United States Senate

WASHINGTON, DC 20510

November 7, 2019

The Honorable Robert Wilkie
Secretary of Veterans Affairs
810 Vermont Ave, NW
Washington, DC 20420

Dear Mr. Secretary:

We write today to discuss recent incidents where veterans received inadequate care or were harmed while receiving health care services at Department of Veterans Affairs' (VA) medical facilities. We are concerned about systemic issues that may be present within VA, affecting veterans' ability to receive high-quality, timely health care. We write with specific examples from Department facilities, in addition to questions for VA on how to ensure these incidents are not repeated at any other VA facility and protocols are put in place to safeguard patient care system-wide. The Department must get a handle on its shortcomings so that veterans feel safe using its facilities and providers choose it as a place to practice medicine.

Quality of Care Controls

A September VA Office of Inspector General (OIG) report highlighted that serious lapses in quality of care in the acute behavioral health unit at the Philadelphia VA medical center may have contributed to a veteran's death in 2017. VA requires that all medical facilities have an emergency response plan in place for cardiopulmonary arrest and that all clinical staff be trained in basic life support. Yet, providers in Philadelphia were unable to provide timely care when a veteran became unresponsive. The OIG determined that the veteran's care was also hampered by staff noncompliance with the patient observation policy, a lack of staff communication, and pharmacological errors. Further, VA requires providers to obtain voluntary informed consent from patients before a treatment or procedure, but the OIG found that only 13 percent of patient records from 2017 and none from 2018 contained this consent (for patients initiated on methadone in this hospital unit). The Department must follow its own guidelines, and it must make certain that its facilities nationwide, and not just in Philadelphia, are in compliance with their emergency response plans and are adhering to the national guidelines referenced in the OIG's report. We therefore request information about how the Department ensures compliance with emergency response plans and how it monitors compliance with its guidelines, including informed consent.

Credentialing and Privileging

In Arkansas, a VA physician was charged with involuntary manslaughter in three patient deaths that were due to incorrect or misleading diagnoses. These veteran deaths were entirely preventable. The pathologist had a known drinking problem, and was suspended from work twice for working while impaired. Nevertheless, he was allowed to come back to work each

time, before finally being fired in April 2018. In his 12 years as chief pathologist, misdiagnoses occurred in more than 3,000 cases and could be responsible for additional veteran deaths. He was also found to be falsifying patient records to conceal his misdiagnoses after other staff noted problems. This raises several questions for the Department, including why this individual was allowed to continue to work at VA after noted instances of being impaired while at work and why he was able to modify reviews of his work to make it appear he was providing adequate care. Veterans must have confidence that when they turn to the Department for health care services that the individuals charged with caring for them are monitored and held accountable for their actions. VA needs to take action system-wide to ensure that a protocol is in place for reviewing providers' fitness to care for patients, flagging concerns, and restricting providers from modifying their records to conceal mistakes. Please review these matters and provide us with the results.

A Wichita, Kansas VA doctor has been prohibited from treating veteran patients and was placed on administrative duties on September 17, 2019, after local press revealed that he was under investigation in Missouri for mishandling surgeries using robot-assisted technologies that he was not trained for. According to the Missouri Board of Registration for the Healing Arts, this led to unnecessarily long surgeries that resulted in errors, complications for multiple patients, and allegedly contributed to the death of a civilian woman.

Even more troubling is that six months prior to the local press reports and VA's decision to place this doctor on administrative duties, the doctor had surgical privileges at the Wichita VA facility suspended on March 25, 2019. In fact, since November 2018, the Wichita VA has conducted three separate external reviews involving more than 40 cases. While the Department claims that the doctor was properly vetted before employment, issues regarding his damaging performance history were available in the National Practitioner Data Bank and were seemingly disregarded in the hiring process.

Though this doctor is under investigation in a neighboring state and the VA has conducted three separate reviews in less than a year, he remains on administrative duties and will be fully compensated as though he is treating veterans. We request information on why this doctor has not been suspended and remains in a status of administrative duties receiving full compensation. Please also provide a full explanation of the VA's vetting and hiring process as it relates to this doctor and an assessment on his future employment in light of the multiple investigations regarding his ability to furnish safe and quality care. We also request that VA provide information on the Department's policy for vetting all providers upon hiring, continuously monitoring their performance, and training VA staff on credentialing and privileging.

An August 2019 OIG report also highlighted serious issues with credentialing and privileging at the Gulf Coast VA Health Care System in Biloxi, Mississippi where hospital administrators knew there were issues with a surgeon's medical license, yet hired him anyways. The OIG found that this thoracic surgeon provided poor quality of care and potentially compromised the health of two patients. While VA has a policy specifying credentialing and privileging requirements for health care providers, these protocols were not followed at the Biloxi facility. VA also did not take enough action to report these quality of care concerns to the

National Practitioner Data Bank, state licensing boards, and VA's personnel credentialing system.

An instance of a provider operating with insufficient credentials was also discovered at a VISN 10 medical facility. An ophthalmologist was found to be performing cataract surgery despite not possessing multiple qualifications, not completing an approved residency training program, and being ineligible for board certification. Due to failures at the leadership level, patients were exposed to unnecessary risk for two years, and this resulted in multiple patients having to seek additional care to resolve post-operative complaints.

Again, at minimum, the Department must follow its guidelines. Therefore, we request that VA undertake a bottom-to-top review of its credentialing and privileging processes to ensure the appropriate processes are in place and that adequate training has been developed and executed by all who participate in these processes.

Employee Reporting and Whistleblowing

The media reported in August that after a VA hospital police supervisor reported 27 "dangerous" deficiencies among his fellow officers, he was stripped of his badge and transferred to a new role. This incident, among others, raises questions about VA's treatment of whistleblowers and protection against retaliation. All VA employees should feel empowered to contact the OIG if they notice or suspect wrongdoing or malpractice in a VA facility.

The OIG recently shed light on the VA's failures to properly implement the VA Accountability and Whistleblower Protection Act of 2017. The OIG found that the VA Office of Accountability and Whistleblower Protection (OAWP) improperly conducted investigations and put whistleblowers at risk, undermining the objectivity of investigations and creating a culture of fear and retaliation. It was found that OAWP did not interview all critical witnesses as part of investigations, conducted investigations in search of evidence to confirm "desired outcome" rather than the truth, and provided incomplete evidence files to the Office of General Counsel. Further, the OAWP failed in its overarching mandate to protect whistleblowers. The OIG found that OAWP did not appropriately protect whistleblowers' identities when investigating or referring cases, making employees fearful of retaliation for reporting suspected wrongdoing. In addition to fulfilling the 22 recommendations from OIG, VA leaders need to take a serious look at what processes are in place within OAWP and across VA to facilitate the timely and fair investigation of whistleblower reports and to create a culture where whistleblowers are empowered and unafraid to come forward with their concerns. To that end, please detail what steps VA will take to improve the processes and culture at VA so that employees can report problems without fear of retaliation.

Drug Monitoring and Incident Reporting

The OIG and federal law enforcement partners continue to investigate the murders that took place at the Clarksburg VA Medical Center after the death of multiple veterans from hypoglycemia. While we do not know the specifics of what occurred in West Virginia, we do know that VA should take this opportunity to take a hard look at its internal processes to ensure that patients are safe at VA facilities. For example, we understand that VA released an updated

Controlled Substances Management policy in May 2019 specifying procedures for maintaining accountability of all controlled substances and compliance with Drug Enforcement Administration (DEA) regulations. While insulin is not classified as a controlled substance, it can cause harm or death if inappropriately used. What controls does VA have in place to monitor the supply, access, and use of other drugs and supplies that fall outside of the controlled substance category? Further, drugs and supplies could be misused or stolen from VA property if not properly monitored. A 2018 Government Accountability Office (GAO) report highlighted that VA's pharmacy inventory management could benefit from system-wide oversight, and VA officials cited in May 2019 that a plan was complete.

We urge VA to conduct a nationwide review of both its narcotic and non-narcotic drug controls to ensure that the Department is doing all that can be done to mitigate the behavior of bad actors. This includes a review of how drug carts are locked and monitored and pill and vial counts are administered. Further, VA should review its facility, Veterans Integrated Services Network (VISN), and VA Central Office (VACO)-level reporting requirements of incidents (including deaths) at its facilities to ensure that the right data is being pushed and pulled, and that individuals at each level are accountable for the information they are gathering, sending, and receiving. This information should also be reported in a manner where human error or indifference is accounted for and "warning signs" or unusual health patterns are reported and investigated by facility and VISN leadership.

Facility Cleanliness and Safety

We were recently outraged and appalled to learn that at a veteran receiving end-of-life care at the VA Eagles' Nest Community Living Center in Decatur, Georgia suffered more than 100 ant bites over his body after he was left unattended and his room became infested by ants. Dying just days later from cancer, it is shameful that this Air Force veteran had to spend his last few days subject to subpar care and neglect, rather than the peace and dignity that all veterans deserve. As part of the response to this incident, VA leadership informed Committee leadership there will be an immediate review of all areas of the Atlanta VA Medical Center to ensure proper pest control procedures. This is insufficient. VA leadership needs to ensure that no veteran in any VA facility, nationwide, will suffer the same experience. Just this month, a fly problem caused three operating rooms to be temporarily closed at the Manchester VA Medical Center. To safeguard patient care across the system, VA should conduct a review of pest control procedures at all VA facilities nationwide.

VA must also examine housekeeping staff pay and turnover. VA housekeeping staff are essential in keeping VA facilities clean and safe for our veterans. As reported in a September 18, 2019 House Committee on Veterans' Affairs hearing on barriers to hiring, there are numerous shortages of housekeeping staff across the VA and high turnover rates for staff. A September 2019 OIG report found that 55 VA facilities have a severe shortage of custodial workers, which is the fifth-highest type of occupational shortage across VA, and has particularly impacted the Tucson and Northern Arizona VA Medical Centers. Trouble recruiting and retaining personnel also impacted the West Haven, Connecticut VA and interfered with the ability of veterans to receive surgical procedures in the OR. Along with infrastructure problems affecting the Sterile Processing Service Unit, this led to veterans receiving care below the standard to which they are entitled. Housekeeping staff for VA medical centers need to be paid at rates that are more

competitive with the pay scales at other hospitals and health care organizations. VA has stated in previous congressional testimony that it is working with the Office of Personnel Management to consider and evaluate a legislative package proposal to address the hiring challenges. We would appreciate learning more about the Department's progress in developing this proposal and improving hiring.

High-Level Vacancies

We are also concerned about the number of acting and vacant positions within VHA – locally, regionally, and in Washington. Having unstable leadership at facilities, VISNs, and in headquarters means fewer people providing oversight, stability, and direction for the workforce, and accountability for results. To understand the current state of staffing in leadership positions, please provide the number of vacant or acting positions in the medical center leadership teams (i.e., quadrad), VISN leadership teams, and all VHA central office positions that are above the GS-14 level. Please provide this data broken out by medical center, VISN, and VHA Central Office position/office and with the title of each vacant/acting position. Please also detail your plans to fill these critical positions.

We appreciate your attention to this request and look forward to working with you to ensure the Department provides the highest-quality care possible to our nation's veterans.

Sincerely,

Jon Tester
United States Senator

Jerry Moran
United States Senator

Bernard Sanders
United States Senator

Pat Roberts
United States Senator

Richard Blumenthal
United States Senator

Shelley Moore Capito
United States Senator

Kyrsten Sinema
United States Senator

Tom Cotton
United States Senator

Robert P. Casey, Jr.
United States Senator

Tammy Baldwin
United States Senator