Unit. In addition to these very important initiatives, we completed several local projects including a new endoscopy clinic, new Primary Care Clinics, a new Ambulatory Surgery Suite and rooms, new ENT and Ophthalmology clinics, a new Cafeteria, renovated the Recreation Room and the front Lobby, opened the only Learning Center in the VA or private sector for patients and employees and relocated the Administrative areas from prime patient care space on the first to the 5th floor. We are nearing completion on the new Laboratory, which is being completely reconstructed to support tests sent to us from the other VISN 15 hospitals.

The 70 bed Medical ward was completed in the spring of 2001, providing

rooms, which were as nice as any in the city. Our veterans deserve nothing less. At this time we began construction of the new Operating Room Suite, to be completed in the fall of 2002. This was our 'crowning ' achievement, a much needed facility for the Veterans of Missouri and Kansas. This was a major accomplishment and my appreciation to our local Representatives and our Senators in both Kansas and Missouri.

For the past 6 years, I had two 3 million dollar projects to renovate the 'halls and walls'. I made the decision that the patient care related projects were far more important then the cosmetic changes in the 'halls and walls' project. We definitely need this project and it was my plan to do it after the Operating Room was completed, along with the project to renovate the 5th floor to accommodate the Surgery beds and our new SPD. The SPD area has been the subject of attention. I also had a roof project that I was doing in increments, I could not afford to do the entire roof at once, even though we knew it was needed. The SPD problems were directly related to the leaking roof. At no time was patient care compromised because of anything in SPD. Upon completion of the above two projects, we would have a wonderful, state of the art facility, second to none. A facility our patients and employees would be proud of.

Workload

During my tenure, our workload dramatically increased. Patients treated went from 12,000 to 32,000 and outpatient visits went from 130,000 to 200,000. Our hospital became a popular place for the Veterans we serve. A significant number of Veterans came to us from the state of Kansas. I believe this dramatic increase in patients was a result of our 'patient focused healthcare environment' initiatives. There is nothing more important than Quality of care and Service. The Kansas City VA and its dedicated employees were the best and the Veterans came. We did not wait for patients to come to us, we took the expertise of the staff to the patient's hometown. We held oncology and GI clinics in Leavenworth and Topeka and ENT clinics in Wichita. This meant the patient did not have to travel to Kansas City. We opened 5 Community Based Outpatient Clinics, providing Primary care near the patient's home.

Sanitation

It is interesting to note the most vocal individuals regarding sanitation at the hospital are well-known malcontents and/or disgruntled employees or former employees. I can honestly say the housekeeping staff was not reduced any more or any less than other areas. In fact, in 1998, I added 8 positions to the housekeeping staff and purchased 200,000 dollars of new

equipment. This decision was the subject of our presentation to the JCAHO, identifying a problem and our solution to it.

At this period of time, several decisions impacted the quality of our sanitation efforts. Our local Union objected to our Compensated Work Therapy program, wherein we were able to use housekeeping job assignments in the rehabilitation program for Veteran patients. At any time there may have been 10 patients in various assignments. We were forced to stop this very worthwhile patient care program while other hospitals benefited tremendously.

Supervisory positions were reduced throughout the hospital. Housekeeping was no exception. In fact, we allowed the night housekeeping staff to function with a work leader. I agreed to this organization after meeting with the Union and the employees and granting their request for individual promotions versus a supervisor position. This did not work as well as we had thought and when we intervened several times with a supervisor giving work assignments, we were hit with 70 Unfair Labor Practices in one day!

More importantly, JCAHO reviewed the hospital in the fall of 1998, reviewing sanitation along with everything else, gave us compliments on the cleanliness of the hospital and a score of 97. In the fall of 2001, another JCAHO review, evaluating the same things gave a score of 99, the highest in the VA system and probably the highest in the country! Several Service Organizations conducted their cyclic reviews and did not report any significant problems with housekeeping. We had many visitors and I talked to many patients and families and housekeeping or the lack of it, was not a topic of conversation.

Much has been written about the 'consultants' report. In the 1998 timeframe, I contracted with a firm to tell us what was needed in housekeeping. I was mainly interested in his plan for cleaning the respective areas and the frequency needed. The consultant and I discussed his recommendations and agreed that my present staff in housekeeping was equivalent to a 'Ford Escort'! An additional 14 positions would give me a Cadillac. The difference being, frequency of cleaning. We discussed what I needed for a 'Pontiac' and he said, around 8 positions and that is what I ended up increasing the housekeeping staf

During this 1998 timeframe, the VISN Director, Ms. Crosetti called me and told me she had been at a Service Organization picnic and one of the members had told her that he noticed a slippage in the housekeeping

efforts at the hospital. She said that she had noticed it also . I told her that it was true and that I was taking the necessary steps to address the problem. I further explained that I had the consultant's report and was hiring positions and that I had lost the services of the CWT program. Everything happened in a short period of time and we were turning things around.

I would have liked to have a 'cleaner' hospital. Unfortunately, I did not have the resources to support housekeeping, as I would have preferred. I can assure everyone that Patient Care did not suffer because of a lack of housekeeping. We must not lose sight of the purpose we are all here for and that is to provide the highest quality of care and no one can argue with our success.

Relationship/Crosetti

It was disturbing to read Ms. Crosetti's comments concerning my performance in the Inspector General's report. She never told me that she thought I was 'unsatisfactory'! I did receive a low evaluation in 1999 because of a personnel issue and I was accused of 'lobbying' Congress for the Operating Room project. Guilty as charged for the lobbying! It is hard to believe that she would give me a minimal successful rating in 1999 and an outstanding rating in 2000, about 10 months later. She even gave me a bonus! Suffice to say, my relationship can be measured in outcomes. Ms. Crosetti took great pride in VISN 15 being the best in the country for several years in a row in Performance Measures and Patient Satisfaction. Kansas City was the best hospital in VISN 15 for 5 years in a row in Performance Measures (measuring quality of care) and patient satisfaction. I always used to say, "Kansas City is the engine that pulls the VISN 15 train"! If she thought that I was unsatisfactory, what did she think of the other Director's? Most important, my relationship with Ms. Crosetti did not negatively affect our ability to deliver the highest quality of care

Summary

I have dedicated 38 years of my life in service to the Veterans in 16 hospitals throughout this wonderful country. While the recent publicity has been terribly biased and one sided, I have been heartened by the many calls and cards from patients, families, employees and volunteers. I attempted to present my position on this matter to the Kansa City Star and interviewed for over 2 hours, only to receive 2 or 3 sentences in the final story. It was so disturbing to see 4 malcontents quoted extensively. I did receive a fair and unbiased report on KMBZ TV last weekend. This episode has been a terrible disservice to me and to the many dedicated

and compassionate employees at this fine medical center. Our employees are the finest in the country.

The accomplishments in the past 6 years cannot be overlooked---JCAHO scores of 97 and 99, #1 in Performance Measures and Patient Satisfaction for 5 years in a row, Morbidity and mortality rates are in the top 5% of all hospitals, dramatic increases in satisfied patients using our hospital and the many construction projects mentioned earlier. We have achieved a true **Patient Focused Environment,** my goal in 1995.

Due to budget constraints, I had to make choices and I chose patient care. I provided the highest quality of care to the Veterans of Missouri and Kansas and I am proud of it. Our judge and jury is the Patient's that we serve and our patient's are saying, "we are glad you made the decisions that you did"! The Kansas Department of the Disabled American Veterans organization presented me with their 'Achievement' award in the year 2000, the only Director of a VA hospital ever honored in this manner.

Secretary Principi completely vindicated me as the Director when he ordered the hospital to receive 10 million dollars two months ago for the 'halls and walls' project and for additional employees. I ask you, **"What could I have done with 10 million dollars?"**

Thank you for this opportunity to appear. We do need to move on. Our employees need to get on with **"Keeping the Promise"** to our Veterans. I will address any and all questions.

Hugh Doran

Statement of
Robert H. Roswell, M.D.
Under Secretary for Health
Department of Veterans Affairs
Before the
Subcommittee on Health
Committee on Veterans Affairs
U. S. House of Representatives

June 17, 2002

Mr. Chairman, members of the subcommittee, and other members of the Missouri and Kansas Congressional Delegations,

I thank you for the opportunity to bring you up to date on the actions taken to correct environmental concerns at the Kansas City VAMC. I will begin by sharing information about the situation that brought us together today, recap findings from the OIG and other reports, share with you actions already taken and discuss my actions for assuring that situations such as this do not happen again, anywhere in the VA Healthcare System.

What is now known is that there was, over time, a general deterioration in the cleanliness of the environment at the KC VAMC. This was brought to national attention when an article appeared in the Archives of Internal Medicine in March of this year. The article attempted to relate an infestation of rodents in a distant part of the medical center to the presence of Nasal Myiasis (commonly known as maggots) in two patients in the Medical Intensive Care Unit. Despite the author's assertions of a relationship between the rodents and flies, there was (and is) no conclusive evidence that such a relationship existed. Most probably the Myiasis was due to gravid flies entering the MICU through construction barriers. The article did, however, incidentally depict the Kansas City VAMC as a dirty hospital and it quite explicitly identified a number of general cleanliness issues.

This led to several immediate actions on the part of the Secretary of Veterans Affairs and my office. The Inspector General was asked to dispatch a team to the medical center to conduct an in-depth audit, the Network Director and Deputy Network Director were detailed to other assignments pending the audit, and an Acting Network Director, Ron Norby, was appointed to lead a remedial effort at Kansas City and provide leadership for the overall Network.

The Office of the Inspector General has completed his report and has found that the Kansas City VAMC was not maintained at appropriate levels of cleanliness nor

was there an adequate pest control program. These conditions existed since at least 1997 and they were known by both Medical Center and Network management.

Overall, there was a lack of effective supervision and leadership in the housekeeping department. A decision was made by the prior Medical Center Director not to fill the Environmental Program Manager position until recently and it had been vacant since 1997. Front-line supervisory positions were also eliminated and the facility failed to hire the numbers of housekeeping staff necessary to maintain the cleanliness of the facility. In addition, there were significant deficiencies in the engineering maintenance staffing that resulted in delayed response to minor and preventive maintenance projects.

Due to the lack of knowledgeable leadership and supervision, the infrastructure within the housekeeping department eroded. There was no formal training program for new housekeepers and no ongoing continuing education for existing staff, no effective quality assurance program, no performance feedback related to the adequacy of housekeeping services and no routine cleaning schedules and assignments necessary to maintain the facility. Very importantly, the pest-control contractor was not adequately supervised and the quality of services was not effectively monitored. This led to unacceptable levels of rodent and insect control.

Equipment for housekeeping was also inadequate and/or non-existent to meet the needs of the facility. For example, even though the hospital had carpeting in many locations, there was no carpet cleaning equipment. In addition, the housekeeping and cleaning duties and responsibilities among departments were not well defined. This was especially true between the medical center and the canteen service.

All of these deficiencies were further exacerbated by the fact that the facility is housed in a building that is 50 years old. Many of the materials and finishes were outdated, inadequate and unattractive. There was no overall interior design plan or systematic plan for preventative maintenance, painting and refurbishment. Lighting throughout corridors was dim and outmoded, which impacted on the overall appearance of the facility. From the IG report, it is clear that Medical center and Network management were aware of these issues and shortcomings. The VAMC did not take the necessary steps to stop the ongoing erosion of cleanliness and the gradual overall degradation in the cleanliness of the medical center.

I am, however, very pleased to report that despite all this, the quality of care provided to veterans at the Kansas City VAMC has remained high. At Town Hall and other meetings of veterans, stakeholders and staff over the past two months, veterans have repeatedly relayed their high level of satisfaction with the care provided at the medical center. The IG report confirmed that the overall quality of care is excellent. I attribute this to the outstanding, dedicated and hard working staff at this facility who have given their talented expertise to serve the health care needs of veterans.

I have just described the situation as it existed roughly two months ago. Since then, an extremely aggressive action plan has been developed to correct the identified deficiencies and to assure that the facility, once it is brought back up to a high standard of cleanliness, is maintained at that level. I am pleased to report that this action plan is well on its way to being implemented and the results are already dramatically apparent as you walk through this medical center. Mr. Hill, the newly appointed Medical Center Director will, in his testimony, describe the plan and accomplishments that have already been achieved. I will therefore not offer further comment in this area except to say that I believe that the plan is comprehensive, addresses the issues identified by the IG and others and, when completely implemented, will once again make this medical center a showplace for cleanliness.

I would like to share with you several actions that the Secretary and my office have taken to assure that this situation does not occur elsewhere in the VA Healthcare System. First, we have asked all facilities to review their physical plants, the cleanliness of their facilities and their pest control programs and certify, in writing, that they are being properly maintained. This certification has been concurred on, in writing, by each Network Director. I have asked all facilities to assure that their senior leaders are conducting regular weekly environmental rounds and that they have mechanisms in place for rapidly addressing issues and environmental deficiencies when they are noted. I have also asked Network Directors to conduct environmental rounds at each facility when they visit to assure that local managers are indeed attending to these issues. Further, I am incorporating the expectation for maintaining facilities into the performance measures for Network and facility directors this next year. Finally, I have asked the VHA Office of Performance to closely monitor and trend all reports from accrediting bodies, review groups (including the IG) and others and to track what actions are taken to correct deficiencies. The senior staff in my office will review these reports frequently and provide appropriate counseling and follow-up with managers having accountability for remedial activities.

Secretary Principi, in a personal discussion with all VHA Network managers and through follow-up correspondence, made it clear that managers will be held personally accountable for correcting deficiencies in their facilities when they are noted and when they are under their control. I also feel it is important to hold managers accountable for maintaining their facilities. In recognition of the gravity of this situation and the potential for new information to arise during today's hearing, the Department has deferred initiating action regarding top management officials until the hearing proceedings are completed. The Department intends to conclude its review in the near future.

In summary, the cleanliness and environment for care was allowed to deteriorate unacceptably at the Kansas City VAMC over the past several years. An aggressive action plan has been developed that I am convinced will bring the facility back to a superior level of cleanliness. I have full confidence in the leadership Mr. Hill brings to

the facility and know that he and his team will work tirelessly to complete corrective actions and to maintain the cleanliness of this facility in the future. I am particularly pleased that the quality of care has been high at the Kansas City VAMC and I am confident that it will remain high. It is an honor to serve the veterans of this community and they deserve nothing less than a facility that provides the highest quality of care in a clean, safe environment.

Thank you for the opportunity to come before you today. I would now like to ask Mr. Hill to further discuss the actions that have already been taken and those planned to rebuild the environment of care at the Kansas City VAMC.

Statement of
Kent D. Hill, Director, Kansas City VAMC
Veterans Health Administration
Department of Veterans Affairs
Before the
Subcommittee on Health
Committee on Veterans' Affairs
U. S. House of Representatives

June 17, 2002

Mr. Chairman, members of the subcommittee and other members of the Congressional delegation for the Kansas City VAMC,

I thank you for the opportunity to bring you up to date on the specific plans and accomplishments in correcting the environmental deficiencies at the Kansas City VAMC. I will provide you with information on the immediate actions taken on those items identified by the Office of Inspector General team and the long-range goals for maintaining the facility into the future.

Although the Kansas City VAMC leadership had in the weeks before the release of the Archives of Internal Medicine article begun to review and slowly phase in measures to correct housekeeping and maintenance deficiencies, the article and subsequent Inspector General audit brought national attention to the environmental problems and required the Medical Center to expedite planning and corrective action. Indeed, as the 21 member Inspector General (IG) team conducted its environment-of-care audit and provided almost daily feedback on its findings, Medical Center personnel promptly corrected those items that it could while formulating the written plans to accelerate the re-building of a housekeeping and maintenance infrastructure.

Most of the environmental problems reported by the IG fell into one of several categories: an overall lack of cleanliness; failure to maintain equipment, furniture, utilities and hospital surfaces; and inadequate pest control. The correction of problems with so many facets required expertise and a thoughtfully designed plan. However, until this plan could be complete interim steps were taken, as follows:

- Overtime for the Medical Center housekeeping and maintenance personnel was expanded and housekeeping aids from the Eastern Kansas Healthcare System were detailed to Kansas City on an overtime basis.
- A very seasoned Environmental Care Manager from Eastern Kansas was also detailed to our facility. He brought the expertise needed to direct the additional personnel and to help us begin developing a long-range plan.
- Additional housekeeping equipment was purchased immediately.

- Recruitment for temporary housekeeping personnel was initiated until permanent staff could be added.
- The Environmental Care Manager initiated a systematic training effort to increase existing staff skills.

The pest control contract was inadequate and action to acquire a more effective contract had already begun. The Medical Center accelerated efforts to hire a nationally recognized company that would respond within 24 hours of a request. The new contract also required the contractor to keep and report performance data to monitor the effectiveness of the treatment plan.

The environmental rounds policy was changed to require more participation of facility management, including Union representatives, and a mechanism for following up on deficiencies.

Employee food storage policies have been redeveloped and implemented. Confusion between Medical Center and Canteen personnel over responsibilities for housekeeping duties has been eliminated by the development of a Memorandum of Understanding. This memo clearly delineates lines of responsibility, calls for regular inspection of all Canteen areas and establishes penalties for non-compliance.

The Supply, Processing and Distribution (SPD) area, where many of the Medical Center's supplies and instruments are sterilized, was cited by the IG for poor maintenance, cleanliness, and inadequate storage space. While the long-range solution to this problem is a new SPD area (negotiations for this project are underway), immediate corrective actions have been taken. Cleanable surfaces have been installed, ceilings repaired and professional ductwork cleaning initiated.

The Inspector General audit team reported that the sisal wall covering located throughout the facility was poorly maintained, dark, and had the potential of harboring dust and dirt particles. The Medical Center had already recognized this problem and had begun the systematic removal of sisal and upgrade of treatment areas over a period of years through its Non-Recurring Maintenance (NRM) and construction programs. Nevertheless, the IG findings elevated the urgency of this work and immediate steps were taken to finish upgrading treatment areas. NRM maintenance contracts to remove sisal, repair and update ceilings and floors will be awarded this calendar year. Until then, a DoD contract for labor was utilized to remove sisal in several clinics/wards, install cleanable, bright wall surfaces, and adjust hall lighting. The results are remarkable and give some indication of what the facility will look like when the contracts are complete.

The Medical Center has had no interior design plan to help select appropriate, cleanable furniture, floor coverings and wall surfaces. An interior designer was brought from Eastern Kansas to help assess and correct the most acute problems. Replacement furniture for many of the waiting areas has been ordered. Floor coverings designed for high traffic are now in use.

A contract to replace insect screens on exterior stairwells has been awarded and a window-washing project has begun. Other contracting activities have been initiated to renovate some of the public restrooms, seal the building exterior, replace leaking roofs, correct environmental deficiencies in the emergency room involving patient privacy, and upgrade or replace worn floors and cabinetry.

The corrections that I have mentioned will, when completed, bring the facility environment up to an exceptional level of cleanliness and maintenance. However, we are establishing a structure that will sustain these improvements over time. To that end our plans call for re-establishing appropriate numbers of permanent personnel in housekeeping and engineering, providing a supervisory structure operating under a formal environmental management program. This will include communication of expectations, training, monitoring and feedback. Open communication with our union partners and employees at all levels is critical to the ongoing success of our environmental plan.

In summary, the Kansas City VAMC is in the middle of an environmental improvement plan that will bring the facility back to a high level of cleanliness and maintenance. You have already heard about the quality of care offered and the superior efforts of those who provide it. It is an honor for me to work with the outstanding staff here to serve the veterans of our community.

Thank you for the opportunity to speak today. I would be happy to answer any questions.

STATEMENT OF JACK SITES

I want to thank the members of Congress for being here today.

My name is Jack Sites. I am a former prisoner of war and a national service officer for the American Ex-prisoners of war.

When I was a prisoner of war I learned the value of cooperation and working together. We have a new director who stepped into a hornet's nest. After meeting and talking to him, I feel very confident that he knows the value of cooperation.

The Inspector General, as you know, has made many good recommendations which are being implemented by our new director.

I now believe this is the time for all employees, volunteers, and service organizations to offer full support and cooperation to Director Hill in his endeavor to make the Kansas City V.A. Hospital one which we are proud to be a part of.

This is possible with all these dedicated people working together.

TESTIMONY FOR VETERANS AFFAIRS HEALTH SUBCOMMITTEE HEARING

Presented by Bonnie G. Hilburn
National Service Officer III
Paralyzed Veterans of America

I thank you for the opportunity to address the issues at hand. I have been a national service officer for fifteen years, eleven of which have been here at the Kansas City VAMC.

I base my opinion on the thousands of voices of veterans and their families that have received treatment at the Kansas City VAMC. I also have heard the voices of the employees that have dedicated themselves to this facility and to those who have left due to budget constraints and changes that have come about within the last few years.

This is an exceptional VA hospital. Aside from some of the issues mentioned in the IG report, a major fault that was done was to accommodate the upper echelon of the Department of Veterans Affairs. I noticed no one mentioned the fact that during Mr. Doran's appointment how much improvement was made at this facility. He had an overwhelming task of upgrading a building that was built in 1949 in front of him when he first arrived here. No one before had done anything to fix this building. The grounds and entrance were vastly improved and a cover put over the front entrance. The eighth floor was renovated to provide totally wheelchair accessibility. A new SICU and MICU were accomplished and the new operating room was begun. I believe Mr. Doran did everything he could with what he was being allotted to work with.

The sanitation problems (as bad as that was) was minor when considering the many other problems that we have experienced since the Gramm Rudman cuts originally were put into effect. With reduction of staff and the hiring freezes imposed, this hospital has encountered many difficult obstacles to overcome.

All VA hospitals were told they had to be financially competitive with civilian hospitals, and yet were unable to bill Medicare. Thousands of new veterans were enticed into the VA system with the promise that they would receive treatment and care such as they would receive anywhere else. I believe the staff here has done an admirable job in doing this with far less funding than a civilian hospital.

A person coming into this facility today must wait as long as six months to see a primary care doctor. They must wait another few months if they need a wheelchair or certain other prosthetic items. If they need it sooner they are usually overbooked. This isn't fair to those who remain patient and try to let the system work. Almost every VA employee I know is doing the job of two or three people. I have noted many that have pushed themselves to the point of illness and I have known a few who have died due to stress related causes.

MISSOURI STATE COUNCIL
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STATEMENT OF MISSOURI STATE COUNCIL
VIETNAM VETERANS OF AMERICA

SUBMITTED BY

ALAN GIBSON, PRESIDENT
MISSOURI STATE COUNCIL

BEFORE THE
HOUSE VETERANS AFFAIRS SUBCOMMITTEE
KANSAS CITY VETERANS ADMINISTRATION HOSPITAL

REGARDING PROBLEMS WITHIN THE MEDICAL CENTER

June 17, 2002

Chairman Moran, Ranking Member Filner and other distinguished members of the House of Representatives, Missouri State Council, Vietnam Veterans of America (MSCVVA) is honored to appear here today to express our views in response to Medical Problems at the Kansas City Veterans Administration Medical Center (KCVAMC). It is indeed a shame that it takes a press article to get one of the problems under control.

Before we go further into this Hospitals situation, we feel that these problems permeate the VA System but were the one that come to light. There was an account of maggots in a foot of a Veteran in the Columbia, VA Hospital just a few weeks ago.

We can trace the foundation of these problems to two sources.

1. The "flat line" funding for the VA even though the costs of services and supplies continued to rise.

2. The measurements of Directors of the Medical Centers and of the VISN (Networks) for receiving bonuses depended on how much money they saved.

Both of these issues, simply put, mean a cut in services and programs for veterans at the Veterans Health Administration (VHA). Prescription drugs raised an average of 10% and

COLA raised an average of 3.5% each year during the last 5 years with a "flat line" funding. Not hard to figure where those expenses come from. In fact, medical inflation in the civilian sector from FY '96 to date has varied between 10.1% and 11.3%. Even assuming that salaries do not rise as quickly as the private sector, VVA believes that the true inflation rate at VHA is about 8% per year.

Likewise the savings made by the Directors resulted in the VISN Director receiving at or near the maximum bonus in each of the last 5 years. Let us not kid ourselves, these savings come from vitally needed programs for ill veterans programs and further reductions in health availability primarily, and not from administrative areas. It is believed that VISN 15 (and probably all the VISN's) made the decision to:

1. Completely restructure the organizational chart. Although the claim was that moving to the VISN system would reduce administrative overhead and reduce the number of clinicians who did not see veterans but were primarily paper-shuffler, in fact the administrative number of positions in VHA has increased since 1996.

2. Develop a plan that would prevent or make it very difficult for veterans to travel from their local areas to a VA of their choosing for better care.

3. Contract with local private hospitals for care.

4. To remove physicians from direct control of their programs

5. To reduce the number of physicians (in whole and/or in eighth's)

6. To drastically reduce program funding so the purchase of types and quantities of supplies required for an expanding workload could not be accomplished.

7. To drastically reduce the number of inpatient beds that could accommodate patients referred from other centers. This in turn prevents patients from being referred to specific hospitals with particular expertise from being sent. This also reduces the number of beds being used and those could be cut because of "lack of use". To us this sounds like a vicious cycle. The Congress needs to probe the so-called reasons heard about the need to reduce beds.

8. Gradual conversion of our hospitals to outpatient centers (so numbers can be greater).

9. Create dissent, discontent, and discord within the ranks of VHA with rumors that other programs will soon be closing in order that employees scramble to find jobs at other facilities (not VA) in fear that they may be out of a job when the program(s) close.

10. Once employees leave, VHA does not replace them, so therefore the number of beds and programs have to be reduced due to lack of staff & patients.

11. Create performance measures for the Hospital Directors that are nearly impossible to meet unless drastic action to reduce costs of staff, inpatient beds and yes, in the case that brings you all here today, housekeeping.

12. Have all VISN 15 hospitals contract with the private sector for as many services as possible.

"Congratulations" are in order for the managers in VISN for responding quickly to the real priorities of the VHA senior bureaucracy, since most of these were accomplished within two (2) years. No wonder the bonuses mentioned above were given and accepted while Veterans must wait for services (up to 18 months for eye appointment, 1year after registering with the VA to have an intake and receive a primary care Dr. even when been diagnosed at a Cancer Treat Center with Cancer and a prognosis of 6 months to live, 2-9 months to have cardiac problems scheduled for surgery, live on the streets while attending alcohol & drug abuse treatment during the day. This list could go on and on but believe time precludes you from sitting here and listening to me for at least two days. I have a hard time doing that myself. I believe you all see our point about some of the causes for these problems.

If you please, two more items to speak about on diminishing health care for Veterans.

1. In July (I believe it was) one VA Hospital received a "Scissors Award" and "A Center of Excellence" designation for its cardiovascular program. By July 1, 2000 this program was cut to one (1) Cardiologist.

2. This is a veterans' health care system, and as such a complete military history needs to be taken for each veteran and used in the diagnosis and treatment plan. That is not done here, nor apparently anywhere else in the country. This must be fixed soon.

3. The over $300 Million set aside for Hepatitis C testing of veterans cannot be accounted for once it reached the VISN levels. This lack of accountability is not acceptable to this organization. If it happens for this program, how many others have been cut and where did the money go. It certainly was not for health care or for cleanliness of facilities such as the KCVAMC.

MSCVVA cannot stress too strongly that the VHA needs an increase to at least $25.5 Billion for general operating funds for FY 2003, as a bare minimum. The numbers recently secured by the VVA national office indicate that the current rate of increase of category 7 veterans seeking VHA services is 18% and the rate of "new" categories 1 thru 6 veterans seeking services from VHA are now increasing at the rate of 9% per year. Should this prove out to be the case after further analysis, the amount needed just to stay

where we are, long wait times and shoddy care, would be over $28 billion. So, more money is needed.

MSCVVA believes that it is time to make spending for veterans' health care mandatory. It is NOT "discretionary" as whether to properly treat America's disabled veterans. The level must start at the capitation of funding available in FY 96, and index it for 8% per year, with the gross number of funding available to rise as the numbers served rises.

MSCVVA believes that it is high time to start holding the VHA structure much more accountable here in VISN 15, as well as nationally. First, the bonus and presidential awards processes should be transparent and the criteria clear. Second, each hospital must have a real veterans committee that meets with the Director and the Chief of Staff at each hospital every three months at minimum, with the agenda set by the veterans' service organizations and other stakeholders as well as the VA. These meetings must be separate and apart from the VA Voluntary Services meetings, and should be open to the public, including congressional staff.

MSCVVA urges the Congress to demand that the VHA develop an effective financial tracking system by FY 2005 whereby you cannot "lose" $326 million as VHA did in the case of the missing hepatitis C funds. Now I don't know about Kansas or California, but we in Missouri believe that $300 million is a good chunk of money, even in a system as big as the VA, and should not just disappear. We can and must do better.

Similarly, we in Missouri believe that VHA (and all of VA) cannot go on without a "real time" management information system. The Secretary and the Undersecretary for Health cannot tell you today how many people they have with what kind of training and what kind of equipment at the Ft. Riley VAMC, at KCVAMC, at San Diego, or any place else. Can you imagine the Chief of Staff of the Army or the Commandant of the Marine Corps lasting even 24 hours if they could not answer those questions? We urge the Congress to require such a system by at least FY 2005, if not FY2004.

If the VA computer and information technology people are not up to the job (and they may not be, given the lousy track record of that area and the consistently poor job of furnishing them with clear requirements/specifications by top VA officials from all areas, benefits as well as health), then it is time to find someone who can get the job done. UPS can find their packages in the outback of Australia or the Ozarks of Missouri. Maybe we should seek advice from them.

The point I am making Mr. Chairman, is that the Missouri State Council of Vietnam Veterans of America strongly believes that we need significantly more money put into this system, at the same time that Congress demands much, much more accountability out of the VA. The money is necessary, but without strict accountability money alone won't solve the problems.

Mr. Chairman, this concludes the testimony of the Missouri State Council, Vietnam Veterans of America. I will be more than happy to answer any question that the committee may have.

MISSOURI STATE COUNCIL, VIETNAM VETERANS OF AMERICA
Funding Statement
June 17, 2002

The state and national organization Vietnam Veterans of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For further Information, Contact:

Director of Government Relations

Vietnam Veterans of America

(301) 585-4002 extension 127

ALAN GIBSON

Alan Gibson is starting on his 7th year as President of the Missouri State Council and is a member of the Board of Directors for Vietnam Veterans of America, Inc where he serves as Co-chair of the Employment, Training & Business Opportunity (ETaBO), Agent Orange and Government Affairs Committees. His is a graduate of Webb City High School in Webb City, MO, attended Missouri Valley College in Marshall, MO and

received his degree from the University of Georgia, Columbus (a BS of all things) in Columbus, GA.

Served in the United States Army from February 1959 to March 1979. Various assignments included service in Vietnam with the 101st Airborne Division and the 25th Infantry Division.

He has a Lifetime Teaching Certificate from the State of Missouri and retired from the State after serving as a Disabled Veterans Outreach Program Specialist (DVOP) for 12 years out stationed at the Harry S. Truman, VA Hospital in Columbia, MO

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN MORAN TO DR. STEPHEN KLOTZ

Honorable Jerry Moran
Chairman,
Subcommittee on Health
U.S. House of Representatives
Committee on Veterans Affairs
One Hundred Seventh Congress
335 Cannon House Office Building
Washington, DC 20616

July 2, 2002

Dear Sir,

Thank you for your letter of June 21, 2002 requesting follow-up of some further questions. Some critics of the paper in the *Archives of Internal Medicine* do not comprehend the connection of the flies with the mice. The attached responses, I hope, will answer this question and others.

If the Committee has further questions regarding the paper or my recent testimony I will be glad to answer them the best I can.

Sincerely,

Stephen A. Klotz, MD
Professor of Medicine, University of Arizona and
Physician, Southern Arizona VA Health Care System

Attached: Responses
Earliest manuscript draft I can find of the paper (sent to the *New England Journal of Medicine*)

1. Dr. Klotz, some have suggested you were disgruntled in some way during your employment in Kansas City. As you recollect them, what were your motivations for writing this article?

Answer: The "disgruntled" employee is discussed in the following answer (below). The motivations were straightforward for writing the article published in the *Archives of Internal Medicine*. The motivations were:

1) Reporting, for the first time, the unique relationship between the flies and mice and the incidental nasal myiasis. Human nasal myiasis has been reported before and all cases occurred with the same fly described in the paper (Green Bottle Fly or *Phaenicia sericata*). The relationship of *P. sericata* with rodent carcasses is well known in the Pest Control industry but certainly not appreciated in the medical field.
2) Transmitting the details of such an unique infection control issue to other physicians and health care providers.

2. Were you disgruntled at Kansas City, as one witness claimed?

Answer: I certainly was not disgruntled in **any** way with my employment at the Kansas City VA Medical Center. I enjoyed my time and position and had an excellent working relationship with the employees. This included Mr. Doran (former hospital Director) and Ms. Crossetti (VISN 15 CEO). I maintained a funded basic science laboratory studying fungal diseases for the ten years I was at the Kansas City VA (1990-2000) and supervised an HIV Clinic, Infectious Diseases Consult service, and standardized the antibiotic testing and use for VISN 15 (the latter with help from Ms. Crossetti). I am still collaborating with a number of individuals at the hospital on a clinical research project that was initially awarded to me. I moved to Tucson, not because of anything the KCVAMC did or did not do, but to take advantage of opportunities to become Director of the Infectious Diseases Fellowship program, Director of a larger HIV Special Immunology Program and to move my laboratories to the Tucson VA where two other Infectious Diseases doctors are working on the basic science of fungal diseases. No, I was not disgruntled as suggested by some.

3. Your hypothesis was that rodent carcasses drew flies into the hospital. Other witnesses have suggested construction at the time allowed common blowflies to enter. In either event, what should have been done here that was not done to stem this problem?

Answer: *P. sericata* is a common fly, particularly in rural areas where livestock abound. The biology of this fly is well known, particularly to Pest Control specialists, and the pertinent characteristics of the fly were presented in the article in the *Archives*.

The setting in the hospital at the time of the incidence of nasal maggots was the following: 1) We were trying to control a massive **mouse infestation** that originated from storage rooms around the cafeteria. The cafeteria was the likely epicenter of the infestation as supported by data in Table 1 in the paper. 2) There was a **simultaneous fly infestation**. *P. sericata* were observed over the entire hospital, not just one or two individuals. In fact, upon one visit to the Medical ICU some 10-20 flies were observed. Management's response was to issue fly swatters to the nurses in the unit. Insect

"zappers" were then installed at entrances and other sites in the hospital. Upon surveying the dead insects found in the trays of these devices, I found that the majority of flies were the easily recognizable Green Bottle Fly. There were no or few House Flies in the "zapper" trays—the *P. sericata* were obviously originating within the hospital.

The idea advanced by critics that the flies merely flew through open spaces near the ICU during construction does not hold up to scrutiny. For example, the preferred egg laying substrate for this fly is a rodent carcass. Many rodent carcassess were scattered about the hospital because the Pest Control company was broadcasting poison bait and placing glue boards out to trap the mice. It is important to map where glue boards are placed and the sites should be checked often to remove trapped live mice—such was not done in the Kansas City VAMC and glue boards when retrieved often had dead mice on them.) *P. sericata* adult females are in constant search for rodent carcasses and rarely if ever fly above 10 feet above ground. Of note, the openings into the ICU were over 50 feet from the ground. Furthermore, these "openings" were not permanent holes, they were doors on hinges, therefore, one shouldn't imagine direct portals into the hospital.

Several individuals remarked that "no dead mice with maggots were ever found" and therefore the paper is nothing but "hypothesis". These individuals are unaware of the biology of the fly, *P. sericata*, as well as the body of knowledge in the Pest Control industry. Ignorance of the facts will not change the outcome or rewrite what occurred in the hospital. If questions remain about the flies and mice, I would strongly recommend you contact the following experts in the field: Dr. Robert Corrigan, RMC Pest Management Consultant, 5114 Turner Road, Richmond, IN 47374, Tel. 765-939-2829, RCorr22@aol.com who is the leading expert on rodent control, or Dr. Nancy Hinkle, one of the authors of the *Archives* article, who is a leading expert on flies (Department of Entomology, University of Georgia Athens; 706-542-1765).

4. How strongly do you believe that eradication of mice would have led to eradication of flies from the Medical Center?

Answer: Both pests, mice and flies, needed to be eradicated. Removing all mouse carcasses attached to glue boards and stopping the practice of broadcasting rodent poison stemmed the problem. The hospital did begin live trapping and this certainly led to a major reduction as noted in the Table in the paper. The link between the presence of the flies and rodent carcasses was underscored a year after the last nasal myiasis incident when an infestation of *P. sericata* occurred in an operating suite. Search of the surrounding area turned up seven glue boards with mouse carcasses. These glue boards were "lost to follow-up" after being placed in the building. The presence of these flies is a sure sign of decaying flesh somewhere.

5. Did you see another *Archives of Internal Medicine* article concerning myiais in health care facilities, and if you did, did this article have any influence on your decision to submit an article to the *Archives* concerning this facility?

Answer: I was aware of the article on myiasis in the *Archives* and even cited it. It came to my attention after I had sent drafts of my article to *New England Journal of Medicine*, *Lancet* and *JAMA*. That article had nothing to do with my submission to the *Archives*. I

have published articles before in the *Archives* for the main reason that the journal enjoys a wide circulation.

6. Did you submit your manuscript to the *New England Journal of Medicine*, and what was the result of the submission?

Answer: The *NEJM* was the first journal that I submitted the manuscript to for consideration. The Editor replied that they would consider publishing the manuscript as a Letter but this would require that I delete either the Table or the Figure. I was unwilling to change the manuscript and therefore sent it to another journal.

7. Your article was peer reviewed, as I understand it. Would you furnish the Committee copies of your original article manuscript, peer reviews you received concerning your article, and your responses to these critiques?

Answer: I would be glad to provide the Committee with whatever I have. I do not have any correspondence from the *NEJM*. I am sure the Editor would be glad to provide a copy of the review if requested by the Committee. Basically, as stated above, the *NEJM* requested that I remove one of the items to shorten the article and a Reviewer thought there might be problems (legal?) upon publication and felt the article was ironical in tone. The "ironical" tone was removed before resubmitting the manuscript. Attached is a copy of that original manuscript or very close to it. For at least four years I have been saving only what is on a diskette or in my hard drive—hence, copies of correspondence over this manuscript I no longer have. What has been said above about the NEJM is also true of the *Archives of Internal Medicine*.

8. In your opinion, who is responsible for infection control in a VA medical center?

Answer: The Chairman of the Infection Control Committee is responsible for infection control in a VA Medical Center. That individual has the capability of closing a hospital if deemed necessary. One of the first documents the Joint Commission on Accreditation of Hospitals checks when inspecting a hospital is the letter from management giving that authority to the Chairman. Patient care was not compromised by the outbreak of the mice and flies at the Kansas City VA and hence, there was no need to close the facility. What was needed was a rapid and effective response to the infestations. The steps taken by management were not sufficient to correct the problem as was highlighted by the Office of Inspector General's report. This highlights a problem, in that the Chairman of Infection Control has the responsibility for infection control, but correcting problems always requires the cooperation and resources of the management which may or may not be forthcoming.

July 1, 2002

JUL. 1 4 2002

U.S. House of Representatives
Committee On Veterans' Affairs
One Hundred Seventh Congress
335 Cannon House Office Building
Washington, D.C. 20515

Dear Sub Committee Chair Jerry Moran :

The following information is in response to your questions concerning cleanliness at the Kansas City Veterans Affairs Medical Center.

1. What was your relationship to the Infection Control Committee at this Medical Center ?
   Infection Control Nurse committee member who was responsible for planning the meeting agenda as well as co chairing the meeting with the Medical Center Infectious Disease Physicians .

2. Did you read the Archives article of March 25th, and if so, what were your reactions to it ? Was it accurate and fair, based on your experience at this Medical Center ?
   Yes, I have read the article. My reaction was that this article points out the many problems and complications that may occur when there is a staff shortage especially if it's during a period where Mayor remolding is in process. As I reviewed the article, I felt that it was based on facts and Dr. Klotz is able to prove all points.

3. The rodent situation discussed in the article occurred hundreds of feet from the Medical ICU, in a different wing, and on a different floor of the Medical Center. Did you observe these problems when they occurred, and what happened if anything as a result of your observations ?
   During the first quarter of 1998, we experienced a problem with rodents in the storage room of the fourth floor canteen. This situation was addressed in our infections control committee meeting we made recommendations to canteen management and the medical center administration. Most of the recommendations were taken under advicement by management routine visits back to the area was made by the Infection Control Committee. During this time the medical center was preparing for a visit from the Joint Commission on Accreditation. The entire medical center was terminally cleaned. I do not recall additional rodent infection during this time. I retired September 3rd , 1998.
4. When you were employed at this Medical Center, was there a strong infection control program in place?
   Yes, the infection control committee was very strong. The membership met on a monthly basis. There was appropriate membership from designated services throughout the medical center. Monthly agenda contained review of medical center infection control policies and procedures, disease preventions, hospital and community acquired infection and employee education.

5. In your opinion, who is responsible for infection control in a VA medical center ?
   Infection control is the responsibility of the Infection Control Nurse and the Infection Disease Physician. Each has received special training in this special field. All employees including Administration are expected to recognize and adhere to Infection Control policies and procedures. The infection control nurse has the responsibility to educate employees in infection control.

Very truly yours,

Teola Tillman RNBSA
Former Infection Control Nurse

Questions for Mr. Hugh Doran, Former Director, Kansas City VAMC

1) What actions did you take on the recommendations made by the consultant's report that was commissioned by your chief of facilities in October of 1997?

I authorized the hiring of 8 additional housekeepers, utilized the "cleaning plan" for individual areas, established a night floor crew as a self directed work team as suggested by the local Union and gave full Supervisory duties to the incumbent work leader, Joe Mahoney.

2) The consultant's report made several recommendations that might have alleviated the problems without requiring additional staff, but would have required organizational changes. Were these recommendations implemented?

Yes, see above. I do not have a copy of the report and therefore cannot respond further.

3) Did you request additional funds to hire housekeeping staff?

The hiring of 8 additional housekeepers was accomplished within existing resources.

4) According to Mr. Slachta's testimony, there was knowledge of the sanitation problems throughout the facility. Did you have any recourse since the VISN 15 Director took no action?

As reported in my testimony, I began each fiscal year with a deficit 4 to 8 million dollars. I did not receive an additional allocation. I disagree with Mr. Slachta's assessment. Our hospital's sanitation was no different then others. We managed the "problem" as best we could within the resources allocated and our defined patient care priorities.

5) In regard to the problem of mice in the canteen area, you stated in your testimony that you did not have the money to do anything to this area at this time as you were in the process of building a new cafeteria. Since sanitation should be a top priority in a hospital, were any alternatives available to you to remedy the mouse problem?

I immediately took the appropriate "alternatives"...thoroughly cleaned the area, re-located the storage area and closely monitored the area, including frequent inspections by the Infection Control nurse and myself.

6) You worked as an executive in many VA medical facilities. Did you ever encounter problems in any of them similar to the problems here that created so many difficulties?

As I stated in my testimony, ALL hospitals have similar problems. Friends of mine have said, "I hope the IG does not come here and do the same inspection they did at Kansas City!" All hospitals have similar budget problems. Three individuals occupied the Director's position following my retirement, including the present incumbent and none of them did anything different then I did regarding housekeeping staffing, because no one had the resources until the Secretary gave the 10 million!

7) You have the benefit of hindsight now, since you retired from your VA Kansas City position about a year ago. In retrospect, what would you have done differently than you did to address these problems that were the subject of our hearing?

I would not have done anything different. I addressed the alleged problems in the appropriate manner. The budget deficit I had to manage each year did not allow me to do the things I would have liked to do.

8) In your written statement, you posed a rhetorical question about what you might have done with an extra $10 million in your budget. What would you have done with such extra funding had it been made available while you were the chief executive officer?

First, I would hire 5 Primary Care Physicians to take care of new patients who are now waiting 6 months for their initial appointment! I then would hire 12 Registered Nurses for the inpatient wards and the Outpatient clinics. I would then do the re-location of 3 west (surgery) ward to the 5th floor along with the new SPD area, making them both adjacent to the new Operating Rooms. Next would be the "halls and walls" project, along with the roof project. Lastly, I would hire 8 additional housekeepers and several engineering tradesmen. All of this is consistent with the mission and my well-documented plans.

9) Did you ever make a request for supplemental funds to help you deal with the cleaning or rodent problems? If so, what resulted?

It was WELL understood by all VISN 15 Directors that you operated your hospital within your initial allocation. I never requested funds specifically for pest problems. (The Director at Eastern Kansas presented a 'white paper' on his deficits and this act resulted in a 90-day performance plan!)

10) The local union officials who testified seemed to focus much of the accountability on decisions you made that they opposed. In the interest of fairness to you, and in recognition of your work in 17 VA medical centers over a 30-year career, would you please respond for the record?

Both Union officials have personal axes to grind with me. It is well documented. We had a functioning Partnership Council for many years, which had significant input into strategic planning for the hospital. Ms. McEwen, President of the Professional Union, was my former Chief of Nursing Service. At the time of my retirement, we were integrating the Professional Union into our Partnership Council. My record as Director is outstanding. Under my leadership, the Kansas City Medical Center became a "flagship" in every respect.

11) In your opinion, who is responsible for infection control in a VA medical center?

As in any organization, there are various individuals 'responsible'...the Infection Control Nurse, the Program Director of Performance and the Director. In our hospital, Infection Control was the responsibility of ALL employees.

In closing, I must take exception to the treatment I received from Congressman Filner. His personal attack on me was unprofessional and totally uncalled for. It was painfully obvious his objective was not to 'learn' from the individuals involved in this unfortunate incident, but simply to embarrass me. How naive of me to "volunteer" to be a participant, thinking I could add to the fact-finding process. I had a tremendous amount of admiration for the House Veterans Affairs committee; unfortunately, one member was allowed to "grandstand for the cameras".

To. Mr. Jerry Moran
Chairmen Subcommittee On Health

In response to your questions:

1. Can you provide examples of one or two changes that local management should have made that, from your point of view, might have resolved this problem with rodent and insect infestation?

Answer: First and foremost, listened to the employees. Check the IG report, there were Infection Control Committee Minutes dated 1998, 1999 in which the people on that committee were informing Mr. Doran on a monthly basis of rodent droppings and insects in the hospital. The committee was reporting this situation over and over to the director. I as the union president was trying to deal or negotiate with Mr. Doran over what I thought was a serious problem, Cleanliness of the hospital. The agency had a consultant come in and do a through survey of the housekeeping situation. The result, this facility was at least 15 to 16 employees short in housekeeping to maintain this facility at an acceptable level. These concerns were also being addressed to Pat Crosettii the VISN head. Nothing happened. All these employees, committees and union informing the top management officials, and nothing changed. From time to time we would hear a little "lip service" but that was all. Even the IH (industrial hygienist) Bill Yeager was trying to do something about this deplorable situation. He was fired. You must understand the management structure that Mr. Doran put in place when he got here. He had PPCI managed by Ms.Barbara Shatto. PPCI, Patient Performance Care Improvement. This Group controlled any and all information coming in or going out of this facility. They did all the patient abuse reports, they did all the patient surveys, they did all the IG complaints, the safety office, the police department and education was all under this person, (Shatto). She was also the Compliance Officer. Her and Hugh Doran worked very well together. All the good stuff went out and all the bad stuff was kept here. If it had to go out and it was not good they messaged it in such a manner as it would look good. Cleanliness is not the only problem in this facility. Doran and Shatto dismantled the MAS (Medical Administration Service)
So data systems were lost. They did not hire coders so third party billing fell over a year behind.. Please remember one thing here, EMS (housekeeping) was not the only section that was short staffed. When Mr. Doran came here there was 1400 employees, when he left there were about 960. He didn't hire more doctors or nurses ether.

Question 2. If the Director were required to move funds and personnel slots from direct patient care to maintenance or engineering to solve the cleanliness problems, and the result was diminished quality of care to the Medical Centers patients, should he have done so and why? .

Response to question 2
I think the answer to question 2 is a question back to you sir: Do you think if you were a patient in a hospital anywhere in the USA and while in that hospital you contracted maggots in your nose, wound or anywhere else would you feel you received quality care? Cleanliness is to quality like air is to life. You can't have one without the other. It is incumbent on the management team to be able to make decisions and prioritize where they are spending the money to assure quality care. I would like to point out many of the VA Directors did just that. Mr. Doran just wasn't one of them.

Question 3
Mr. Dorans written statement alludes to having received "70 unfair labor practice" allegations in one day, dealing with his decision related to the use of Compensated Work Therapy Patients to meet some of the Medical Centers needs in environmental management and to provide them with therapeutic training. Can you explain to the Committee the goal of the union in filing so many ULPs- what was the nature of the Medical Centers violations alleged in the ULPs?

Answer: This is a total LIE. I have included a copy of the ULP that Doran is referring to. I did not file 70 of them I filed 76 of them. The EMS employees were fed up with all the mandatory overtime and never working their regular area's or jobs. I negotiated an agreement with management that established regular area's of responsibility for each EMS employee. With in a week the agency violated the agreement. As stated in the ULP management declared an "Emergency" and totally disregarded the agreement. Management started changing duty assignments and hours of work. There were about 10 or 11 employees this affected and it had happened for about 7 to 10 days before I found out. So to get maximum affect I filed one ULP for each instance it happened. FLRA (Federal labor Relations Authority) combined them all into one ULP. This was but another case of the management at this facility by-passing the union in dealing with employees on conditions of employment, and this was an agreement that the agency made with the union itself.
As far a CWT's, they are not suppose to be used to replace an FTE (Full Time Employee) position in the Federal sector. A CWT is still a patient. The attitude here was, they were in the military, they don't need to be trained to sweep and mop floors. They were used many times before an inspection or special clean ups

Question 4 From your vantage point representing crafts and trades in so-called "blue collar" labor at the Medical Center, assuming everything that occurs in the Medical center is a "ze ro-sumgame" . with gains of resources in one part of the institution becoming loss of resources in another part of the institution, do you agree that "quality of care" should be subject to collective bargaining?

Answer: YES I DO! Who better to know what quality care is than the employees responsible for delivering it! If you will recall my counter part, Ms. McEwen's testimony, she stated it was the employees who are the ones who actually make the VA's Mission come true. Why would you not ask the experts. I recall Mr. Filner saying when he went into a hospital and wanted to find out what was going on, he talked to the nurses. If you had a VA hospital director who couldn't deal with the union how could you expect him to deal with his employees. Aren't the employees the union?

Question 5. How do you define "quality of care?"

Answer: Quality care, in my opinion, is patients being able to receive medical care in a timely fashion, by competent professionals and staff in a environment which is supportive, safe and clean. As my counter part Ms. McEwen, stated in her testimony, Quality care is maintained when there are appropriate checks and balances put into place. I am hopeful that your committee will see, through this experience, the value of checks and balances within the VA and begin initiating those changes necessary to not allow a situation such as happened here at the Kansa City VA Hospital. When there are differences, then a closer look may be needed. Certainly, one was needed here.

Summary. A Federal Union does not have the right to strike. If the management at a Federal Agency does not want to deal with the union, they are very capable of not having to do so. One of the first statements Doran made to me when I was first elected president of my local and I quote " I have all the money and all the lawyers and I will always win" I ask "what if you are wrong" his reply "I am never wrong" I ask "what if I'm right" Doran's reply "even if you happen to be right , I can fight you so hard and so long that by the time you get it in any court to be heard, they will have forgotten what you were there for". This was the first meeting I had with him as president and I didn't even have an issue with him. I went to his supervisor, Pat Crosettii, it did no good. Togo West who was in charge at that time refused to talk to me. When in March this year I watched on television the same Hugh Doran Group (Barb Shatto, Mel Davis, Doctor Emmot) tell the people this was an isolated incident that happened years ago and that the hospital was clean and safe, it made me sick at my stomach. Yes I gathered all my documents the next day and gave them to Senator Bond. I just wish there would have been some one in the system I could have went to and showed what was going on and got some thing done with out all this negative publicity.

THANK YOU
Bryan D Baldwin
President AFGE local 2663

Bryan D Baldwin

Form Exempt Under 44 U.S.C. 3512

UNITED STATES OF AMERICA
FEDERAL LABOR RELATIONS AUTHORITY

CHARGE AGAINST AN AGENCY

FOR FLRA USE ONLY
Case No. DE-CA-00554
Date Filed 6-30-00

Complete instructions are on the back of this form.

1. Charged Activity or Agency
Name: Honorable Togo West
Address: 810 Vermont nw
Washington, DC 20420
Tel.#: (202) 737-8700 Ext.
Fax#: ( )

2. Charging Party (Labor Organization or Individual)
Name: AFGE Local 2663
Address: 4801 Linwood Blvd. KC,Mo. 64128
Tel.#: (816) 861-4700 Ext. 6781 or 6777
Fax#: ( )

3. Charged Activity or Agency Contact Information
Name: Hugh Doran
Title: Director Kansas City VA Med.Cntr.
Address: 4801 Linwood Blvd. KC,Mo. 64128
Tel.#: (816) 861-4700 Ext. 2048
Fax#: ( )

4. Charging Party Contact Information
Name: Bryan D.Baldwin
Title: President AFGE Local 2663
Address:
Tel.#: (816) 861-4700 Ext. 6781 or 6777
Fax#: ( )

5. Which subsection(s) of 5 U.S.C. 7116(a) do you believe have been violated? (See reverse) (1) and

6. Tell exactly WHAT the activity (or agency) did. Start with the DATE and LOCATION, state WHO was involved, including titles.

On or about May 5th, 2000 at approximately 15:00 hours, I Bryan D. Baldwin President of AFGE local 2633, at the Kansas City VA Med. Center, received a phone call from bargaining unit employee Russel Lewis. Mr.Lewis informed me (Bryan Baldwin) that John Howard (facilities manager) called a meeting with him (Russel Lewis) and another bargaining unit employee (Tonia K. West).

Both employees hold EMS positions in the Facilities product line. Mr.Howard was in the process of changing the employees conditions of employment.

I (Bryan Baldwin) went to the EMS office where the meeting was taking place. Upon entering the office, Mr.Howard stated to me, "I'm declaring an emergency, employees are refusing to work any more over time." I said, "Is this a staffing shortage problem?" Mr. Howard became very angry, he raised his voice and ordered me out of the room. He yelled, "This is my meeting, you get out!"

Having observed Mr.Howard in the past get angry and threatening employees, along with throwing things at them, I left the room upon his demand.

Mr.Howard preceded to change employees regular duty assignment s, tours of duty, and conditions of employment.

7. Have you or anyone else raised this matter in any other procedure? ___No X Yes If yes, where? (see reverse) PARTNERSHIP COUNCIL

8. I DECLARE THAT I HAVE READ THIS CHARGE AND THAT THE STATEMENTS IN IT ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT MAKING WILLFULLY FALSE STATEMENTS CAN BE PUNISHED BY FINE AND IMPRISONMENT, 18 U.S.C. 1001. THIS CHARGE WAS SERVED ON THE PERSON IDENTIFIED IN BOX #3 BY (check "X" box) ☐ Fax ☐ 1st Class Mail ☒ In Person ☐ Commercial Delivery ☐ Certified Mail

BRYAN D BALDWIN — Type or Print Your Name
Bryan D. Baldwin — Your Signature
29 JUNE 2000 — Date

FLRA Form 22 (Rev. 1/99)

American Federation of Government Employees
Affiliated with the AFL-CIO
Professional Local #910
At
Department of Veterans Affairs Medical Center
Kansas City, Missouri
(816) 922-2040 phone
(816) 922-4702 fax

Congressman Jerry Moran
Chair
US House of Representative
Committee on Veterans' Affairs

Dear Congressman Moran:

I am in receipt of your follow up questions from the congressional hearing held here at the Kansas City VA Medical Center.

I do not recall stating that Mr. Doran ever responded positively to any calls that I made on behalf of the professionals here at the Kansas City VA Medical Center. However, I can share with you times when I did bring to his attention the lack of resources and his total disregard for the information or concerns.

In 1999-2000 we had a terrible "brain drain" here at the Kansas City VA. We had many, many physicians leave our facility. Some of those physicians had been with the VA for several years and some had been with the VA for a very short time. I brought to Mr. Doran's attention our concerns with the shear number of individuals who were leaving and the effect that had on our ability to deliver quality care. Several were specialist which were not replaced.

Mr. Doran's response was "they needed to go" and the patient satisfaction surveys showed the patients were happy. The survey showed patients to be satisfied because management manipulated it, the details of how I will share some other time.

The lack of some of the physician specialist certainly did effect our ability to give care.

In addition due to his reorganization we had supervisors in charge of things they were unfamiliar with. One being pharmacy which was placed under engineering during Mr. Doran's reorganization. This was disastrous, as the engineer in charge did not understand the complexity of the service being provided. We brought this to the attention of Mr. Doran, who felt the pharmacist "just didn't want to work" paying no attention to the fact that medications were being cancelled or missed upon discharge, pharmacist were unable to appropriately counsel patients on their medications etc. Systems were falling apart and patient care did suffer.

You asked who is responsible for infection control. Ultimately, the Director, as per his job description. However, you should know that all professionals have this as a part of their responsibility as well. We are all trained in it, and are expected to report failures, problems etc. which we did on a consistent basis, and were consistently ignored by Mr.

Doran. Even the minutes to meetings such as the infection control committee did not reflect the vigor of the discussion by the professionals to management. Thus, a 99% from JCAHO.

These and other problems are just more documentation as to why I urge the Veterans Affairs Committee to put in some meaningful checks and balances using the unions in that process. Mr. Doran, a director of a VA hospital, thought the KCVA was clean enough. There should be a formal process by which VACO and your committee solicit information not only from the directors of hospitals, but from their union partners. Where there is a discrepancy is where VACO and the Veteran Affairs committee, if you so chose, can start asking questions, looking at why is there a discrepancy before there is a need to publish articles about the lack of care in VA hospitals.

Again, thank you for asking for our opinion and for your interest in serving the Veterans. I am hopeful that you will see fit to begin establishing some check and balance system for the protection of the Veterans you serve.

Sincerely,

Linda McEwen
President
AFGE Local 910

Post-Hearing Questions for
Robert H. Roswell, M.D.

June 17, 2002, HVAC Hearing
On Cleanliness and Management Practices
At the Kansas City VAMC

Question 1. The Inspector General's administrative investigation states that, "Ms. Crosetti told us she considered Mr. Doran to be an unsatisfactory director, and documented her concerns." Please explain how this could be consistent with Mr. Doran's receiving substantial Senior Executive Service bonuses in both 1998 and 2000.

Response: Mr. Doran consistently scored very high on the performance measures within the National Network Performance Contract, on which the bonuses were based. Ms. Crosetti did not award bonuses based on performance measures specific to environmental cleanliness and the overall environment of care. Her concerns, as expressed to the OIG, were not related to the performance measures used to award bonuses. For FY 2003, however, performance measures specific to environmental cleanliness and the overall environment of care will be added to the Network Directors' performance contracts.

Question 2. There are dozens of older VA hospitals, not unlike Kansas City, in age and condition. Have you reviewed their status, including staffing levels in these so-called "low level" janitorial and pest-control activities, and what do you find the situation to be?

Response: We have reviewed the environmental sanitation and pest-control activities and staffing levels at our facilities. To assure that these essential programs are properly addressed, each facility Director has been required to certify in writing, with the concurrence of the respective VISN Director, that their facilities are clean and that the pest control programs are adequate. This certification of competence provides me with a high degree of confidence that these essential services are being provided. Let me note that we do not consider environmental sanitation and pest management to be "low level" activities; rather they are critical components of VA's overall quality assurance program. The staff performing these important tasks is well-trained and important members of the VA's health care team.

It should be noted that in the two cases in Kansas City, the maggots were more than likely caused by an ineffective construction barrier adjacent to the ICU rather than lack of cleanliness. In other instances, fly larvae have been found in wounds of patients who frequently go outside the facility to smoke. The Acting Network Director for VISN 15 has chartered a committee to review these

instances to see if there are any creative preventative measures that can be incorporated into our care delivery approaches, other than simply restricting patients to the ward.

With the establishment for FY 2003 of performance measures addressing environmental cleanliness and the overall environment of care, we believe that facility and VISN Directors will take greater steps to monitor the performance and ensure the appropriate training of staff involved in environmental sanitation and pest-control activities. In addition, the Director for the Center for Patient Safety has been charged to conduct an overall analysis of cases of myiasis. VA considers the occurrence of myiasis to be a serious problem that warrants appropriate steps to monitor and satisfactorily resolve it.

Question 3. Dr. Roswell, the Inspector General's reports from the late 1990's and through January of this year consistently revealed problems of cleanliness and presence of rodents at Kansas City. What actions did VA Central Office take to address these reviews when they came in?

Response: Many of the reports discussed in the OIG report were produced and shared at the facility and VISN level only. Staff and executives at the VA Central Office reviewed the reports available such as the JCAHO survey results and OIG reports as they were generated as well as the responses received from Kansas City VAMC and VA Heartland Network management. It appeared from these responses that while there were issues to be addressed, appropriate actions were being taken. The tone of the reports (particularly the January CAP report) did not generate a major level of concern at senior managerial levels. For example, in the "Organizational Strengths" section of the report, the IG indicates that:

> "KCVAMC management created an environment that supported high quality patient care and performance improvement. The patient care administration, QM, financial and administrative activities reviewed were generally operating satisfactorily, and management controls were generally effective."

In the Executive Summary of the report there is only brief, bulleted mention of the need to "correct environmental deficiencies that compromised the safety of patients." The entire section of comments on the environment of care is approximately three quarters of a page and most of the items mentioned were specific to certain locales, pieces of equipment, etc.

The facility received a score of 96 on its 1998 JCAHO accreditation visit and one of the highest scores in the nation (99) on its 2001 JCAHO accreditation visit. Unless one was intimately familiar with the facility, the changes that had been made to the environmental sanitation department and the deteriorating

cleanliness, one could assume that the facility was operating in a relatively effective manner.

These examples are not given to justify what is now known to have been a steadily worsening situation. They are given to create the context under which VA Central Office officials would view the facility and determine that no specific Central Office interventions were required.

The Veterans Health Administration (VHA) has developed new procedures to not only review and track CAP reports and monitor implementation of recommendations, but to provide better oversight and trend findings from CAP reports. With the cooperation of the OIG, distribution of draft reports is now directed to the appropriate network director for response to the OIG, through VA Central Office. Follow up on report recommendations is conducted in the same manner. VHA expects that these procedural changes will improve the awareness of Network Directors and VA Central Office officials of conditions at the medical centers, and allow for more immediate response to unsatisfactory situations. Distribution of draft and final reports is also being expanded within VA Central Office to ensure that individuals and offices with national program responsibilities, such as the Chief Information Officer, will receive OIG reports for review and appropriate action on relevant issues. VHA and OIG top management have scheduled monthly meetings to ensure critical issues are addressed. In addition, status reports for all open OIG and GAO reports are now issued weekly, monthly and quarterly to VHA top management, Chief Officers and Network Directors in order to better track VHA responses to draft reports and recommendation implementation. The Office of the Medical Inspector will be responsible for reviewing these reports and providing the trending information on a regular basis.

Question 4. In your judgment, has this problem been resolved at Kansas City, and how do you know?

Response: I believe that the problem is in the process of being resolved at the Kansas City VAMC. I reviewed the initial action plan developed by the Medical Center and the Network and my office receives weekly updates on progress in implementing that action plan. It is my belief that major progress has already been made in returning the facility to an acceptable level of cleanliness. More importantly, I believe that the infrastructure is being re-established to maintain an acceptable level of cleanliness once corrective actions have been completed.

Question 5. You have been a health care executive in a number of field locations, as well as a network official. Had a similar infestation occurred in one of your facilities as described in the various reports documenting this facility's problems with rodents and flies, what would your general approach have been to resolving it, and would it have differed from actions taken in Kansas City?

Response: As a network director, if a similar infestation had occurred in one of my facilities, my approach to resolving this would have been to convene a review team, external to my Network, comprised of individuals with expertise in infection control, environmental safety, and patient safety. Most likely the team members would have been a physician with expertise in infection control and/or a nurse infection control practitioner, an environment of care expert, and a patient safety expert. I would have charged the team with conducting an analysis of the causes of this situation, requested that the facility review and comment on the report and develop an action plan. I then would have followed up to ensure that the actions had been implemented and that no further incidents had occurred. My goal would have been to assure that the infrastructure was in place to provide appropriate and ongoing building maintenance. So, yes, my actions would have been different from those taken.

Question 6. Before approving bonuses for executives in your networks and facilities, does your staff review Inspector General and other external reports of activities under their jurisdiction? Please describe any such reviews and how these reviews are factored into bonus decisions.

Response: Management officials throughout VHA receive copies of reports from the Office of the Inspector General, Office of the Medical Inspector, JCAHO, Veterans' Service Organizations, CARF, NCQA, and other accrediting bodies on a regular basis throughout the fiscal year, which forms the performance appraisal period. The network director and Deputy Under Secretary for Health for Operations and Management review these reports. These reports are considered as part of the subordinate executive's overall performance, in conjunction with achievements on the performance measures, financial management, budget execution, strategic planning, stakeholder relations, and other factors. The scope, severity, and degree to which report recommendations might impact on the timeliness or quality of patient care are carefully weighed and considered as part of their overall assessment of performance.

Bonuses for medical center directors are recommended by network directors and are reviewed by various VHA officials and submitted for approval by the Under Secretary for Health. All VHA bonus recommendations are then submitted for review and recommendations, through the VA PRB and the Office of the Assistant Secretary for Administration and Human Resources Management, to the Secretary for final approval. In considering whether or not to give a bonus, as well as the amount of the bonus, the individual's overall performance is evaluated by VHA management in relation to their performance contract.

The performance contract is comprised of three sections—Part A (Core Competencies), Part B (Performance Measures) and Part C (Network Performance Measures). Part A of the contract relates to the individual's interpersonal effectiveness, systems thinking, flexibility/adaptability, organizational stewardship, service to veterans, creative thinking, personal

mastery and technical knowledge and skills. Under the "personal mastery" and "technical knowledge" sections of Part A, there are specific requirements that the individual possess knowledge of requirements for operating high-quality programs, knowledge of accreditation requirements and the standards of a number of oversight bodies. There is also the requirement that the individual "balances the organization's needs and resources to effectively carry out the multiple missions of the organization."

Certainly in evaluating facility directors on an ongoing basis, evidence of their abilities to meet the elements of the performance contract is reviewed, including reports from oversight and accrediting bodies. This will be even more prominently addressed in the performance contracts for next year when performance measures specific to environmental cleanliness and the overall environment of care are added. In addition, VHA will review all bonus justification documents to ensure they address all CAP and other OIG/GAO reports that were open or submitted during the performance period.

In VA Central Office, I have asked that a better trending process be established so that each program office can trend issues identified in all of these reports and take corrective actions. The Medical Inspector is responsible for reviewing these reports and providing my staff and me with trending information on a regular basis.

Question 7. Who is responsible for Infection Control in a VA medical center?

Response: The ultimate responsibility for Infection Control in a VA Medical Center is the Center's Director. Considering that the traditional Infection Control Program is comprised of several components that include the following: disinfection and sterilization, microbiology, infectious diseases, patient care practices, employee health, education, management and communications, and epidemiology and statistics, the leadership for each component may well have responsibility for the role of their component in the overall Infection Control Program for the Medical Center. Determination of oversight for the Medical Center's Infection Control program is made by the Center's top management based on local facility factors. On the VHA's annual Infectious Diseases/Infection Control census that is distributed to all VA Medical Centers, there is a request for each reporting site to identify the location/supervision of the Infection Control Program at the reporting site (a reporting site may represent more than one facility). Seven choices (Director's Office, Chief of Staff, Laboratory Service, Medical Service, Nursing Service, Quality Assurance, or Other [specify]) are given for the selection of one. Preliminary data from the VHA's annual Infectious Diseases/Infection Control census for FY 2001 revealed the following as reported by the sites:

Location/Supervision of the Infection Control Program	Number Reported
Director's Office	7
Chief of Staff	19
Laboratory Service	4
Medical Service	42
Nursing Service	16
Quality Assurance	36
Other	18

Question 8. When VHA executives provide "self-assessments" at the end of their performance rating periods, do they routinely self report on their responses to external audits, investigations and the like? If they do not do such self-reporting, should this procedure be added as a part of executive self-assessments?

Response: The Deputy Under Secretary for Health for Operations and Management conducts quarterly performance reviews with all network directors. Part of that time is set aside for issues that are not included in the performance plan. Monitors that are routinely discussed pertain to external accrediting organizations, such as JCAHO, CARF, and OSHA requirements. When presenting their self-assessment at the end of the performance-rating period, network directors may use the reports from various oversight and accrediting bodies as evidence of their success in meeting their performance measures. For the most part, however, network directors report their accomplishments on the core competencies – an individual's interpersonal effectiveness, systems thinking, flexibility/adaptability, organizational stewardship, service to veterans, creative thinking, personal mastery and technical knowledge and skills. The self-assessment is usually limited to 3 pages and responses to external audits are not always addressed in this end of year evaluation.

Since there is no face-to-face meeting for the end of the year performance review, discussion of external audits at the quarterly performance reviews is the preferable manner to deal with these issues. The reviews are more frequent than the end of year self-assessment and there is the ability to have a dialogue on the various issues. As described in the response to Question 3 above, the revised procedures for reviewing and tracking OIG CAP reports and the implementation of recommendations will provide specific information to the Network Directors and the Deputy Under Secretary for Health for Operations and Management that could be used in future reviews.

Question 9. A recent Archives of Internal Medicine article showed 68 incidents of myiasis in hospital and nursing home patients nationwide. Were any of these

facilities in the VA system? If you do not know, would you review this article and provide a report to the Committee?

Response: The article was titled Wound Myiasis in Urban and Suburban United States authored by Ronald A. Sherman, MD, MSc, DTM&H published in the journal of Arch Intern Med/Vol 160, July 10, 2000.

- The article was a report on a three-year multicenter prospective, observational study of wound myiasis in urban and suburban United States. 42 cases of U.S. acquired myiasis were reported on from 20 participating centers (3 were VA Medical Centers) over a 3 year period of time. Only 2 cases were considered to be nosocomial (healthcare-associated) and neither case was from a city associated with a participating VA Medical Center. Of the 20 Centers that participated in the study, only 12 Centers submitted cases (45 cases submitted with 3 excluded from analysis as they did not meet the definition of U.S. acquired myiasis). Considering the strong role of anonymity in the research arena, it is not known whether any of the 40 non-nosocomial cases of myiasis were submitted by any of the participating VA Medical Centers.

- Since it could not be determined from the article if any of the non-nosocomial cases were submitted by the participating VA Medical Centers and myiasis is not a standard reportable condition, a review of the article as requested is presented below:

- Literature review between 1960 and 1995 revealed 400 English language articles indexed, 72 articles described 137 cases of U.S. acquired myiasis. Prior to this study, there was only one prospective study of human myiasis ever published and that study was limited to the Australian city of Brisbane. The literature consisted mostly of case reports.

- The frequency of myiasis in the U.S. is unknown. Several authors have noted that the number of cases of myiasis occurring in the U.S. is probably underreported for aesthetic, cultural, social, and medico/legal/political reasons. The report, Myiasis: Epidemiological Data on Human Cases published by the Public Health Service, U.S. Department of Health, Education, and Welfare in 1963 estimated that about 7000 cases of myiasis occur annually in the U.S.

- 20 participating centers (3 VAMCs [Long Beach, Dallas, Augusta] participated) were included in the paper reviewed.

- Centers were to send maggots found on patients to a specified site for maggot/fly identification.

- 45 cases (from 12 of the 20 participating centers) were submitted, but 3 were not included in the analysis, as they did not meet the definition of U.S. acquired myiasis. (Cases were not identified by center but by city, so we are unable to identify if or which cases may have been submitted by a VA facility.)

- 42 cases of U.S. acquired myiasis were determined. 40 of the cases were considered to be non-nosocomial (community acquired) and 2 cases were considered to be nosocomial (neither from a city where there was a VA Medical Center participating in the study).

- Of the 47 identified maggot/flyspecies, 41 (87%) were blowflies (30 were of the *Phaenicia sericata* species. This species is a facultative parasite, meaning these maggots favor dead hosts or the necrotic tissue of living hosts). Most North American blowflies are facultative parasites as opposed to the obligatory myiasis causing maggots that infest living hosts and tend to be more invasive than the facultative parasites.

- Demographics of those 42 persons found to have maggot infestation: ages ranged from 35 to 87 (mean, 60 yrs and median was 51), male-female ratio 5.5:1, 16 known to be homeless (clothing of 10 of the 16 was soiled at time of presentation to the ER), of 35 with known medical histories 17 (49%) had peripheral vascular disease, coronary artery disease, cerebral vascular accidents or some other manifestations of circulatory compromise, 13 (37%) were alcoholics, 5 (14%) had solid tumors, 4 (11%) had diabetes, none had hematopoietic tumors and none had received immunosuppresssive agents.

- Clinical manifestations of myiasis and the causative species identified in this study (most cases [83%] were simple wound myiasis caused by maggot species of noninvasive blowflies) differed significantly from those reported in the literature (out of 236 cases, 45 were wound myiasis and 1/3 of them caused by invasive maggot species).

- Important to make maggot identification as being <u>obligatory</u> or <u>facultative</u> as it may impact on patient management.

- Limitations of the study include its geographic limitation, (such as lack of Midwest and Northern sites where flies related to certain animals may have been encountered in the human population) and from underreporting. This study would suggest that the vast majority of myiasis is community acquired, caused by facultative North American

blowfly species that prefer dead or devitalized tissue, and that no VA facility reported a healthcare-associated (nosocomial) case.

Question 10. Based on the thousands of health care facilities in the United States caring for millions of patients, are 68 incidents of maggot infestation in patients many or few, and please explain your conclusion and its basis.

Response: As noted in the response to question 9, the number of cases was 42 rather than 68. While the CDC has made some estimates (in 1963) regarding human myiasis, there are only two prospective studies in the literature and neither was population based for large geographic areas such as the U.S. or Australia. Therefore it is not possible to define either a numerator or a denominator to use as a benchmark for any real comparison. There is also a major disincentive to reporting this infestation in the literature, and underreporting has been documented. It should be noted, however, that the North American prospective study revealed that the vast majority of cases were community acquired and not healthcare-associated.

Question 11. Can a medical intensive care unit, or an operating suite, be made free from pest invasions like the ones that were reported here, or is there a natural limit to exclusion of such pests from these sensitive environments?

Response: It is possible to ensure that ICU and operating suites are virtually free from insect and large pest invasion. The design of these units utilizes both physical and mechanical barriers, and on occasion, chemical barriers, to reduce intrusion by pests. However, on rare occasions, any secure environment can be compromised. It is the goal of an integrated pest management program to forestall or prevent infestation, and to control or eliminate existing infestation. Preventive pest management is considered to be the most economical and effective means of protecting our patients, employees, visitors and Government property

Question 12. Your testimony indicates that in retrospect and as a result of the IG reports conducted this past April, the Kansas City VA Medical Center suffered from mismanagement and had difficulty maintaining housekeeping and pest control as a top priority at the hospital. These problems date back for quite some time; did the VA Central Office have any knowledge from the VISN as to the nature of the problems in this facility?

Response: As stated earlier, there was no general knowledge at the VA Central Office of the seriousness of the conditions present at the Kansas City VAMC until the publication of the article. The concerns that Ms. Crosetti had expressed in Central Office about the director of the Kansas City VAMC were not related to the deteriorating cleanliness at the facility.

Question 13. You mentioned that the managers in this hospital will be held accountable for the deficiencies throughout the facility. What will you do to ensure that these types of incidents do not occur at this hospital again, or at any other VA medical center?

Response: As I mentioned, I have put in place a performance-based certification of compliance requirement for facility and VISN Directors. A policy directive concerning environmental rounds and an environmental sanitation quality assurance program are also being developed to provide continuous environmental service review at the corporate level. These governance activities, close monitoring of all reports from accrediting bodies, and the efforts of review groups, such as the IG, will maximize assurance that these types of incidents will not jeopardize the high quality of care that VA provides to the veterans of this nation.

Question for Mr. Kent Hill, Director, Kansas City VAMC

1. Mr. Hill, with respect to difficulties you have encountered in cleaning the medical center, what can you tell us about the current state of cleanliness and when do you expect the cleanup to be complete?

Several significant and noticeable strides have been made in the cleanliness of the medical center. Management staff and AFGE officers conduct weekly environmental rounds and have not identified any areas of the medical center that currently have a sub-optimal level of cleanliness. In addition, an inpatient satisfaction survey of 100 veterans was recently conducted. The study showed that over 75% of inpatients rated the cleanliness of their bedroom, restroom, waiting room, elevators/entrances, and canteen/cafeteria as either "Very Good" or Excellent". This will be the baseline from which future progress will be judged.

The medical center has a detailed environmental improvement plan that addresses housekeeping, pest control and maintenance issues. A small portion of that plan includes a schedule to perform focused cleaning throughout the medical center, which has already begun and will be completed by the end of September. Once the entire medical center has received this focused cleaning, we will have the systems and manpower in place to maintain a high level of cleanliness. The medical center will, however, always be looking for ways to improve as a result of the newly implemented continuous improvement process in the housekeeping department.

2. At this point, what can Congress, and this Committee in particular, do to help ensure that such an incident does not occur again, here or elsewhere?

Dr. Roswell has already taken action to review and certify conditions at all medical centers. He has communicated the expectations that senior leaders at medical centers conduct weekly environmental rounds and promptly correct deficiencies. VISN Directors are also to make rounds when they visit the medical centers. It is also my understanding that these expectations will be delineated in senior leadership performance measures next year.

I believe that these steps, as well as the heightened awareness throughout the system regarding the need to maintain a clean, safe environment, will be effective in preventing other incidents.

3. We heard in testimony at the hearing that the resources were not available to bring the hospital up to high standards of cleanliness, housekeeping, pest control, etc. Absent the release of the article from the *Archives of Internal Medicine,* would any of these problems have been addressed, in your opinion?

In the weeks before the release of the Archives of Internal Medicine article, the Kansas City VAMC had begun to review and slowly phase in measures to correct housekeeping and maintenance deficiencies. Some additional housekeeping aides and supervisors had already been approved and action to acquire the services of a more effective pest control contractor had begun. The Medical Center was working with contracting staff to incorporate provisions in the contract that would require the contractor to be licensed and to keep and report performance data to monitor the effectiveness of their program. The article and subsequent media exposure brought national attention to the environmental problems and required the Medical Center to expedite planning and corrective action. If

Inpatient care suffers because we don't have enough nurses. X-rays and lab tests that are accomplished but remain unread or take extremely long periods of time because of lack of technicians. All because of the heavy load of patients that doctors and staff are having to be responsible for. We can't attract new doctors or nurses because the pay grade scales are so low. Even when anyone applies, the process takes so long that most have found jobs elsewhere before the VA can process their paperwork.

My priority is with veterans who have spinal cord dysfunction. Their needs require immediate attention. A new spinal cord injury can't wait months for an appointment or a wheelchair or for overburdened emergency rooms. They can't afford to have their blood or urine tests forgotten. Their needs must be met immediately and through preventive medical attention. A once a year visit isn't enough. That is why we strongly advise that VA personnel be allowed more opportunity for educational options and incentives. We need to keep all of our personnel up to date on the latest research and technology.

Why is it so hard to see that our veterans are struggling with their health care providers and timely medical treatment? Don't they deserve the same treatment as any other hospital provides? Actually, don't they deserve the very best treatment to those that have borne the battle? I implore you to see that the Independent Budget that was put together by VA and service organizations be followed dollar for dollar.

Which brings me to the point I wish to make. You can't put twelve gallons into a ten gallon jug. You can't expect quality when you have such quantity. We need to give all veterans and their spouses exceptional care. They have paid the price. They came when they were asked-now its up to Congress and the American people to do their part. How can we expect our next generations to come forward when we need them and not be there when they need care.

Support the "INDEPENDENT BUDGET" as it is written.
The reason that there are delays in getting appointments is because the VA system is a good one. If given the appropriate funding this system will flourish and will be the best in the world.

Thank you for allowing me to address these issues. I will be happy to answer any questions that you may wish to ask me.

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