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COMMITTEE ON OVERSIGHT AND REFORM

2157 RAYBURN HOUSE OFFICE BUILDING

WASHINGTON, DC 20515–6143

MAJORITY (202) 225–5051
MINORITY (202) 225–5074

http://oversight.house.gov

Opening Statement
Chairman Gerald E. Connolly (D-VA)
Hearing on "Ensuring Quality Health Care for Our Veterans"
Subcommittee on Government Operations
June 20, 2019

Nearly 100,000 veterans living in the Washington, D.C., Northern Virginia, and Maryland area depend upon the Washington, D.C. Veterans Affairs Medical Center (DC VAMC) for their medical care.

For years, serious and urgent problems festered at the DC VAMC, endangering the lives of those veterans. From 2013 to 2016, leadership at the medical center and the Veterans Health Administration "received at least seven written reports detailing significant deficiencies." It is shameful how many warning signs have been ignored and for how long.

In March 2017, a confidential complainant alerted the VA Office of the Inspector General (OIG) to equipment and supply issues "sufficient to potentially compromise patient safety." The conditions were so appalling that the OIG took the highly unusual step of issuing an interim report in April 2017. The ensuing investigation culminated in the scathing March 2018 Critical Deficiencies report that brings us here today.

There are far too many glaring problems in this 158-page report to enumerate. But the OIG did issue 40 recommendations, and we need a mechanism to monitor progress on those. At the root of these deficiencies is what the Inspector General Michael Missal politely deemed a "culture of complacency," but what I would call a culture of indifference. Leaders at multiple levels "failed to address previously identified serious issues with a sense of urgency or purpose. In interviews, leaders frequently abrogated individual responsibility and deflected blame to others." How else do you explain the laundry list of critical deficiencies known to VA leadership that have threatened harm to patients and yet persisted for the better part of a decade?

Last month, my colleague, Rep. Eleanor Holmes Norton, and I visited the facility and met with the new director, Michael Heimall, and his senior leadership team for several hours about actions they have taken to address the exigent concerns raised by the VAOIG. Shortly after that visit, Ranking Member Meadows and I sent the director a letter requesting information regarding mental health treatment at the DC VAMC.

Today, I am here to put the DC VAMC leadership on notice – Congress will not stand for continued failures that threaten the health and safety of our veterans at what should be the VA's flagship medical center.

According to the OIG, the DC VAMC put veterans at risk – through needless hospitalizations, unnecessary anesthesia, and failure to use preferred surgical techniques – because important supplies, instruments, and equipment were not immediately accessible. As of March 31, 2017, the facility had a backlog of 10,904 open or pending consults for prosthetic items ranging from eyeglasses and hearing aids to surgical implants and artificial limbs. One patient waited more than a year for his prosthetic leg, and eventually gave up and moved to another state where a different VA facility promptly filled his request. The level and breadth of neglect detailed in this report is inconceivable and callous.

The OIG has found that some progress has been made. After a tumultuous two-year period in which the DC VAMC was led by five different directors, a new permanent director, testifying before the Subcommittee today, has taken the helm and all senior leadership positions are occupied by permanent staff. In May 2018, the OIG reported that the availability of supplies had improved and the prosthetics backlog had been eliminated.

But given the history here, we must beware false metrics. Leaders must also measure and examine customer satisfaction. Are veterans receiving the appropriate care that meets their medical needs and treatment expectations? Are employees really empowered to report patient safety incidents and do they trust that their leadership will address them? How can we ensure that this never happens again, whether at this facility or any other one that is charged with delivering care to those who served our nation in uniform?

Previous wake-up calls have come and gone, and veterans in need are continuing to suffer. In February 2019, one of my constituents sought inpatient admission for drug withdrawal symptoms, anxiety, and pain management at the DC VAMC. After the hospital declined to admit him, the veteran's wife found him dead of a gunshot wound in their home the following week. Just last month, there was a shocking report of a psychiatric patient who escaped from a locked area of the DC VAMC, traveled to Virginia, and abducted and assaulted a woman, resulting in his arrest. I'd like to play a clip from that NBC4 report.

Incidents like these remind us that there is a long road ahead. Putting procedures in place is the easy part. Eradicating the culture of indifference at DC VAMC, however, will take a significant investment on the part of leadership. We are here today to insist that Director Heimall rise to the task – that he stay long enough and work hard enough to hear every patient's and employee's concerns, to rectify those issues, and to communicate needed changes that foster trust within the facility.

We should never have to tell this story. Men and women who put on the uniform to protect our country had every reason to believe they would receive the highest quality healthcare as a

statement of our gratitude. Instead, they encountered mediocrity. No one, inside or outside of government, can possibly accept that standard. For everyone who works at DC VAMC – from the custodian to the cardiac surgeon - there must be one standard, and that is excellence. We will settle for nothing less.