STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
CRITICAL IMPACT: HOW BARRIERS TO HIRING AT VA AFFECT PATIENT CARE AND ACCESS
SEPTEMBER 18, 2019

Chairman Takano, Ranking Member Roe, and members of the Committee, thank you for the opportunity to discuss the Office of Inspector General's (OIG's) oversight of how ongoing recruitment and hiring challenges within the Department of Veterans Affairs (VA) can affect patient access to quality care. The mission of the OIG is to oversee the efficiency and effectiveness of VA's programs and operations through independent audits, inspections, reviews, and investigations. In response to Congressional mandate, the OIG has examined and reported on staffing concerns within the Veterans Health Administration (VHA) for the past four consecutive years (with the 2019 report expected to be released by September 30), and has raised issues with shortages or related issues whenever appropriate in the context of its other routine examinations of programs and processes. While it has made some significant strides, VHA continues to face a number of challenges to reaching full staffing.

This statement focuses on the barriers and challenges the OIG has identified in VA's efforts to recruit and retain a highly-qualified workforce that delivers health care to millions of veterans. The OIG also acknowledges areas in which VA has made some laudable progress. The OIG has identified frequent changes (and lapses) in leadership and workforce issues as major management challenges for VA and consistently found staffing shortages as a root cause for many of the problems in veterans' care and access identified in oversight reports. VA's inability to adequately recruit, onboard, and retain clinicians and support staff, particularly within specific service areas, reflects problems with competitive pay, field-wide shortages with some professions or positions, leadership and climate, planning, and other factors. Efforts to remediate these problems are hampered by VA's inability to maintain accurate medical facility vacancy numbers.

VA has experienced chronic healthcare professional shortages since at least 2015. It is critical for VA to move forward with developing staffing models calculated from defined requirements based on accurate data and implementing OIG recommendations related to hiring and retention. VA must enhance its ability to maintain a full workforce given the demand for VA health care, even as community care options are expanded. This is particularly important given an increasingly competitive recruitment environment and anticipated healthcare worker shortages in several practice areas. The OIG reports

highlighted in this statement provide stakeholders with examples of areas where the results of OIG reviews found instances of staffing shortages impacting the delivery of care.

CONGRESSIONALLY MANDATED STAFFING REPORTS

Congress has passed at least three laws since 2014 requiring a periodic accounting of vacancies within VHA, all of which have related OIG reporting requirements on VA's occupational shortages.[1]

OIG Determination of Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2018

Since January 2015, the OIG has reported on VHA clinical staffing shortages as required by the *Veterans Access, Choice, and Accountability Act of 2014* (PL 113-146).[2] Although the 2018 report was the fifth OIG report on staffing shortages within VHA, it was the first report that included facility-specific data reported by leaders at 140 VA medical centers.[3] Users can examine the particular self-reported needs of an individual facility as opposed to only national data. It was also the first report to include nonclinical positions (such as human resources, police, and custodial personnel) as required by the *VA Choice and Quality Employment Act of 2017* (PL 115-46).[4] These nonclinical occupations ultimately affect the ability of VHA facilities to provide quality and timely patient care in a safe and clean environment. The facility-specific results underscore for readers how variable the clinical and nonclinical needs are from one medical facility to another.

Medical center directors most commonly cited the need for medical officers and nurses, which is consistent with the OIG's four previous VHA staffing reports. The data showed that 138 of 140 facilities listed the medical officer occupational series (or a related VHA assignment code) as experiencing a shortage, with the psychiatry and primary care positions being the most frequently reported. Of the 140 facilities, 108 listed the nurse occupational series (or a related VHA assignment code) as experiencing a shortage, with practical nurse and staff nurse as the most frequently reported. Within nonclinical occupations, the OIG found that human resources management and police occupations were among the most often cited as shortages.

These results demonstrated that there are some clear commonalities, but the results also revealed wide variability in occupational shortages reported by individual medical centers. This was critically important to recognize because facilities have distinct staffing needs that must be considered in light of

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[1] Veterans Access, Choice, and Accountability Act of 2014, Section 301; VA Choice and Quality Employment Act of 2017, Section 201; and VA MISSION Act of 2018, Section 505.

[2] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages* reports were previously published on September 27, 2017; September 26, 2016; September 1, 2015; and January 30, 2015.

[3] *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages for Fiscal Year 2018*, June 14, 2018.

[4] VHA's own rankings in previous reports included Human Resources Officer as a position with shortages, but because the statute had excluded administrative positions, OIG did not include Human Resources Officer in the ranking methodology.

the facility's mission and its local resources. For example, a rural facility specializing in treating mental health needs may be staffed differently than an urban facility providing a broad array of services. Moreover, the rural facility may have a much smaller pool of qualified behavioral health professionals from which to recruit than VA facilities in urban areas.

The OIG's 2018 report also identified challenges to meeting staffing goals. Although hiring has increased, in four years of publishing the determination of VHA occupational shortages, the OIG has repeatedly noted the relatively long onboarding process and difficulty in finding suitable candidates. Medical center directors were able to use free text to explain the reasons for shortages, which varied significantly. OIG staffs' thematic analysis of the responses resulted in three frequently cited categories: (1) lack of qualified applicants, (2) noncompetitive salaries, and (3) high staff turnover.[5] Facilities reported recruitment challenges because of tough competition for quality healthcare professionals, and were using various recruitment tools such as special salary rates; recruitment, relocation, and retention incentives; and the education debt reduction program. The noncompetitive salaries were noted as a particular issue with recruitment of nonclinical staff, such as police officers. The survey responses noted that high turnover amongst high-performing staff had follow-on impacts as remaining staff became burned out from working overtime to cover existing vacancies. Additionally, facilities noted that both OPM classification appeal downgrade decisions and outdated OPM classifications affected their ability to offer competitive salaries and advancement opportunities within the organization, resulting in VHA being a less competitive employer for new staff and less likely to retain highly-skilled staff. An additional challenge for managers is navigating the recruiting and on-boarding process. In a separate OIG report, one manager described the recruitment process at their facility as being "exquisitely problematic."[6]

VA's Corrective Actions

Staffing for future needs requires hiring in anticipation of future losses, as well as ongoing and projected changes in clinical demand, staffing productivity, and allocation of personnel. The OIG recognizes that VHA has made progress in implemented staffing models in specific areas such as primary care and inpatient nursing. However, operational staffing models that comprehensively cover other critical occupations are still needed. Well-developed predictive staffing models would allow VHA to better assess and implement effective measures to address staffing shortage concerns. It is not enough, for example, to address doctor and nurse positions if the staffing model also does not provide for staff to schedule those providers' appointments, handle lab capacity for their testing, for sterile processing staff to clean their instruments, or the custodial staff to clean additional rooms.

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[5] The thematic analysis categories were developed after reading all the responses. Responses that fell outside of the developed categories were classified as "other."

[6] *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center Augusta, Georgia*, November 2, 2017.

The FY 2018 report's recommendations repeat the OIG's previous calls for VHA to develop additional comprehensive staffing models that address national needs, while supporting flexibility at the facility level. This approach would help ensure taxpayer dollars are invested in delivering the highest quality of care to veterans as promptly as possible. These staffing models, however, cannot be completed without accurate data. As detailed below, in a recent report examining VA's self-reported staffing data, the OIG found that VA and some of its medical facilities were unable to provide accurate data on the numbers of vacancies. Focusing on serving the individual and aggregate needs of veterans in different geographic areas and using that understanding to develop comprehensive staffing models will help VA achieve more efficient and targeted hiring and retention practices. Both of the FY 2018 report's recommendations are open as of September 18, 2019, despite the Executive in Charge for VHA providing a target date for completion of May 2019. The recommendations call on VHA to refine and formalize its position categories for clinical and non-clinical staff across all facilities.

In September 2017, the OIG made the following four recommendations to the Acting Under Secretary for Health in the FY 2017 report.

1. We recommended that the Acting Under Secretary for Health ensure that the Veterans Health Administration implements staffing models for critical need occupations. VA's self-determined Targeted Completion Date: September 2018.
2. We recommended that the Acting Under Secretary for Health review the Veterans Health Administration report on regrettable losses and implement effective measures to reduce such losses. Closed on August 2, 2018.
3. We recommended that the Acting Under Secretary for Health continue incorporating data that predict changes in veteran demand for health care into its staffing model. VA's self-determined Targeted Completion Date: September 2018.
4. We recommended that the Acting Under Secretary for Health continue assessing the Veterans Health Administration's resources and expertise in developing staffing models and determine whether exploration of external options to develop the above staffing model is necessary. VA's self-determined Targeted Completion Date: June 2018.

VHA has provided information on the progress they have made in addressing the recommendations, and OIG staff will continue to review VHA's future work.

Staffing and Vacancy Reporting under the MISSION Act of 2018

The OIG now reports on how VA can improve its administration of a website that publishes staffing and vacancy information in accordance with the MISSION Act.[7] Specifically, Section 505 of the MISSION Act requires VA to publish by departmental component, such as the Veterans Benefits Administration, National Cemetery Administration, and staff offices, or by medical facility for VHA, the following information:

- The number of current personnel
- The number of employment gains and losses processed during the previous quarter
- The number of staff vacancies by occupation
- The percentage of new staff who were hired within the Office of Personnel Management's (OPM) time-to-hire target of 80 days

The MISSION Act also requires VA to report annually on the steps taken to achieve full staffing capacity and any additional funds needed to achieve that mark. The first required OIG report assessing how VA is meeting this mandate found VA to be in partial compliance with the Section 505 requirements of the MISSION Act.[8] Generally, OIG found that VA reported its current personnel levels and time-to-hire data as prescribed. However, the staff vacancy, as well as the gains and losses, used alternative aggregation methods and were not sufficiently transparent for stakeholders to use the information reliably to track VA's progress toward meeting its full staffing capacity.

Vacancy Information Lacked Detail

Section 505 of the MISSION Act requires that VA publish the number of vacancies by occupation.[9] Instead, in each quarterly release, VA presented its vacancy data by occupational groups and job families, which are broad categories covering a set of related job functions. Most of the reported vacancies were generalized under the Medical, Hospital, Dental, and Public Health Group, referred to as the 0600-occupational group. However, this group includes clinical positions, such as doctors, nurses, and pharmacists, as well as nonclinical positions in medical records administration, housekeeping management, and consumer safety. The lack of specificity is significant because, as currently reported by VA, vacancy numbers for the 0600-occupational group do not sufficiently identify position-specific staffing needs in VHA. For example, VA reported in November 2018 that the North Florida/South Georgia Veterans Health System had approximately 347 full-time equivalent (FTE) vacancies within the

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[7] Under the *John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* or *VA MISSION Act of 2018*, VA's Office of HR&A coordinates the quarterly retrieval, aggregation, validation, and publication of the data (PL 115-182).

[8] *Staffing and Vacancy Reporting under the MISSION Act of 2018*, June 25, 2019.

[9] In implementing 5 U.S.C. § 51, OPM identified 676 occupational series (or occupations) divided into 59 occupational groups and job families as of September 2018.

0600-occupational group. That number is too broad to provide meaningful insight on specific vacancies, such as nurses versus physicians. VA's Office of Human Resources and Administration (HR&A) staff stated they did not list vacancies by series because it would reduce the readability of the report and because they lacked enough staff to break down the data by series. While these concerns may have merit, the OIG maintains that reporting the data by specific job or position would improve the value to VA and the public.

Gains and Losses Not Reported as Required

The MISSION Act requires VA to publish the number of employment gains and losses that were processed during the quarter preceding the data's publication date. However, VA did not follow these specifications and, instead, published data on all actions that took place during all four quarters of FY 2018, instead of only the fourth quarter as required. VA maintained that a report covering a single quarter would not capture losses that were initiated but not processed until after the quarter concluded. However, the MISSION Act does not require a complete accounting of all gains and losses, only those that were processed during the quarter. VA should adjust this methodology to ensure that data are reported in compliance with the MISSION Act.

Published Staffing and Vacancy Data Lacked Transparency

The OIG team identified opportunities for VA to improve the administration of posted personnel data by clearly articulating any caveats or context required to understand published figures. For example, VA did not disclose in their Section 505 staffing reports that it was aware the medical facility vacancy numbers were overstated. HR&A and VHA officials told the OIG team that inconsistencies and how the human resources software, HR Smart, was used created problems in counting vacant positions. Since December 2017, VA has been undergoing a process to correct this issue. Nevertheless, to improve the value and utility of the data, VA should inform the public of any known facility-level inaccuracies.

HR Smart is a position-based software, which means records are tied to the particular job position—not to the individual filling that position. The position, once established, exists regardless of whether it is filled. VA policy requires human resources staff to reuse an existing HR Smart position when an employee leaves a job. However, the OIG team was informed that human resources staff were creating new positions in HR Smart after employees left without deleting the existing job position, which was inflating the vacancy numbers to show two vacancies for the facility's single position—the original slot and the newly-created position.

From October to November 2018, VHA's calculations for the discrepancy between the number of FTE in HR Smart and the authorized FTE level grew from one percent to 2.4 percent nationwide. In December 3, 2018, an internal VHA memo indicated some individual VA medical facilities had HR

Smart position counts that were overstated by as much as 20.7 percent or understated by as much as 8.1 percent.[10]

Any variance between HR Smart and the authorized FTE for each location means that VA cannot precisely report on vacancies by facility as the MISSION Act requires. Also, VA medical facilities risk reporting vacancy numbers that do not accurately reflect their needs. VA's three administrations recognized that their position counts were inaccurate and began efforts to correct these figures before the initial release in August 2018. In general, this involved reconciling approved organizational charts with FTE counts in HR Smart. As of February 2019, the efforts to clean up HR Smart position counts and correct VA vacancy numbers were ongoing.

At the time the OIG published its report, VA's public website did not maintain each iteration of its published data, which further undermined its value as it limited the public's ability to compare data over time. For example, on November 14, 2018, and again on February 15, 2019, VA released the quarterly staffing and vacancy information, but replaced the prior publication rather than posting it as an additional release. Initially, VA staff claimed that historical releases were not maintained due to concern that data could be manipulated. For comparison, VA proposed that it has maintained its annual budget submission for public use dating back to FY 2008, and preserved public reports detailing veteran population and expenditures for compensation and pension benefits, medical care, construction, and readjustment and vocational rehabilitation for each state, congressional district, and municipality dating back to FY 1996. Subsequently, VA changed its position and is presently maintaining historical data.

VA Established a Methodology for Data Reporting, But Additional Improvements Are Needed

The OIG report identified several errors in VA's reported data that should be corrected to ensure accurate representation to the public. VA misreported time-to-hire information in two instances. VA's website incorrectly reported figures in November 2018 as pertaining to the fourth quarter of FY 2018 only, when in fact it represented time-to-hire data for all of FY 2018. Similar mislabeling occurred in February 2019, when VA's time-to-hire data noted that several occupational groups and Senior Executive Service positions were excluded.[11] These occupational groups support critical, mission-oriented work for the department. While HR&A leaders explained the exclusions were in error, VA should have verified that labels were accurate. In order to boost stakeholder trust in the validity of the data, VA's methodology needed to be updated to include quality control steps to verify the accuracy of its data labeling.

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[10] OIG staff did not receive definitive explanations from VA regarding the causes of understated position counts.

[11] The excluded 0600-occupational family includes physicians and nurses, who would be providing direct care to veterans. The excluded 0900-occupational family includes veterans claims examiners and veterans service representatives, who would be processing veterans' benefits. The excluded 4754-occupational series is for cemetery caretakers, who would be providing burial for veterans and maintaining the cemeteries.

VA lacked a documented methodology for implementing the MISSION Act's requirements until February 7, 2019.[12] The methodology VA established in February described how to compile the information supporting the MISSION Act's four requirements. The guidance ensures the work is not dependent on a single individual, allows for consistency across quarterly reporting, and provides an opportunity for VA to review each step of the process.

The OIG team noted that VA did alter its method for sharing data with its different administrations and staff offices to improve the accuracy of internal quality assurance checks.

Recommendations

In May 2019, the OIG made the following five recommendations to the Assistant Secretary for HR&A to improve the administration of VA's staffing and vacancy reporting. VA concurred with the recommendations and provided acceptable implementation plans.

1. Ensure VA vacancy data are reported by occupation as required by Section 505(a)(1)(C) of the MISSION Act. Targeted Completion Date: VA's self-determined Before publishing FY 2020 Quarter 1 MISSION Act Report, which will occur in February 2020.
2. Make certain that VA staffing gains and losses data are reported by quarter as required by Section 505(a)(1)(B) of the MISSION Act. VA's self-determined Targeted Completion Date: Before publishing FY 2019 Quarter 3 MISSION Act Report, which will occur in August 2019.
3. Annotate limitations clearly within the staffing and vacancy data to improve transparency and usability of the data, to include changes from HR Smart data-cleansing efforts. VA's self-determined Targeted Completion Date: Before publishing FY 2019 Quarter 3 MISSION Act Report, which will occur in August 2019.
4. Ensure that the staffing and vacancy reporting website maintains historical information on the data elements required by the MISSION Act. VA's self-determined Targeted Completion Date: Before publishing FY 2019 Quarter 3 MISSION Act Report, which will occur in August 2019.
5. Update the methodology for collecting and reporting on VA staffing and vacancy data to ensure consistency in future quarters. VA's self-determined Targeted Completion Date: Before publishing FY 2019 Q3 MISSION Act Report, which will occur in August 2019.

VA has begun implementing the changes in Recommendations 1, 2, and 4, but all recommendations remain open. OIG staff will monitor VA's progress until all proposed actions are complete.

PRIOR REPORTS IDENTIFYING STAFFING-RELATED PROBLEMS

[12] VA did not have a documented methodology for the initial two postings of staffing and vacancy data in August and November 2018. VA's process to aggregate data was undocumented and the responsibility rested with one HR&A data analyst. HR&A staff told the OIG team that standardized processes were necessary for staffing and vacancy collection.

Each year, the OIG provides Congress with an update summarizing the most serious management and performance challenges identified by OIG work as well as an assessment of VA's progress in addressing them.[13] These challenges are aligned with the OIG's six areas of focus outlined in its strategic plan: (1) leadership and workforce investment, (2) healthcare delivery, (3) benefits delivery, (4) financial management, (5) procurement practices, and (6) information management.

The following OIG reports are highlighted to demonstrate how OIG staff have identified staffing and workforce concerns over the past several years that can affect the quality and timeliness of patient care. In particular, these reports highlight how shortages of non-clinical personnel, such as human resources, logistics, scheduling, and custodial, can have impacts in the timeliness of care delivered across VA medical facilities.

Health Care Inspection: Evaluation of System-Wide Clinical, Supervisory, and Administrative Practice, Oklahoma City VA Health Care System, Oklahoma. In early 2016, the OIG became aware of concerns regarding clinical and administrative operations at the system, subsequently expanding to other provider-related issues.[14] The report describes how underlying causes for shortcomings within multiple program areas, processes, and operations were, in part, the result of leadership turnover and vacancies at multiple levels, most notably the medical director position, prior to May 2016. System data indicated that full-time employee-equivalent staff levels were often below authorized levels, despite the use of incentives and direct-hire authorities. At the same time, the system experienced serious front-line patient care staffing shortages, particularly in primary care, mental health, specialty care, nursing, and non-VA care coordination, which has clinical and non-clinical components. The system director took action on the OIG recommendation, including establishing a process to automatically recruit for clinical and medical support assistant positions.

Critical Deficiencies at the Washington DC VA Medical Center. In March 2017, the OIG received a confidential complaint and additional subsequent allegations that the medical center had equipment and supply issues that could be putting patients at risk for harm. The OIG conducted an inspection, issuing an interim report in April 2017, and a final report in March 2018.[15] The final report provided findings in four areas: (1) risk of harm to patients, (2) hospital service deficiencies affecting patient care, (3) lack of financial controls, and (4) failures in leadership. These deficiencies spanned many years, impacting the core medical center functions that healthcare providers need to effectively provide quality care. In particular, the report detailed the failure to inventory and to ensure supplies and equipment reached patient care areas when needed. An inadequately staffed human resources function contributed to key

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[13] *U.S. Department of Veterans Affairs Office of Inspector General Management and Performance Challenges*, November 2018.

[14] *Health Care Inspection: Evaluation of System-Wide Clinical, Supervisory, and Administrative Practices, Oklahoma City VA Health Care System*, November 2, 2017.

[15] *Interim Summary Report*, April 17, 2017; *Critical Deficiencies at the Washington DC VA Medical Center*, March 7, 2018.

vacancies throughout that facility, including shortages in logistics, prosthetics ordering, sterile processing, and environmental management services. The OIG made 40 recommendations, to which VA concurred. While VA provided detailed action plans on how the recommendations would be implemented and identified progress made, of the 40 recommendations, 9 are still open as of September 18, 2019. One open recommendation calls on the VISN 5 Director to ensure the timely completion of hiring actions at the facility until staffing deficiencies in the Logistics Service and Sterile Processing Service are fully resolved.

Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center, Florida. In January 2018, the OIG initiated a healthcare inspection of the medical center at the request of Congressman Bill Posey. The allegations included that a patient died while experiencing a delay in obtaining approval for aortic valve surgery outside VA.[16] It was additionally alleged that the facility failed to timely approve, process, and coordinate non-VA care coordination (NVCC) consults, and these delays were causing adverse clinical outcomes. The OIG substantiated delays in the processing of other thoracic surgery NVCC consults entered during a 10-month period in 2017 related to an increase in the number of consults and limited staff available to process consults. However, the OIG did not identify adverse clinical outcomes associated with the delays. The OIG concluded the absence of a fully implemented tool to assist with care coordination increased the possibility of disruptions in the care coordination for the NVCC patients. The OIG made six recommendations, including that the medical center director conduct a review of Integrated Health Services workload demand and available staff, and takes appropriate action to ensure staffing allows for consults to be acted upon within VHA timeliness standards. All recommendations are now closed.

Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center, New York. Following allegations from several sources, the OIG conducted a healthcare inspection to assess long-term care nurse staffing and quality of care issues in the Community Living Centers (CLC).[17] Among other findings in the September 2018 report, OIG staff substantiated that nursing leaders were aware of staffing shortages; administrative registered nurses provided CLC nursing care; facility leaders pressured CLC managers to accept admissions despite inadequate staffing. The OIG was unable to substantiate that the use of float staff and overtime placed residents at a higher risk for adverse events. The OIG found the facility failed to use alternative staffing. There was also a delay in filling vacant positions and a lack of approval for increased staff. Also, overtime funding exceeded the cost of filling vacant positions. The OIG made three recommendations

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[16] *Delays in Processing Community-Based Patient Care at the Orlando VA Medical Center*, February 20, 2019.

[17] *Alleged Inadequate Nurse Staffing Led to Quality of Care Issues in the Community Living Centers at the Northport VA Medical Center*, September 18, 2018. That same day, the OIG released two other reports regarding allegations of poor quality of care at the CLC: *Alleged Poor Quality of Care in a Community Living Center at the Northport VA Medical Center* and *Alleged Quality of Care Issues in the Community Living Centers, Northport VA Medical Center*.

related to CLC nurse staffing and recruitment, alternative staffing, and overtime management. The recommendations related to nurse staffing and overtime management remain open.

Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System, California. In March 2018, the OIG conducted an inspection at the request of Congressmen Pete Aguilar and Mark Takano related to a series of concerns regarding the environment of care (EOC), infection control (including *Legionella*), care provider availability, leadership responsiveness, and the dental clinic at the VA Loma Linda Healthcare System.[18] The OIG substantiated many of the identified concerns related to inconsistent levels of cleanliness and repair through the EOC, including the dental clinic, as well as inadequate staff training and ineffective facility leader corrective actions. OIG also found high staff turnover, necessitating contracting for cleaning work and borrowing staff from other VA medical facilities. The OIG found inconsistent water temperatures to deter *Legionella* and in the notification of water testing results. The Sterile Processing Service's storage room was not consistently within temperature and humidity parameters, and the facility's healthcare-associated infection rates underperformed VHA's national averages. There were high hospitalist and mental health staff vacancy rates and recruiting challenges. The OIG made 14 recommendations regarding staff recruitment, EOC, infection control, *Legionella* inhibition, training, and documentation. OIG staff will monitor VA's progress until all proposed actions are complete.

Pathology Processing Delays at the Memphis VA Medical Center, Tennessee. In July 2018, the OIG initiated a healthcare inspection at the medical center following allegations of patient harm and death due to delays in processing laboratory specimens and reporting pathology results in the Pathology and Laboratory Medicine Service (P&LMS).[19] The OIG learned of delays in processing the reports, and found that in 2018, nearly 40 percent of P&LMS positions were vacant, and recruitment incentives for these critical staff vacancies were not being used. The OIG also found that Veterans Integrated Service Network (VISN) and national P&LMS leaders were aware of the vacancies but took no mitigating action. Facility leaders cited lengthy recruiting processes and lower pay leading to continued vacancies, as well as limited promotional opportunities leading to retention challenges. Additionally, turnover among human resources staff impacted P&LMS hiring efforts. The OIG made a recommendation to the VISN director to ensure that the medical center director and leadership team properly assess staffing needs in pathology and laboratory services and develop plans to recruit and retain those staff. The VISN director concurred with the recommendation, with a projected completion date of September 27, 2019. OIG staff will monitor VA's progress until all proposed actions are complete.

Although these are just a few examples, it should be clear that staffing deficiencies occur throughout VHA with far-reaching implications. Last month, the OIG reported how staffing shortages have created

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[18] *Review of Environment of Care, Infection Control Practices, Provider Availability, and Leadership VA Loma Linda Healthcare System*, June 18, 2019.

[19] *Pathology Processing Delays at the Memphis VA Medical Center, Tennessee*, August 27, 2019.

extensive backlogs in scanning electronic health records from community providers with the potential to undermine coordinated patient care and well-reasoned medical decisions.[20]

CONCLUSION

The OIG has prioritized oversight of VA leadership and workforce management, particularly adequate staffing by qualified professionals—recognizing that deficiencies in these areas are the root cause for many issues identified during OIG oversight reviews. Although VA has made important improvements, additional fundamental changes are needed for significant and sustained improvement, such as accurately tracking VHA's vacancy numbers; considering the implications for support staff and other team members in staffing models for particular positions; reliable and transparent reporting; recruiting and retention oversight that includes consideration of both individual facility and veterans' needs within a community; and strong and consistent leadership to create a stable and welcoming environment. To more efficiently utilize its resources, VHA must identify needed staff positions based upon comprehensive staffing models that are completely implemented.

The OIG thanks Congress for its commitment to ensuring VA has the resources to provide veterans with timely access to quality care that can be provided by caring and qualified staff.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.

[20] Health Information Management Medical Documentation Backlog, August 21, 2019.