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## United States Senate

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ON INTELLIGENCE

April 12, 2012

The Honorable Eric Shinseki  
Secretary of Veterans Affairs  
810 Vermont Avenue NW  
Washington, DC 20420

Dear Secretary Shinseki:

I know you share my belief that caring for and respecting our nation's brave military veterans is among the federal government's highest responsibilities and priorities. That's why I simply cannot understand why the U.S. Department of Veterans Affairs (VA) continues to fail our veterans so frequently – as recently demonstrated in Missouri at the John Cochran Division of the St. Louis VA Medical Center (VAMC).

As you know, the St. Louis VAMC sent notices to more than 1,800 veterans in 2010, in which the facility blithely informed them that they may have been exposed to bacteria or viruses during the course of an entire year due to improperly cleaned dental equipment. In these notices, area veterans were offered free screenings for hepatitis B and C, and HIV.

This shocking failure by the VA to provide our veterans with safe and adequate care rightly prompted demands for answers, and I joined other elected officials in calling for an immediate explanation and resolution regarding this disturbing situation.

In a letter that you sent me on July 30, 2010, you assured me that the “St. Louis VAMC has undergone a thorough examination, and many safeguards are in place that are designed to prevent a similar situation from occurring. In-depth staff training and management reviews were immediately conducted by the St. Louis leadership, medical staff, and VA's Supply Processing and Distribution (SPD) program office teams.” You also stated that the VA “will not tolerate risk to our Veterans.”

During a March 15, 2012 Senate subcommittee hearing regarding your agency's budget, I revisited this situation and asked the VA's Undersecretary for Health, Dr. Robert Petzel, for an update on the St. Louis VAMC. Dr. Petzel assured me, “We've made tremendous progress... We're very pleased with the leadership. I think that [St. Louis VAMC Director] Ms. Nelson has really taken hold of the problems... The measures that we follow indicate that there's been tremendous progress in improving the general quality of care.”

Based on that answer, I believed that there had been an adequate resolution to the challenges that plagued the hospital. But unfortunately, I was incredibly disappointed to learn otherwise when the VA Office of Inspector General (OIG) issued a completely different account less than one month later.

On April 5, 2012, the report regarding the Cochran facility noted that two of the three recommendations made by the OIG regarding this incident have not been implemented. Incredibly, the report noted that the St. Louis facility “was not effective in monitoring compliance with some mandatory requirements” and it “did not provide the necessary level of oversight and did not routinely verify the adequacy of some practices or the accuracy of data and status reports.” In addition, the report noted that “the lack of consistent Processing & Distribution (P&D) section leadership has contributed to the ongoing P&D problems.”

Certainly nothing about the OIG’s recent report indicates that there has been any leadership accountability in response to these problems. Further, recent news reports indicate that the St. Louis VAMC ranks at the bottom of the VA’s 126 facilities nationwide in terms of patient satisfaction.

At best, the discrepancy between Dr. Petzel’s response and the information outlined in the VA OIG report less than one month later demonstrates a disturbing disconnect between the agency’s leadership in Washington and its local staff. At worst, this discrepancy was a blatant misrepresentation to the Senate Appropriations Committee regarding the reality on the ground.

We have a responsibility to provide our nation’s veterans with the best available care, and they deserve answers to these troubling questions immediately. Therefore, I request that you respond to me as soon as possible with the following information, along with appropriate documentation:

- 1) What specific efforts did the VA Undersecretary for Health make to ensure that the OIG’s recommendations were implemented with regard to the John Cochran Division of the St. Louis VA Medical Center?
- 2) What “measures” was the Undersecretary referring to in his March 15, 2012 Senate testimony when he noted the “tremendous progress” in improving the general quality of care?
- 3) Has anyone within the St. Louis VAMC or anywhere in the VA been held accountable for either the initial failure to properly sterilize medical equipment, or for the subsequent failure to implement recommendations made by the Inspector General?
- 4) Specifically, on what date was the VA Undersecretary for Health’s office made aware of the Inspector General’s findings?
- 5) Before you sent me your letter on July 30, 2010, what steps did you take to ensure that “many safeguards are in place that are designed to prevent a similar situation from occurring?”
- 6) What specific steps are you personally taking to intervene in this situation to ensure:
  - a. The St. Louis VAMC comes into compliance with all of the Office of Inspector General’s recommendations;

- b. The quality of care improves at the John Cochran facility;
- c. Communication is improved between the John Cochran facility and the Washington VA office; and
- d. Confidence in this facility is restored among the region's veterans?

I look forward to your prompt response. I am hopeful that this situation is heading toward resolution, but am increasingly discouraged by this agency's ability to resolve extremely basic care challenges in places like St. Louis.

Sincere regards,



Roy Blunt