VETERANS AT RISK: THE CONSEQUENCES OF THE U.S. DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER NON-COMPLIANCE

FIELD HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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TUESDAY, JULY 13, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 1:04 p.m., in the En Banc Courtroom of the Thomas F. Eagleton U.S. Courthouse, 111 South 10th Street, St. Louis, Missouri, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner and Miller.

Also present: Representatives Carnahan, Costello, Clay, Blunt, Shimkus, Akin and Luetkemeyer.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good afternoon. This is an official hearing of the U.S. House of Representatives Veterans' Affairs Committee. I'm the Chairman of the Committee, Bob Filner from San Diego, California. The Ranking Member for this hearing is Mr. Miller from Florida.

Thank you, Mr. Miller, for joining us.

Mr. MILLER. Uh-huh.

The CHAIRMAN. I'm glad to see all of you, but this is not the kind of occasion which merits any celebration. I appreciate everybody's interest in looking into the sad and tragic events that occurred here in St. Louis with the oversight responsibility of Congress.

I ask unanimous consent, Mr. Miller, for Mr. Carnahan, Mr. Costello, Mr. Blunt, Mr. Shimkus, Mr. Akin, Mr. Clay, and Mr. Luetkemeyer to be invited to join us for the full Committee hearing today.

Hearing no opposition, we welcome all of you. This is a very large delegation of Members of Congress who are not on the Committee. They are here because of the importance of the issue, so we thank you all for being here.

I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks.

Hearing no objection, so ordered.

I do want to thank the staff of the Thomas F. Eagleton Courthouse for their generosity in providing the space for us at today's hearing. We are all here because we are concerned about what hap-

pened with the dental clinic and the dental equipment at the U.S. Department of Veterans Affairs (VA) Medical Center in St. Louis.

As a result of the lapse in the protocol for cleaning dental equipment, more than 1,800 veterans have been put at risk, risk for having been exposed to hepatitis B, hepatitis C, and HIV (human immunodeficiency virus).

On behalf of all of us, we want to make sure you know how bad everybody feels about this situation. We want to apologize to the citizens of St. Louis for putting them through this very tragic situation. The probabilities of infection in this situation are low but they are there, and that puts families and the whole community at risk.

We are not only sorry for the citizens of St. Louis, but we are outraged that this could occur when we are dealing with the veterans of our Nation—those who we always pay the highest honors, respect, and gratitude for their service—and now in our own medical system they have to face these risks.

We want to get to the bottom of the events both leading up to the lapse in protocol for cleaning the equipment, and in the examination of the steps that VA officials took once they learned of this incident, and evaluate whether they have been effective in providing timely information to our veterans.

I'm also very concerned with what I see as a lack of transparency. Members of Congress were not informed until the matter became public. I came off a plane from San Diego to Washington and Congressman Carnahan approached me in the cloakroom of the House of Representatives and said, "Have you heard what went on here in St. Louis?" I was very embarrassed because I had not heard.

I want to especially thank Congressman Carnahan for being on top of this and making sure all of us were aware of what was happening, because the information did not come to us from our Executive Branch—as it should have.

Thank you again, Mr. Carnahan, for being on top of all of this so quickly, as were all of you from both Missouri and I guess they say "across the river" here, don't they?

When mistakes are made, the only way to deal with them, in our view, is through honesty and truthfulness. You have to do that to make sure you have the trust, and in this case, I think we have to rebuild the trust with the public.

How are we going to make sure that not only this doesn't happen again in terms of the actual cleaning of the instruments, but of the way the public was informed and treated with that information? Accountability is our bottom line here. We want to see who was at fault and what accountability measures will be taken to deal with that.

We are going to hear from veterans who were treated at the clinic and who have received the letter that says they are at risk. We want to understand their situation, their fears, and their questions while they are dealing with this.

Unfortunately, I have to tell the audience this is déjà vu all over again. We've had this kind of problem in other places, and each time we are told it won't happen again. In December of 2008, we had improper reprocessing of endoscopes, which put thousands of veterans in Tennessee and Florida at risk of hepatitis and HIV. In

February of 2009, another 1,000 veterans in Augusta, Georgia, received notification that they were at risk for hepatitis and HIV because of ear, nose and throat endoscopes that were not cleaned properly. Just last week, Mr. Miller, in your State, another 80 or so veterans were notified that they were at risk. Clearly, we have some problems here and I don't think we've remedied them when they keep occurring.

I just want to raise some issues, which my colleagues then will take up, with the timeline of this whole thing.

Dr. Petzel, when you get here on your panel, I hope you will respond to this.

When you look at the timeline for what occurred, apparently the procedures were not being followed for a whole year, between February of 2009 and March of 2010. They were discovered in a routine inspection but if your routine inspections find things that have been going on for a year, there is something wrong with that routine inspection. Why do we only find out after a year of this going on? It seems to me that this has to be an ongoing issue. But whatever you do, Dr. Petzel, in the VA there has to be more rigorous and more regular inspections. If they take place quarterly or bimonthly, we can't let things go on for a year.

When they discovered this in March of this year it took until May for the VA to put together a Clinical Risk Assessment Advisory Board to look at the risk. That's 2 months after they first discovered this.

I don't understand that at all. I think what should have happened when the risk was discovered was to announce it. Stand here with the Governor of the State, with the Members of Congress, with the Senators. Let's stand here and say, look, this has occurred and we are investigating it. All of the veterans who visited the dental clinic in the last year had better come in right away for some tests.

Two months go by and they call a board, who decided, as I understand it, Dr. Petzel, that the risk was sufficiently high—it wasn't zero—and they said we ought to notify everybody who was there at that time. That took another 2 months. On June 28th, the letters went out and they had their meeting on May 6th.

This is a serious issue. To allow that kind of waiting period and I know there is a cautiousness, but you are dealing with potentially fatal diseases of hepatitis B and C. We know the horrific consequences of HIV. You had 4 months where people could have given blood to your blood bank because they didn't know it wasn't safe or potentially unsafe—not to mention any sexual behavior. People might have changed their behavior had they known there was a risk. They didn't even know about it. I think that's intolerable, that it took that 4 months before anybody was notified.

As Congressman Carnahan points out, the letter that was sent out seemed a little cold. You have the option of being tested. Call up our 800 number. Now, I hope that 800 number is being staffed. They say 24 hours a day but we all know people who call 800 numbers and are on hold for hours, or somebody answers that doesn't even know what they are talking about.

I was going to call the 800 number this morning but I didn't have time. I was flying here but I wanted to see how they would actually respond to somebody. I hope they are responding.

I will tell you if you have 1,800 people with serious risk, I would have called in 1,800 VA employees—we have 250,000—and said, each of you is responsible for one of these veterans. Make sure you call them, counsel them, and give them the emotional support they need. Advise them of what the tests mean and when they are going to happen, and provide them with information about follow-up tests.

If you can't have one-on-one, call in 600 VA employees and put three to one, or call in 300 and make it six to one. As far as I understand it, we sent out these letters and the veterans are supposed to call in. Maybe we are following up, but I doubt if we are following up the way a case worker would where they track down these veterans. Such as address changes, phone number changes, etc. You've got to track people down. You've got to find them, and you've got to hold their hands and make sure they understand what's going on. We are not doing that. We are just not doing it. They are not only American citizens, they are our veterans.

It seems to me that we have to do a far better job not only in the transparency of a mistake, but then in counseling and helping people. I think we will have a panel on this. Even if you get a negative test for HIV, you are not always sure it's really negative. You've got to re-test 6 months later, but I'm sure somebody could testify to the exact process. We are going to have to stay with these people and be with them long term.

We owe it to them. They have fought for our Nation and we cannot let them just wander around, call up an 800 number, figure out when a test is going to be, and then maybe they will hear about it in a few weeks. Somebody has to be responsible for each of those 1,812 people. That's how I'm looking at this.

Mr. Miller, I appreciate, again, you coming from Florida to be with us to make this an official hearing as we need two Members of the Committee present, and I thank you for your commitment to our veterans that you have shown for all of your career in Congress.

You are recognized.

[The prepared statement of Chairman Filner appears on p. 66.]

OPENING STATEMENT OF HON. JEFF MILLER

Mr. MILLER. Thank you, Mr. Chairman.

I, too, share the anger and the frustration that you hear in the Chairman's voice. He has already recognized those Members that are here.

I do want to specifically mention one that could not be here because of a scheduling conflict, and that was Congresswoman Jo Ann Emerson. She does have a staff member here today.

And I, too, want to say that when this first became public, Roy Blunt and I had a very serious conversation in our cloakroom and he has sent a letter to Secretary Shinseki asking very pertinent questions. And I hope that today we will get the answers to some of those questions without waiting on a response from the Secretary.

But suffice it to say that we have had incidents like this all across the country. There are dedicated VA employees out there and we salute them, but mistakes like this have happened over and over and over again and as the Chairman said, Florida just had another incident that had been notified to the Congressional delegation in Miami.

The problem I have is that every time we have a hearing on one of these incidents, the VA comes forward and says, "We are putting in new procedures, new controls. It's not going to happen again." But it happens again and again and again. And unfortunately, I would have to say that promises from VA in issues such as this ring very hollow, and that is not something that we would expect from anybody in government, least of all, those from within the Department of Veterans Affairs.

I've got a lengthy statement and I want to ask that it be entered into the record because there are so many of my colleagues here who have a vested interest. I represent the First Congressional District in Florida, which is Pensacola to Destin, and I have the most veterans of any Congressional district in the country in my Congressional district.

I specifically asked to be on this Committee when I came to Washington in 2001 because I wanted to make sure that the veterans of our Nation were getting the care that we, as Americans, have promised to those who have borne the battle and worn the uniform of this country.

But without further comment, I would like to ask again that my statement be entered into the record without objection.

[The prepared statement of Congressman Miller appears on p. 67.]

The CHAIRMAN. Thank you. Thank you, Mr. Miller.

As I said, Congressman Carnahan from St. Louis has been on top of this from the beginning and has acted as our liaison for knowledge. We thank you for all the work you have done and you are recognized for an opening statement.

OPENING STATEMENT OF HON. RUSS CARNAHAN

Mr. CARNAHAN. Thank you, Mr. Chairman, and to Mr. Miller for being here traveling from Florida, as well. For my colleagues from both sides of the aisle and both sides of the river, we thank you for being here.

Mr. Chairman, your prompt response to the request of myself and Congressman Clay to hold these field hearings in St. Louis and to formally begin this Congressional investigation into how our veterans were put at risk by the safety lapses at Cochran Medical Center.

Since we learned early this month that veterans throughout St. Louis and Illinois could have been exposed to blood-borne pathogens such as hepatitis B, hepatitis C, and HIV while receiving dental care at Cochran, I've heard from many constituents, veterans and their families who are gravely concerned about this matter.

After their service to our country, this is not a fight our veterans should face. They deserve answers to this dental debacle, and relevant quality personnel and management questions. They deserve the best care available in our country. On behalf of the veterans

that I am honored to represent, I'm here to demand answers and action to make this right.

From where I stand, there are five core issues that I would like to see addressed here today. First and foremost, those 1,812 veterans who received that cold letter in the mail just a few weeks ago, to be sure they are getting the special care and follow-up they need.

Second, we need clear answers on how this happened and how it could have gone on for so long uncovered.

Third, I'm determined to get to the bottom of whether an employee of the medical center was terminated, in part, because she raised concerns about the sterilization procedures as far back as August of 2009. And I have to say any sign of retaliation or intimidation of employees throughout this process should not be tolerated and needs to be reported immediately.

I want to know what concrete steps are being taken to reach out to current and former employees, to be sure they are providing the necessary information to be sure we get to the bottom of this. We must make sure employees who have information that is relevant to this matter or any other problem are not only aware of their rights, but are encouraged to come forward and cooperate.

Fourth, I want to determine whether this latest incident at the dental clinic is limited to that incident or is part of a larger systemic problem at this facility. The VA Medical Center has been cited for serious infractions, which leads me to suspect there may be broader issues that need to be addressed. In April of 2010, the VA Office of Inspector General (OIG) conducted an inspection to, "Determine the validity of allegations regarding ongoing issues with the Supply Processing and Distribution (SPD) departments related to reprocessing endoscopes. The inspectors found that the SPD department did not have defined clean and dirty areas and there was severe communication breakdowns between staff regarding proper reprocessing procedures.

Moreover, in the 2009 Survey of Health Expectancies of Patients, the VA approved Patient Satisfaction Survey that tracks satisfaction responses from inpatient and outpatient veterans showed that Cochran scored the lowest score out of 128 VA hospitals around the country in inpatient services. A score of 46 percent is unacceptable.

And lastly, and most importantly, we need action. We need to determine what next steps need to be taken to restore and rebuild the faith of our veterans.

Let me be clear. This should not be an exercise to paint with a broad brush in a negative way our Veterans Administration or our health care services. As was said earlier, there are many professional and committed people that work in the VA. They should be commended and there are some important quality measures that we should all be proud of. But there is broad acknowledgment that serious mistakes have been made and there is much work to be done.

This past week I met with a group of 30 veterans, many on my Congressional District Veterans' Advisory Committee. There was a strong belief in the quality of care, but also a deep concern about these recent problems. At the end of the day it's critical the VA identify and rectify any existing problems, make sure this never

happens again, and takes actions needed to rebuild our veterans' shaken confidence.

To all the witnesses here before us today, thank you for being here to appear before us to get to the bottom of how this happened, to help us determine the answers, reforms and actions that honor our veterans with health care they earned and that they deserve and that is the best.

Thank you, Mr. Chairman, and Mr. Miller.

[The prepared statement of Congressman Carnahan appears on p. 68.]

The CHAIRMAN. Thank you, Mr. Carnahan. Thank you for putting that so clearly before us.

Mr. Blunt, you have shown your commitment to veterans here during your time in Congress. We thank you and thank you for being here.

You are recognized.

OPENING STATEMENT OF HON. ROY BLUNT

Mr. BLUNT. Well, thank you, Mr. Chairman, and thank you for being here. Thank you and Congressman Miller for taking time to call attention here in St. Louis where we have the most access to witnesses. And our staff, some of our staff was in the facility again yesterday to talk to people at the facility. I thank both of you for being here.

You know, recently I've had a chance to speak at the annual meeting of both the Veterans of Foreign Wars (VFW) in Missouri and the American Legion, and at both of those meetings I told them that of all our obligations as a country, at the top of the list of obligations is our obligation to our veterans. It should be a priority for us. I know it's a priority, Mr. Chairman and Mr. Miller, for your Committee. And thanks for your good work on this Committee.

Most of what needs to be said here we are going to hear from the witnesses, and I would just share my sense that one of the questions are, how could 1,800 people have been exposed to this risk over such a long period of time? How does this go undetected, or perhaps even detected and ignored? That's a possibility that's been raised here today.

Secondly, as the Chairman pointed out, how can we wait from March until almost July to notify people?

And then third, the callousness of that notification all were unacceptable. All were unacceptable.

If, as the Chairman suggested, as Mr. Costello has told me about an event in his district in recent years, this is déjà vu over again, it's unacceptable all over again. And Mr. Chairman, Yogi Berra, who is one of the most famous given credit for that comment, grew up just a few blocks from here. And he grew up in a country that understood its obligation to those who fight for freedom, and to those who are willing to fight for freedom. And that's what your Committee focuses on. That's why we are all so upset about this problem.

And you know, I've heard even earlier today, that some unsophisticated person getting this notice would be scared by it. My view is the more you know, the more you would have been scared by it.

And the notice was unacceptable the way it went out, and apparently it's the way the VA always deals with these issues. And this is at the top of our list of obligations.

And Mr. Chairman, again, thank you for drawing attention to this in a way, hopefully, that will make the future problems like this dealt with in a better way, and make this problem dealt with in a better way from now until every single veteran, and their family who is affected by it, is beyond the impact of it and hopefully and prayerfully all beyond the impact of that in a positive way.

And I give it back.

The CHAIRMAN. Thank you, Mr. Blunt.

Mr. Costello, you are our senior Member here today. We thank you for all of your years of service and commitment to veterans.

You are recognized.

OPENING STATEMENT OF HON. JERRY F. COSTELLO

Mr. COSTELLO. Mr. Chairman, thank you. And I want to thank you for calling this hearing here in St. Louis on very short notice.

I thank Mr. Miller for traveling here today from Florida to participate in the hearing. And let me just say that I have a lengthy statement that I will enter into the record so that we can continue with our witnesses. We have three panels.

But let me say that we are here to get answers. I think Mr. Carnahan outlined what some of the questions are. We have 1,812 veterans who have been put at risk. Three-hundred seventy of those veterans live in the Congressional district that I'm privileged to represent.

It's an absolute outrage that this happened, given that this is not the first time that this has happened. You outlined in your statement, and Mr. Miller made reference to, the fact that over 10,000 veterans were put at risk in Tennessee, Georgia and Florida. And as a result of that, these veterans now here in St. Louis know that they have been exposed but they do not know if they have life-threatening diseases as a result of this.

This Committee held a hearing, at my request, in 2008 as a result of what happened at the Marion Veteran's Hospital in Marion, Illinois. In 2007, nine veterans died as a result of substandard care at the Marion Veterans' facility. How many veterans have to be exposed and put at risk? How many veterans have to die before the VA gets it right?

Let me say that, finally, as Mr. Carnahan pointed out and others, the vast majority of the employees at the VA facility in Marion, Illinois, are outstanding, dedicated employees. It's the management that was at fault. It was the lack of aggressive oversight that was at fault.

And finally, in addition to the questions that Mr. Carnahan and you raised, Mr. Chairman, I want to know if, in fact, anyone is going to be fired as a result of this, as opposed to reassigned or located somewhere else. That happened in Marion. As opposed to firing the Director, they just reassigned him to another facility.

So I want to know what action is going to be taken to the people who are identified that, in fact, both in the Administration and the on-line employees, that are responsible, I want to know what's

going to happen there. Are they going to be pushed to another facility or are they going to be fired?

I think it's about time that agencies like the VA start firing individuals that do not do their job. And that may send a message out to everyone throughout the entire Department that, in fact, your job could be in jeopardy if you do not follow proper procedures.

And with that, Mr. Chairman, I thank you and I look forward to asking questions of our witnesses.

[The prepared statement of Congressman Costello appears on p. 69.]

The CHAIRMAN. That you so much, Mr. Costello.

Mr. Shimkus, you've joined us from across the river, too. Thank you for being here.

OPENING STATEMENT OF HON. JOHN SHIMKUS

Mr. SHIMKUS. Thank you, Mr. Chairman. And I appreciate my colleague Congressman Miller coming up from Florida, and of course my good friend, Jerry Costello, who has already weighed in on the issues that we dealt with at the Marion VA.

And I'm sure the folks out in the audience are hearing these stories and they are saying, why are we continuing to put up with this stuff? And so I knew you would probably elaborate that.

We need to know who knew what, and when, and then we need to do, as Jerry said, when are we going to hold someone accountable? When, in a big Federal agency, are we going to start holding people accountable for in essence dereliction of duties?

There is a cultural issue here. There is a cultural issue that we've dealt with in Marion and we've dealt with in other States that has to be changed. I was on a major radio station this morning in the St. Louis area and I had a, one of the call-ins was a veteran named Jason and he said, you know, I visit Cochran and I can't get the Patient Advocate to talk to me. Now, here is a veteran who called in to a talk show to let me know that there is more of a problem than just this.

I have a long-established relationship with Secretary Shinseki and I'm very biased in my high regard and my opinion of him, and my faith, and my trust. If he needs tools to separate the wheat from the chaff, then we need to help him get those tools. And it's unfortunate that we are here.

I welcome my colleagues to the bi-State area and I apologize to the veterans who have been affected on not only this but on other issues. And I think you've heard from the voices of my colleagues that we are going to continue to stay on-focus on this and start demanding change from the Veterans Administration.

Thank you, Mr. Chairman. I give it back.

[The prepared statement of Congressman Shimkus appears on p. 69.]

The CHAIRMAN. Thank you, Mr. Shimkus.

Mr. Clay, again, you've been on top of this from the beginning. We appreciate your commitment to St. Louis and welcome.

OPENING STATEMENT OF HON. WM. LACY CLAY

Mr. CLAY. Thank you, Chairman Filner and Ranking Member Miller, for holding hearing and for inviting me to join the investiga-

tion regarding John Cochran St. Louis VA Medical Center, which I represent in Congress.

Today we will examine and hopefully learn the truth about the improper processing of dental instruments, including a failure to clean dental equipment with a special detergent before it's sterilized.

It is unacceptable that procedures were conducted from February of 2009 to March of 2010 without proper safeguards in place to protect the health of veterans receiving treatments. Making matters worse, the VA knew about the possibility of exposure in March of 2010, yet veterans were not notified of the problem until June of 2010. That is shameful and there is no excuse for withholding that information. This Nation owes an enormous debt to the brave men and women who served our country with courage and honor.

Mr. Chairman, this is about a failure to follow proper procedure, a failure of supervision, and a failure to keep faith with all the brave Americans who have defended our freedom.

The truth about this incident will be revealed in this Committee hearing, but we certainly need honest answers to some critical questions. And one is, what is the chain of command that had primary responsibility to oversee procedures at the VA dental clinic at Cochran?

Two, what was the supervisor in charge—who was the supervisor in charge and when did he or she first become aware of the failure to follow proper procedure? And how did the supervisor find out about the problem during the time that the information about the potential contamination was withheld and did anyone else know about it? Who made the decision not to disclose that information immediately?

And finally, have the individuals involved been disciplined in any way, as my colleague Mr. Costello has asked?

Mr. Chairman, I thank you for conducting this hearing, and I yield back the balance of my time.

[The prepared statement of Congressman Clay appears on p. 70.]

The CHAIRMAN. Thank you.

Mr. Akin, again, thank you for joining us and we welcome your participation.

OPENING STATEMENT OF HON. W. TODD AKIN

Mr. AKIN. Well, thank you, Mr. Chairman. And I likewise have some notes that can be submitted for the record, but I just wanted to sort of digress a little bit and be a little more brief.

First of all, as a Member of the Armed Services Committee, I'm familiar with our soldiers. I'm familiar with their commitment, I'm familiar with their service, and also with the sacrifices that they make. And I guess it's maybe more personal. I have three sons that have been serving as Marines, and I've served in the Army myself. So what's gone on here is unacceptable.

My concern largely centers around what increasingly smells like a systems problem. I don't believe that what we've seen was a result of one or two people who failed to do their job. I believe, rather, that it is a broader organizational management kind of problem that we are dealing with, and it's also a culture that appears to be

suffering from misdirected understanding of what their priorities need to be.

Just as our sons and daughters serve us, this should be a service organization and service must come first. And it appears that at a number of levels organizationally, this is just not the culture. So, and if it were just limited to this one incident, we would say, well, okay, maybe there is one location where there has been some difficulties. Maybe some management problems or whatever.

This appears to be a broader kind of problem, and so my questions are going to be particularly from a systems point of view and from a culture point of view. What are we going to do to make this time different? Because we will not, as Members of Congress, put up with lousy service when we are asking people to give even their lives, at times, for this country.

Thank you, Mr. Chairman.

The CHAIRMAN. I think you hit the nail on the head, Mr. Akin. Thank you so much.

Mr. Luetkemeyer, we welcome you. This is your first term in Congress and you are getting a great introduction to what we do.

OPENING STATEMENT OF HON. BLAINE LUETKEMEYER

Mr. LUETKEMEYER. Thank you, Mr. Chairman and Ranking Member Miller. Thank you, gentlemen, for your service in helping to set this Committee hearing up, and in coming all the way to our beautiful part of the Midwest here.

I've got a very brief statement. I will keep it brief because I know we've got a lot to talk about today.

Commitment to our Nation, to those who fought for it, is a solemn obligation. Providing safe, sanitary health care is the least we can do for them in light of their service and sacrifice. It is absolutely unacceptable that procedures were conducted between February 1st, 2009, and March 11th, 2010, with a lapse in the safeguards in place to protect the health of veterans receiving treatment.

It is deplorable that any assistance less than the best health care available, along with possible exposure due to unsterile equipment, is the level of care being offered to our veterans. In this hearing today, we must determine what were the causes in the breach of standards and what the Department plans to do to remedy this situation to ensure that it does not happen again. Also, that we discern why, upon discovery of this problem, information was not distributed in a timely matter to impacted veterans and to other VA health facilities.

While we are here in St. Louis today, this situation impacted veterans all over the bi-State region and a number of other States. Constituents of mine in at least 12 counties were put at risk.

Finally, I will also point out that my colleague, Mr. Clay, and I are both Members of the House Committee on Oversight of Government Reform, the chief investigative Committee of the House of Representatives, and we requested that that Committee conduct a full investigation of the situation, as well. And we will look forward to that hearing and disclosure, as well.

Mr. Chairman, with that, I thank you and look forward to today's testimony.

The CHAIRMAN. Thank you.

As the first panel begins to come forward, Mr. Carnahan is going to introduce you, but I would like to make one other comment.

Panel one please come forward. Ms. Maddux?

In a July 2nd issue of the St. Louis Post Dispatch, the Chief of Dental Services at the Cochran VA Medical Center is quoted as saying, "Things are done to get votes, and that's a shame." That is, we are here today for show.

We are not here for a show. We are a bipartisan group that wants to get to the bottom of this for the, as all of you have stated, our veterans. That's our only concern here. I think that by blaming politics, it just looks like you are trying to shift the attention away from the mistakes that were made. I challenge——

Mr. SHIMKUS. Mr. Chairman, can you yield on that?

The CHAIRMAN. Of course, I will yield to you.

Mr. SHIMKUS. Just, with my colleague, Jerry Costello, so the public understands, when people die in hospital facilities like they did in the Marion VA, we have to take action. So I really find that egregious on the part of that employee to make that claim, because this is serious business. We don't take this lightly.

Thank you.

The CHAIRMAN. Thank you, Mr. Shimkus.

I challenge the Chief of Dental Service, in fact, I challenge all of you who are here on behalf of the Department of Veterans Affairs, to take responsibility for this disgraceful incident and show all of America, not just St. Louis, but all of our veterans what they are doing to better understand the why and the how of this inexcusable lapse in procedure happened.

I think the VA is already facing an uphill battle, but you must work harder and longer to improve training, implement standardized procedures and, most importantly, regain the trust of the veterans that you serve.

I would—Mr. Shimkus, I share your high regard, as I think we all do, for Mr. Shinseki, former Chief of Staff of the United States Army, now the Secretary for the Department of Veterans Affairs. As far as I know—and we will ask our panel—I don't think he was told about this until late in the process. And if that's true, they've got more problems than this little incident shows.

Mr. Carnahan, again, I think these are your constituents. I ask you to introduce the panel.

Mr. CARNAHAN. Thank you, Mr. Chairman.

I would just echo that. I think you can tell from the statements here from all the panelists that all the folks up here, there couldn't be a more united and focused and bipartisan effort here. So I appreciate all those kind of comments.

I'm honored to introduce two veterans, Susan Maddux, who is a Gulf War veteran, served in the United States Air Force. She is married to another service-connected disabled veteran; and also Terry Odom, also a disabled veteran, suffering from post-traumatic stress disorder, who served in the Navy. Both of these veterans received one of those cold letters in the mail.

I want to thank you first for your service, and I want to thank you for being here to share what happened to you and to help us find answers here today.

The CHAIRMAN. You will be recognized for an oral statement and any written statement you have will be made part of our record.

Susan, you are now recognized.

STATEMENTS OF SUSAN MADDUX, FESTUS, MO (VETERAN); AND TERRI J. ODOM, IMPERIAL, MO (VETERAN)

STATEMENT OF SUSAN MADDUX

Ms. MADDUX. Thank you for allowing me to speak today.

The CHAIRMAN. And we know how difficult this is for you but we are very grateful that you are sharing your experiences.

Ms. MADDUX. My name is Susan Maddux. I'm a 40-year-old Gulf War era veteran. I served in the United States Air Force from 1988 to 1998 as an Aerospace Propulsion Specialist. I'm married to another service-connected disabled veteran and we are the parents of four teenage boys.

On June 29th I received a certified letter from the John Cochran VA Hospital stating I may have been exposed to hepatitis B, hepatitis C and HIV. I found this letter to be very impersonal. In fact, there was little difference in the contents of this letter than from any other communication from the VA. It may have read just like an appointment cancellation letter if not for the signature required to receive it.

I was very angry with the Veterans Administration after reading this letter. For something as significant as this, it should have warranted a more delicate approach than a form letter. The VA has advised us that there is minimal chance of being affected by these diseases. However, I feel that any chance of instruments becoming contaminated is unacceptable within a modern medical facility.

The veterans that are eligible to use dental services at the VA Hospital are not normal veterans. Rather, they are among a select population and are also the most susceptible to harm due to being previously compromised by other illnesses.

Those of us that are privileged to use the dental service are 100-percent service-connected, service-connected for dental health, or POW's. Then there are some veterans that have been hospitalized for more than 120 days that also have access to this dental clinic.

To hear that there are some who think that the reaction of this incident is solely political angers me significantly. Hospital employees are not political appointees but, rather, are employed to perform a job, and that is to care for our Nation's veterans. It is their directive to follow the policies and procedures of their respected profession to ensure they do no harm.

As an Aerospace Propulsion Specialist it was necessary to perform tasks following procedures and policies. This allowed the air crews to have confidence that I had installed or repaired their aircraft engines properly. If I didn't follow those procedures accurately, I put their lives at risk.

In the same sense, the VA employees should strive to instill our trust in that they are doing everything the appropriate way since our lives are in their hands. In this instance, instead of strengthening our trust, the St. Louis VA has weakened our confidence by potentially risking over 1,800 veterans lives.

On June 1st of 2005, I was admitted to the intensive care unit at the John Cochran VA Hospital with bacterial meningitis. This

was several months after having neurosurgery at this VA facility. Two forms of bacteria were found in my cerebral fluid. One of these infections is normally found in the gastrointestinal tract. I nearly lost my life due to this infection. After recovering from meningitis, I was just happy to be alive and I didn't think to ask more questions as to how this happened.

After the disclosure by the VA over sterilization at their dental clinic, it brought me concerns that the VA sterilization issues are not just confined to this one clinic. It also raises questions in my mind as to how long these failures in sterilization policies have truly been going on.

I would also like to express my concern about the length of time for the VA to notify us about this incident. It makes me speculate if there was an attempt to conceal this from the veterans. It has also taken an extended amount of time to get the test results back to us. They need to realize that we have put our lives on hold while we wait for these results.

I would ask that VA employees speak out about policies and procedures that are not being followed; that it should be their duty to ensure our safety, and the managers and administrators should be willing to listen when informed about these issues.

I would also ask or request the VA administrators and managers to look beyond saving money and follow their own motto by "Putting Veterans First."

Thank you for allowing me to testify today, not only for myself, but as a voice for all veterans that use the VA medical facilities.

[The prepared statement of Ms. Maddux appears on p. 71.]

The CHAIRMAN. Thank you, Ms. Maddux.

Ms. Odom.

STATEMENT OF TERRI J. ODOM

Ms. ODOM. Yes, my name is Terri Odom. I am actually an Army and Navy Vet and proudly served.

First of all, I just want to say that all of my care providers at both John Cochran and Jefferson Barracks, from the dentists, to the psychiatrists, to doctors, to therapists, nurses, et cetera, have always shown me professionalism, compassion, and I can't say anything more for that. That's just me personally.

Now, in regards to the dental lapse, I obviously have some major concerns. On behalf of what happened, basically we just want answers. There are more questions coming out of there right now than answers. And I also have major concerns about why it took them so long to notify me and I was notified via certified mail in a very, very cold letter. Like this lady said, it basically might have said, Hey, the parking lot is being paved. Park on the left side. That's how it felt.

I know this mistake by the VA has made my anxiety disorder even worse, for obvious reasons. Like she said, our life is on hold and it's horrifying to know how many more tests we are going to have to have. There has been conflicting reports that perhaps we won't know for 5, to 10, to 20, to 30 years if we have hepatitis C or HIV. And that's a long time to put your life on hold, especially if you already have some serious health issues. And anyone that's

seeking dental care at John Cochran has some serious health issues that are normally service-connected.

In the information number that was attached to the certified letter that I received, I must say, with all due respect to the panel, that the people answering the phone were rude, knew nothing more than I knew, and I realize they were thrown together last-minute.

I even called to verify my blood test, which was scheduled for July 6, 2010, at Jefferson Barracks Hospital. I called on July 5th, 2010, and a nurse actually laughed at my concerns. She said there was such a low risk that I had absolutely nothing to worry about. I asked her if the blood test being offered was because of zero risk or risk.

Looking back now, I realize something in the dental department was wrong. After my first oral surgery I did have severe pain for 28 straight days, and some must ask why did I not return to the dental clinic, or call.

We were taught in the military to suck it up, keep going, and that stride and toughness is still embedded in us veterans today. I had another oral surgery later and some teeth filled. I did receive partial dentures from the VA, but after three visits they still do not fit and my speech is bad with them.

I also, looking back now, remember when the dentist reached for the metal molding piece to make my impressions for my partial plates, that they appeared dirty and rusty. Having a severe anxiety disorder, my attention to detail is somewhat greater than others, and I will leave it at that.

In February of 2010, I was scheduled for a colonoscopy at the St. Louis John Cochran division but had a severe panic attack on the table, with extreme heart rate and elevated blood pressure. I looked around the room and it was beyond filthy. I felt that I could not continue with the procedure. As a result, I did end up in the ER and the procedure was canceled, thankfully, to my benefit.

Also, during a 2009 inpatient stay at the John Cochran division for over 5 days, I was unable to shower due to the mold and unsanitary conditions of my bathroom. The nurses on the ward were very nice and just said, No, honey, you don't want to dare use that nasty shower. They did offer me washcloths and things of such to bathe with. I did offer to clean it myself.

There must be a change in the VA. What has recently happened in St. Louis with the exposure is third-world treatment, if not less. And yes, we are angry and we have every right to be. The VA put our health at great risk and there has to be some accountability. This issue must not just be swept away like it never happened.

I already have major trust issues due to my disability, and now I feel that the very people who are supposed to have my back are trying to put me in harm's way, and I'm not sure why. We deserve better than this. We are not just veterans, but human beings. People make mistakes. I understand that. But when you are dealing with people's lives, there is no room for failure. And I'm outraged at the lack of seriousness the St. Louis VA seems to be putting on this horrible issue. How would any of them like to wait in horror for test results, and then have to wait again and again and again?

I thank you all for being here.

[Applause].

[The prepared statement of Ms. Odom appears on p. 72.]

The CHAIRMAN. Thank you both. You do have a right to be angry.

Mr. Carnahan.

Mr. CARNAHAN. Thank you both for your honest testimony and description here.

As you said, Ms. Odom, obviously there has been a toughness instilled in you, and a commitment to service, and we recognize that and we do want to get to the bottom of this.

I want to ask both of you, you have very well described the coldness of those letters that you received. I want to ask, did you make that first phone call to the VA to set up those appointments, or was there any other outreach to you beyond that letter?

Ms. ODOM. I made the call immediately, and the person that answered the phone was a young man and he did not know anything about it. He said he was just hired to answer the phone and that a nurse would call me in approximately 1 to 3 hours to discuss any further details about the possible risk.

Mr. CARNAHAN. And Ms. Maddux?

Ms. MADDUX. I called the following day. I already had an appointment that day to go to John Cochran, so while I was there I went down to their clinic to get the testing, and I've received no other calls.

Mr. CARNAHAN. And can you describe the process when you got to the clinic in terms of doing the test and any counseling that was provided to you? Any answers at that point that were provided?

Ms. MADDUX. Well, we were given a folder with materials to read. Since I already had an appointment, they kind of walked me through it. I didn't sit through their orientation but I sat down with a nurse and he asked if I had any questions at the time. And then I went across the hall for the blood testing.

I found when I got to the VA facility, there was people stationed at every turn in the hallways and those people had smiles on their face, asking if you needed help finding anything, and that went all the way down to the basement and into the clinic. And I found that to be very fake. And you would never see that on a normal day. And it was just ridiculous.

Mr. CARNAHAN. Let me ask you both, are you satisfied with the advice that you have been given in terms of what kind of follow-up care you are going to need?

Ms. ODOM. No. I was not, I had my blood test, as I mentioned earlier, drawn at Jefferson Barracks July 6th. And when I got to the blood draw clinic, I was told I could not have it drawn until I spoke with a Mrs. Bart Thompson on the second floor.

I immediately went to the second floor. The personnel there said they knew of no such person. I called the 800 number again. The lady informed me that she was from out of Missouri, out-of-state. She knew of no Ms. Thompson on the list.

So I went back to the staff on the second floor and said, I've called the number. What is it? And finally I come across a nurse, I believe she was a nurse that said she did know of a Mrs. Thompson who had been at the last minute thrown into it but went on leave, and that she would personally call back to the blood lab and

say it was okay for me to be tested. But I had no counseling or anything like that, sir.

Mr. CARNAHAN. And then have you been advised in terms of the length of time you are going to have to wait to get results?

Ms. ODOM. I was told that because of the incubation period, that I can possibly return in late August, but they are going to be doing some investigation on how long they may have to follow us. That it may be 2, 3, 10 to 20 years. I had different stories about it, sir.

Mr. CARNAHAN. And Ms. Maddux?

Ms. MADDUX. I was called yesterday with my results and I was told since my dental treatment was at the beginning of March, I would have to be re-tested around September 2nd. And that's all I've gotten.

Mr. CARNAHAN. But no advice about any testing beyond that?

Ms. MADDUX. No.

Mr. CARNAHAN. I guess have you had an opportunity to talk to anyone about how this occurred or about improvements that are being made there to help rectify this?

Ms. MADDUX. No, I haven't.

Ms. ODOM. No, sir.

Ms. MADDUX. I find I take it upon myself, when told I was exposed to this, going on the Internet and researching it myself, as I do with any medication or any treatment that I have been given, to inform myself as best as possible.

Mr. CARNAHAN. And I guess the last question for both of you. If you could, in brief, tell the Committee here, what would you like to be done to help you in terms of being sure you get the right care you need going forward?

Ms. ODOM. I would like just honest answers. And I would not always appreciate it always having to come from the media. No disrespect, but I think it should come from the VA. Honest answers. It seems like, you know, I've received ten different answers on one question. That's unacceptable.

And I would like to know, how long do you plan on following this group of veterans and their families? I have a 19-year-old son. You know, I would like to know this. I have enough issues to deal with currently that I don't think I need extra anxiety to worry, do I get re-tested in August and then wait for results? And then again in December and so forth and so on? I would like somebody to let us just know the truth. We are not blaming anyone. We just want answers, that's all. The truth.

Mr. CARNAHAN. And Ms. Maddux.

Ms. MADDUX. Yes, I would like to have someone appointed that we can call one person and not go through being directed or misdirected all different places to get the answers that we need.

Mr. CARNAHAN. Thank you both.

The CHAIRMAN. Mr. Blunt.

Mr. BLUNT. Thank you, Chairman. And thank you both for testifying. Let me ask a couple more questions.

On the letter, Ms. Odom, you mentioned that you called. How long did you wait until you called?

Ms. ODOM. I fell down to my knees——

Mr. BLUNT. Uh-huh.

Ms. ODOM [continuing]. I'm just being honest, sir, in shock. It was the last thing I expected. You don't normally get certified letters from the VA Hospital. You might get them from the Veterans Benefits Administration (VBA) but never from the hospital.

Mr. BLUNT. Right.

Ms. ODOM. So I opened it, read it three times, let it sink in, fell down to my knees and said, you've got to get back up. I will call. It must not be that big of a deal because, you know, we are finding out by a certified letter.

Mr. BLUNT. Right.

Ms. ODOM. I called and, as I stated earlier, the young gentleman said he had just gotten hired for the 24-hour, 7-day a week manned thing. The Educational Department at John Cochran Division. He said, I'm sorry, ma'am. I can't help you. I don't know anything. But a nurse will be calling you in 1 to 3 hours, and he or she at that time will discuss any concern that you have.

And I waited, literally looking at my phone for it to ring, and it did ring in about 2½ hours.

Mr. BLUNT. And when you talked to that person, what did they tell you?

Ms. ODOM. They told me that the risks were minimal. They told me not to have unprotected sex, use razors, fingernail clippers, share any bodily fluids with anyone else until I was tested. And they were so new into this, they were uncertain of what all had occurred. That we needed to wait until all of our blood tests were back.

And they basically minimized it and stressed over and over again that the risk was very low, and even mathematically. We did the math. I did the math with them. That only one vet out of the 1,812 could be infected. But to me, one vet is deplorable and unacceptable——

Mr. BLUNT. Right.

Ms. ODOM [continuing]. And inexcusable. One person's life and maybe their spouses, et cetera? I don't have words for it.

Mr. BLUNT. And did you get—where did you get this information, or just give me a sense, that they might need to test you over a period of time? I think you said it could be 2 years. It could be 20 years. Who told you that?

Ms. ODOM. I got that information, sir, from, I believe he called himself a physician from the VA this past Sunday that called me to tell me that, you know, because of the incubation period that I would be rescheduled to test again late August.

He at that, at this time is not sure how they are going to track the vets that were affected and how long that we may have to be re-tested again. Sometimes strains of hepatitis C show up years later.

And of course at that time, if you did test positive, they would have to go back to the 1,812, make sure that that strain actually came from this exposure.

Mr. BLUNT. Well, hopefully we will glean from later panels today, or follow-up with the Committee, Mr. Chairman, and get some more specific detail on that.

I mean just the notice in July, for reasons we've mentioned, is bad enough. To wait that long. And then, you know, to have to

worry from the first of July until sometime in August, that is an incredible amount of anxiety, particularly if you are already dealing with service-related anxiety, but even if you are not.

And I'm going to be anxious to find out, for you and for me both, how long this really is going to take before you know that your life, as Ms. Maddux said in her testimony, is on hold. And hopefully we can get some answers there that are helpful for all of us to know. And I'm hopeful that the extent of time that this could take is—we can find out better answers than that.

And the only other question I would have, Ms. Maddux, with Ms. Odom's testimony about other procedures at the facility, I notice you had some concerns in your testimony about earlier procedures. I assume those concerns are heightened now by this incident? You want to talk about that for just a second?

Ms. MADDUX. Yes. I have had numerous procedures since then. Just last month I had a cardiac catheterization done and I'm hoping everything from there was clean.

And I'm concerned, like if I start feeling a fever or something, is that meningitis coming on again? And going through meningitis was the worst thing in my life. I guess I just have to wait and see.

Mr. BLUNT. And you now think that may have related to your care at the hospital? At the facility, rather?

Ms. MADDUX. Well, the meningitis was done after neurosurgery.

Mr. BLUNT. Uh-huh.

Ms. MADDUX. Leading up to it, I started getting fevers in the evenings and just all of a sudden a severe headache started that I wasn't used to. And in fact, that day I was hospitalized. And then——

Mr. BLUNT. They had surgery, these things happened, and then you were hospitalized again with meningitis?

Ms. MADDUX. Right.

Mr. BLUNT. Okay.

Ms. MADDUX. It was about 7 months since the neurosurgery that I was hospitalized again. And while in the hospital that time, I had to have another neurosurgery to remove the shunt and everything they had put in in the last surgery.

Mr. BLUNT. And you were scheduled for other care at the time you got the notice and so you were—you went to the facility pretty quickly after the notice because you were scheduled to go there, is that what you said?

Ms. MADDUX. Yes, I was scheduled 30th for a neurology appointment, so I knew I would be going there anyway, so I went through their process.

Mr. BLUNT. And you got your notice on June——

Ms. MADDUX. Twenty-eighth.

Mr. BLUNT [continuing]. Twenty-eighth?

Thank you all for testifying. I know it's hard to talk about and I'm sure it's hard to live with the uncertainty of this. And one of our goals here would be to create whatever sense or whatever level of certainty and closure we can create, as quickly as we can help create that. But it helps to have the experience that you've gone through here.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Blunt.

Mr. Costello.

Mr. COSTELLO. Thank you, Mr. Chairman.

I thank both of you for your service to our Nation and I thank you for coming forward to testify before the Committee today.

Ms. Odom, you mentioned seeing the dirty and rusty dental equipment. Did you report that to anyone when you saw it?

Ms. ODOM. No, sir, I did not.

Mr. COSTELLO. And I take it from your testimony, both you and Ms. Maddux, that the VA did not assign a caseworker or an individual to you, to either one of you to follow up, an individual that you could call at any time if you had questions?

Ms. ODOM. No, not at all.

Ms. MADDUX. [Shook her head.]

Mr. COSTELLO. You were just left on your own.

And Ms. Maddux, as far as you know, you are going to be re-tested in early September and there is not going to be any other contact with the VA?

Ms. MADDUX. Not for this situation, no.

Mr. COSTELLO. Okay. Again, I thank you for your testimony.

Mr. Chairman, thank you. I give it back.

The CHAIRMAN. Mr. Shimkus?

Mr. SHIMKUS. Thank you, Mr. Chairman.

I appreciate your testimony and thank you for your service. The quote of the VA comes from Abraham Lincoln and says, "Care for him who shall have borne the battle and for his widow and orphan."

And obviously the VA failed in this aspect, and in their opening statements we, our concern is that this isn't an isolated case. And that's really telling.

If it was an isolated case, as I think Chairman Filner and I talked about even prior to coming here, if it's isolated, then there are mistakes and we can move. But if it's endemic, I mean I would agree with my colleague, Mr. Akin, there is a systems problem here.

So let me ask, your experience with Cochran on an—overall, not just this incident, on a zero-to-ten scale, 10 being great, where would you rate—because in the opening statement you especially, Ms. Odom, you mentioned the caregivers and people concerned. Overall, that facility, how would you rate them?

Ms. Maddux first.

Ms. MADDUX. Before coming to St. Louis—I'm originally from St. Louis—I lived in Minnesota, so I had experience with their VAs and I would have to give John Cochran, at the very most, a four. And I find it really dirty, and knowing that there is other VAs out there that do a wonderful job.

Mr. SHIMKUS. Ms. Odom?

Ms. ODOM. Are you talking specifically about the facility, sir? Or the personnel?

Mr. SHIMKUS. Just the overall, if you've had service there and you walk away.

Ms. ODOM. I've had many services there, sir, and I would agree with this lady, that overall, a four at the highest. There is just things that we can do better. It's mainly the sanitation.

Mr. SHIMKUS. And my colleagues have already asked questions about what you saw, when you notified. Have any of you ever used the Veteran Advocate in any process?

Ms. ODOM. They don't call you back, sir.

Mr. SHIMKUS. They don't call you back.

Ms. Maddux.

Ms. MADDUX. Yes, I have. It has been quite a few years ago, but I used that at Jefferson Barracks and I did get answers.

Mr. SHIMKUS. Well, and that—one more follow-up. We have Cochran. But how would you rate the Jefferson Barracks component of care on a zero-to-ten scale?

Ms. ODOM. Ten.

Mr. SHIMKUS. Ten. And as for Ms. Odom?

Ms. MADDUX. I would say a seven.

Mr. SHIMKUS. Okay. That's all I have, Mr. Chairman. Thank you. I give it back.

The CHAIRMAN. Thank you.

Mr. Akin.

Mr. AKIN. Thank you, Mr. Chairman.

Just to try to get a little bit more detail on what my friend Congressman Shimkus was getting at, if you were to take a look at the facility, first of all in terms of the people who are specifically medical doctors, how would you rate the people that you worked with? Did you feel like they were competent and did a good job, sort of one to ten, the doctors themselves?

Ms. MADDUX. As far as the doctors at John Cochran, I would give a seven because I find some that I'm not able to work with.

Mr. AKIN. So the doctors, about seven. Then how about the facility? Just the physical facility.

Ms. MADDUX. The facility is——

Mr. AKIN. I mean the buildings and, you know, the rooms and the bathrooms.

Ms. MADDUX. I find it really——

Mr. AKIN. What's that.

Ms. MADDUX [continuing]. Dirty. It's—you don't want to set your purse down on the floor. Holes in the wall. I know it takes time and money to get through it, but like the cleaning part could be done much better.

Mr. AKIN. How about the other medical personnel? Not the doctors but the other people who are physically doing medical kinds of things, like nurses and other aides?

Ms. MADDUX. Nursing care I would give a seven. But as far as clerks, I find almost every clerk I come in contact with is very rude. It's you are taking up their time.

Mr. AKIN. That was going to be my last question, was the administrative side. Just sort of the process of knowing who to call and getting the right information and having ease of access and being able to get answers quickly and that kind of thing.

What would that be?

Ms. MADDUX. A five.

Mr. AKIN. Five.

Ms. MADDUX. I have to go through many people to get the right answer or to get the right clinic.

Mr. AKIN. Okay. Could I ask the same, Ms. Odom? The same kind of questions? First of all, doctors. You said you felt the doctors themselves were pretty good?

Ms. ODOM. The doctors and nurses and the medical staff that have treated me at John Cochran have been excellent.

Mr. AKIN. Okay. Then the actual facility itself, the buildings, the rooms, the bathrooms, all that kind of stuff?

Ms. ODOM. Everyone here that's toured the building, or any vet that's been to John Cochran sees that there is construction going on, improvements, but it's absolutely deplorable and unsanitary.

I just happened to be there yesterday for a scheduled appointment and noticed a lot of housecleaning going on there.

Mr. AKIN. Okay. And then last of all, from the administrative side, just the ease of knowing how to get in, get your appointment scheduled, knowing who to talk to, just the interface, do you feel like you are a very important customer to them, or is it the opposite?

Ms. ODOM. I take up their time.

Mr. AKIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Luetkemeyer.

Mr. LUETKEMEYER. Thank you, Mr. Chairman.

And thank you, ladies, for your service and your willingness to be here today. And I know it's difficult to be in your position. You are publicly talking about some very personal things and we appreciate your willingness to share, and are very sorry for your situation. Hopefully this hearing will rectify that and hopefully we can make amends for that.

Just curious. I know that, Ms. Odom, you talked a number of times about the conditions there. Have you ever complained to any administrative people about the filthy conditions or unsafe or unsanitary things that you may have seen or experienced?

Ms. ODOM. Yes, I actually called the Patient Advocate because it's actually on a brochure when you are an inpatient. I left my name, number, last four, and I never got a response.

And actually, I felt so horrible for the nurses that were on the floor that said that it's been like that for years that I didn't, I did not follow through with trying to keep contacting the Advocate over and over again.

You know, I don't know, I don't know if it's lack of funds, lack of housekeeping, but I'm not talking about a bathroom, for instance, where I was supposed to take a shower that was just nasty or dirty or messed up, but someplace that was disease-contaminated for obvious reasons. I mean you could not take a shower in there unless it was the last resort.

Mr. LUETKEMEYER. But they didn't respond to you once you called, is that what you are saying?

Ms. ODOM. No.

Mr. LUETKEMEYER. You complained, and there was no follow-up by them on your complaint, to you?

Ms. ODOM. No, sir.

Mr. LUETKEMEYER. Ms. Maddux, did you do that yet?

Ms. MADDUX. In 2003, after moving back to St. Louis and seeing the facilities, my husband and I both did complain about it. We received a call-back asking, well, what room did you see a hole in? Or—it was almost like I was bothering them by making a complaint.

Mr. LUETKEMEYER. Just to reframe what you have said here, it appears that when you were told, when you contacted the VA after you received your letter, you each one got a different explanation of what was going on.

Am I reading that correctly? Or have you talked with each other? Or I mean——

Ms. ODOM. [Shook the head.]

Mr. LUETKEMEYER. Each one has a different explanation of what you were told at the time you called. Am I getting that correct from your testimony here today? It sounds like that.

Ms. ODOM. We've never met each other. I mean what I understand, sir, is I called, and she had a scheduled appointment anyway.

I don't know if you called.

Ms. MADDUX. I called on the 30th, you know, right before I was going there that afternoon. And I believe my appointment time was 3:00 and they gave me an appointment to I guess go through their process for 4:00.

Mr. LUETKEMEYER. I guess the point I'm trying to get at here is, is there a plan or have you been explained—has a plan been explained to you on how to take care of yourself, or how you are going to be treated, or what they are going to do to take care of you over the next several months?

Ms. ODOM. No, sir.

Mr. LUETKEMEYER. No. Okay.

Ms. ODOM. Other than the nurse who did call me back in 2½ hours to explain no unprotected sex, no fingernails sharing, no toothbrush sharing. You know, things like that.

Mr. LUETKEMEYER. No scheduled follow-ups for you on a regular basis?

Ms. ODOM. No, sir.

Mr. LUETKEMEYER. All right. Have either one of you gone to a private doctor or a private clinic and been checked out at all on your own?

Ms. MADDUX. With my service-connected condition I guess I have to sign a contract with my physician, because I'm receiving certain medications, that I do not go to other doctors.

Mr. LUETKEMEYER. Okay. We are talking today mainly about the dental portion of this. Have either of you been to the—had dental service more than just once over the last several months——

Ms. ODOM. I have.

Mr. LUETKEMEYER [continuing]. During this time period that's in question?

Ms. ODOM. I have, sir. Five times.

Mr. LUETKEMEYER. Five times.

Ms. ODOM. And I have a scheduled appointment for the 23rd of August, 2010, which I obviously plan to cancel.

Mr. LUETKEMEYER. Okay. So you actually could have been exposed or were exposed five separate times, is that what you are saying?

Ms. ODOM. Yes, sir.

Mr. LUETKEMEYER. Ms. Maddux? Were you——

Ms. MADDUX. Twice.

Mr. LUETKEMEYER. Twice? So you could have possibly two exposures, is that what you are saying?

Ms. MADDUX. Yes.

Mr. LUETKEMEYER. Okay. When you were—has anybody at this point given you an explanation, whenever you called or since then, given you an explanation of, number one, why this went on this long and what happened and why it took so long to get to you? Have they given you any explanation at all?

Ms. ODOM. They just keep stressing low risk. Don't worry about it.

Mr. LUETKEMEYER. So there has been no explanation to you of how this happened, why it happened, or sort of remedy why it took so long. You just, you got a letter that said, hey, you've got a problem perhaps, and it said, we will take a look at it? Okay.

Ms. MADDUX. I was told I guess the same story line as the media has gotten about, it was found in a routine inspection and that there is minimal risk. Everything should be fine.

Mr. LUETKEMEYER. Okay. Again, thank you very much for your service and being here today. And hopefully we can get to the bottom of this and prevent this from happening in the future. Thank you very much.

Thank you, Mr. Chairman. I give it back to you.

The CHAIRMAN. Thank you. Mr. Miller?

Mr. MILLER. I think most of the questions have already been asked, but first of all, thank you for your service. And as has already been said up here, thank you for your willingness to step forward.

We hear you. And regardless of what people say, I didn't come from Florida trolling for news up here. I came here because I wanted to hear your story and we want to make sure that this doesn't happen again.

If you could go to another medical facility in the community, would you go?

Ms. ODOM. Yes.

Ms. MADDUX. Yes.

Mr. MILLER. Prior to this happening, if you could have gone to another facility, would you go?

Ms. MADDUX. Yes.

Ms. ODOM. No.

Mr. MILLER. And why do you say no?

Ms. ODOM. Because it's taken me years to trust my therapists and doctors, and I finally have that trust with them, that I don't feel like I want to start from ground zero with new doctors. That's me personally, though.

Mr. MILLER. And you say yes.

Ms. MADDUX. Yes. I just received a new primary care physician that I don't care for, and I'm starting all over again getting all this testing and I guess having her trust me.

Mr. MILLER. What happened? You say you don't care for your primary care physician now.

Ms. MADDUX. Yes.

Mr. MILLER. How do you get another one? Can you?

Ms. MADDUX. Yes. Requesting a new primary care. The last one I had, I had for 7 years. But she moved to a different part of the facility and the new one is starting from zero. And with my conditions it's, she keeps questioning, well, do you have this condition?

Mr. MILLER. Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. I, again, thank you. Between your testimony, which is very searing, and the sensitive questions of my colleagues, I think we get a picture that is pretty shocking. All I wanted to say is that we are not going to forget it. We are going to act on it. We appreciate your testimony. Thank you very much.

Ms. MADDUX. Thank you.

[Applause.]

The CHAIRMAN. Now, panel two, will you come forward.

We ordinarily don't do that, but this is a very emotional issue so I see a hand that, if you want to just come up and state your name and ask a question, that will be fine, while panel two is coming up.

VOICE. Hello. Can you hear me?

The CHAIRMAN. Yes.

VOICE. I would just as soon not give you my name because I don't want to get the dentist in trouble that told me this. So—I've been to the dentist a couple times here and I think my first visit was in August. August/September. And I had missed a, I had missed the appointment and it took me months and months to get an appointment again.

I asked him, why does it take so long? And of course he said, we are understaffed. We put in request after request to get dental, to get dentists, and maybe other staff people, I don't know, but it keeps getting denied. This is at John Cochran.

And then a few more minutes I talked with the gentleman and he says, and the other thing is we have a requirement that if someone comes in for a dental check and we find something wrong, like a tooth decay, we have to see that patient again in maybe 2 or 3 weeks. Well, we can't do that because we are understaffed. We have so many people we've got to see.

I said, well, what do you do about that? He said, well, we send up the paperwork saying that we didn't meet that requirement. But somewhere between the dentist and the VA, it gets changed to show that they are meeting their requirements. So they don't get, they don't have that staff. Additional staff.

So the paperwork is getting doctored that, I don't know, maybe the Budget Committee is seeing. Maybe it goes to the administration here at John Cochran. Maybe it gets sent on further.

The CHAIRMAN. Okay.

VOICE. So they are understaffed.

The CHAIRMAN. Thank you very much. We will be looking into that.

Our second panel consists of a former VA dental employee, Ms. Earlene Johnson, and Mr. Barry Searle—is that the pronunciation?

Mr. SEARLE. That's right.

The CHAIRMAN. The Director of the Veterans Affairs Rehabilitation Commission for the American Legion, I assume from Missouri or St. Louis.

Mr. SEARLE. Actually, Washington, sir.

The CHAIRMAN. I'm sorry. From Washington. Thank you for joining us here today.

Ms. Johnson, we will put any written remarks you have in the record, and whatever you want to tell us, Earlene.

STATEMENTS OF EARLENE JOHNSON, ST. LOUIS, MO (FORMER VA DENTAL EMPLOYEE); AND BARRY A. SEARLE, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION

STATEMENT OF EARLENE JOHNSON

Ms. JOHNSON. First of all, thank you. Thank you very, very, very much for this opportunity to speak.

The CHAIRMAN. If you will bring the microphone a little closer, ma'am? Thank you.

Ms. JOHNSON. I did not work in the dental department. I worked in an area called Sterile Processing. Sterile Processing is an area where we do cleaning processing of instrumentation.

I was terminated for trying to help the Vets Gateway Chapter of Paralyzed Veterans and my family members that go to John Cochran. I never worked for the VA Hospital nowhere else. In Oregon, I was a manager over Sterile Processing, in which we collected instruments throughout the hospital. I wasn't a lazy manager. I took that extra step.

You find at John Cochran when you open your mouth about something, you are either retaliated on, or targeted, or you are just praying that the next day you walk in, you have a job. Unfortunately, I was on probation and didn't keep my mouth shut. I called Washington. I tried to warn people in Washington. I couldn't get through. I couldn't get through.

I knew something was going to happen at John Cochran and I didn't give up, even when they terminated me. I still made calls. I have a father that's buried at Jefferson Barracks. He was a sergeant major. I have another father that goes to John Cochran that can barely walk. I have family members that go to John Cochran and it didn't matter to me if I was on probation. There is something wrong. There is something wrong.

When you hire people in positions, you don't hire your friends. You don't hire people that are not qualified for that particular position. You want people that's going to, you know, take extra steps.

What happened in the dental clinic shouldn't have ever happened. If people were taking their jobs seriously, not passing the buck and pointing the finger, none of this would have happened. And I apologize to the 1,800 veterans and I apologize to all of the veterans throughout the United States. Not just John Cochran.

I didn't know what to do. I had to play strategic games around there. They start transferring me from one department to the next because I hurt my arm and had to have surgery. In fact, I tore my tendon. So I tell you what. Since they were transferring me to one department to the next department—and I do have experience in

management, I do have experience in troubleshooting—I just took a look at the departments that they were transferring me to, okay?

And out of I would say four departments, I found only two where the management were managers. And out of the two, the technician should have been the manager. I've seen so much mismanagement at John Cochran. I've seen employees talked to like they were kids. I've managed people and one thing I have learned in managing is that your employees make you. So if you are belittling them, intimidating them, what kind of service do you think you are going to get?

If employees are intimidated, they are not going to speak to you. They need their job just like I needed mine. I needed my job. I had medical issues going. I wouldn't have ever done anything to jeopardize my job. I had medical issues going. Not just for my arm. I had medication that I have to take. If I don't take it every day, I will die.

And then to top it all off, when Unemployment did their investigation, they found out this girl, what did you fire this girl for? You fired her for other reasons than misconduct. They had 30 days to appeal. They didn't appeal it.

This isn't about me. It's about the veterans. Has anyone talked to the veterans about HIV and HIV on instruments? No. Well, first of all, if the procedures in the department was taking that extra step like I warned them when I was there—I told them that you are supposed to get up and check all of the auxiliary units. Auxiliary units are the units like your dental, your eye. Any instrument that needs to be processed needs to come to this department. I told them that.

But see, at John Cochran, to me, in my opinion it's like, oh, that's their department. They do it. No. No. No. No. No. That's where a lot of people have a misconception. When you run a Sterile Processing department, that's your responsibility to take that extra step to walk around, to make sure no one is doing any kind of processing whatsoever, because you have the people who have gone to school who are supposed to know how to clean. They are certified.

I mean if your heart was hurting, who would you go to? An orthopedic doctor or a heart specialist? A heart specialist. It's simple. If you need your instruments processed correctly, would you take them over here to dental, or would you take those instruments somewhere that's located inside the hospital to have them cleaned and processed by people who have gone to school, that are supposed to know how? That wasn't the case at John Cochran.

[The prepared statement of Ms. Johnson appears on p. 72.]

The CHAIRMAN. Ms. Johnson, we thank you.

Ms. JOHNSON. Okay.

The CHAIRMAN. We will have questions for you, so thank you so much for your testimony.

Mr. Searle.

STATEMENT OF BARRY A. SEARLE

Mr. SEARLE. Thank you, Mr. Chairman and Members of this Committee. Thank you for giving this opportunity to the American Legion to view this pressing issue brought to light recently by developments at the John Cochran VA Medical Center.

The American Legion, from its inception, has been both a strong advocate for veterans and proponent for an effective Federal entity whose mission is to care for those veterans.

Central to the American Legion's efforts is a program called "A System Worth Saving." This Task Force, first established in 2003, annually conducts site visits at VA Medical Centers nationwide to assist the quality and the timeliness of VA health care. This Task Force we believe has identified some issues contributing to the issue at hand.

In March of this year, during a routine inspection of the John Cochran Medical Center by VA's Infectious Disease Program Office, it was determined that dental instruments were not being cleaned in accordance with specifications of the manufacturers or in accordance with VA's own procedures for proper sanitation and sterilization. These instruments were being cleaned without proper detergent, potentially putting veterans at risk for blood-borne illnesses such as HIV and hepatitis.

VA's Central Office convened a special Committee to determine an appropriate response. The Committee could not determine that risk to approximately 1,800 patients was zero, an absolute zero chance of infection, therefore, a decision was made to notify all affected veterans. These 1,812 veterans, notified through certified mail, were provided with free testing for HIV and B and C strains of hepatitis, and will be provided with whatever follow-up care is deemed necessary. As of this time, no veteran is known to have contracted any of these diseases through this exposure.

The American Legion feels that VA took responsibility and demonstrated an act of faith to bring this issue to the attention of veterans and the public. Placing patient safety before good publicity deserves to be acknowledged.

However, as the American Legion National Commander, Clarence Hill, recently stated, this is an extremely serious problem that has happened before, and will happen again unless VA ensures strict adherence to proper sanitation and sterilization protocols.

To expose trusting veterans to blood-borne illness through routine medical treatment because of avoidable errors in sanitation of medical equipment is inexcusable. The problem exists not in the business process structure of this system, as the existing protocols were designed to prevent such exposures, but rather, in the failure of those operating the system to execute those protocols. This can only be overcome by diligent management, training and accountability.

This event is not the only reported occurrence of failure to follow procedures within the Veterans Health Administration (VHA) system. The Department of Veterans Affairs Office of Inspector General Report from 21 April, 2010, concerning suspected issues in the Supply Processing and Distribution department related to endoscope reprocessing and communications to St. Louis facility substantiated alleged cleaning issues of equipment.

In its findings, VA OIG identified turnover in several key staff positions as a serious issue. During the 2010 "System Worth Saving" Task Force visits to 32 VA Medical Centers across the country, a commonly repeated theme was the shortage of personnel, especially nurses and personnel with specialty training.

It is the opinion of the American Legion that turnover of personnel and the shortage of personnel at most facilities requires renewed emphasis on standardized procedures, quality review, and individual training, as well as documentation of that training.

If an emphasis on training is subverted to day-to-day operations, dedicated people will make mistakes. Further, the American Legion believes that Central Office must maintain proper oversight of medical care, utilization of facilities, and resources in order to ensure veterans receive the highest quality of care.

On April 28th, 2010, in a Pittsburgh Tribune Review article concerning a reported incident at the Pittsburgh VAMC in 2007, it was noted that the Food and Drug Administration (FDA) had cited the VA facility for not doing a routine blood type certification test, a violation of standard procedure. This resulted in a patient receiving six units of the wrong blood before he died. It was reported that VA officials told the FDA the error stemmed from a heavier-than-usual workload in the blood bank.

The American Legion understands that the policies developed at Central Office with the best of intentions are, for the most part, executed at the discretion of the Veterans Integrated Services Network (VISN) Director or Facility Director level, and therefore vary in local implementation.

It was testified by the American Legion, during a 1 July Subcommittee hearing, we believe that there is a breakdown in follow-up and accountability by Central Office to ensure procedures are being followed. This autonomy of the facility directors is a function of an overly decentralized VA structure. It is no means unique to VHA. It is, we believe, systemic to VA's mode of operation.

For example, in VBA we have seen and, in fact, been told by VA personnel themselves that when you see one regional office, you have seen one regional office. The implication is there is little standardization in VA.

Again, one of the concerns of the American Legion, as stated in testimony over the last few months, has been that VA needs to do a better job in training its people, more effectively ensuring they understand and follow the correct protocols that have been established. There is also a need to enforce central oversight of the regional VISNs, thereby ensuring consistency and accountability nationwide.

When a problem is identified, it is not enough to simply move people to different facilities doing the same job. Unfortunately, at times accountability means negative impact on the individual who is responsible. With correct and effective accountability, there is hope for continued faith in the veterans' health care system.

The American Legion is committed to working with the Secretary to ensure that this situation is successfully resolved and that instances such as this do not become an ongoing issue with our otherwise excellent VA health care system.

Mr. Chairman and Members of the Committee, thank you.

[The prepared statement of Mr. Searle appears on p. 76.]

The CHAIRMAN. Thank you, sir.

Mr. Carnahan.

Mr. CARNAHAN. Thank you again, Mr. Chairman.

And I guess I want to first start with Mr. Searle. Thank you and the Legion for the work they do with VA. And I wanted to ask, with regard to any of the prior annual site visits that are done at Cochran, were there any red flags that appeared in those recent visits, and did they reflect any of the other issues that were raised by the Inspector General recently, or in the recent Patient Satisfaction Surveys?

Mr. SEARLE. Well, actually, the Legion has not been to Cochran in several years. We do 32 facilities a year, so we have them done on a rotational basis, so we have not done a follow-up on this particular facility.

Mr. CARNAHAN. So when was the last time that you had done a site visit at Cochran?

Mr. SEARLE. I believe it was 2007. I can confirm that, sir.

Mr. CARNAHAN. Okay. Thank you very much.

And Ms. Johnson, we really appreciate you being here. From your background and your experience in Sterile Processing, I think you have some unique insights to share. So we especially appreciate your willingness to come forward.

I want to first, I guess, ask you about the earliest time when you began raising concerns about any of the sterilization processes while you were at Cochran.

Ms. JOHNSON. I brought this up before the supervisor. Walking and checking like the dental clinics and the eye, in March.

Ms. MADDUX. Of this year?

Ms. JOHNSON. 2009.

Mr. CARNAHAN. Of 2009. And I know that you had, I understand that you had previously provided copies of an e-mail as far back as August——

Ms. JOHNSON. Yes.

Mr. CARNAHAN [continuing]. Of 2009, where you outlined some improvements that needed to be done. Could you talk about that?

Ms. JOHNSON. Well, when I was hired in, I saw a lot of things wrong with the Sterile Processing department. I saw how it was ran.

After I had suggested to my boss that she should be walking around, you know, checking—in the old days we used to call it CYA. Excuse me, but that's what we called it, you know. And——

Mr. CARNAHAN. And excuse me. Who was your boss at the time?

Ms. JOHNSON. I can't answer that.

Mr. CARNAHAN. Okay. What department were you in.

Ms. JOHNSON. I was in a department called Processing and Distribution at John Cochran Hospital. And that's what made me start the improvement process. I sent an e-mail to her boss as far as improvements for the department.

Mr. CARNAHAN. That was to your supervisor's boss?

Ms. JOHNSON. Yes. They both had copies of it.

Mr. CARNAHAN. And this was in March of 2009.

Ms. JOHNSON. I don't have the dates with me, but I do have the e-mail as far as the improvements were concerned. And you know, nothing happened. Nothing. It was just like I was just there and they are going to do what they wanted to do. That's, they didn't—whatever improvements, they didn't want to.

Mr. CARNAHAN. And you were raising these issues because of your prior experience in Sterile Processing?

Ms. JOHNSON. Yes, sir. Yes, sir. I have 27 years experience in Sterile Processing. I started off as a technician. I grew into a supervisory position, and then I went on into management in Chicago and in Oregon.

Mr. CARNAHAN. And so the earliest time you can recall raising this is March of 2009. Do you recall about how many times you raised these issues?

Ms. JOHNSON. There was another time I brought the issue up because there was a problem in another clinic, which it didn't get to the public.

I brought it up again and I, you know, I told this person that, you need to be walking around and, you know, talking to the supervisors or directors in these departments, making sure that no instruments are being sterilized in their department. All the instruments are supposed to come to our department.

Mr. CARNAHAN. And that's the central sterilization facility?

Ms. JOHNSON. Yes, which they call P&D.

Mr. CARNAHAN. And that's the—you worked in the central facility?

Ms. JOHNSON. I worked in Processing and Distribution, where they do the sterilization of instrumentation.

Mr. CARNAHAN. How many employees worked there when you worked in that department?

Ms. JOHNSON. Oh, I would say approximately 13, 13 or 14. It might have been more.

Mr. CARNAHAN. And when you were terminated, what reason did they give you?

Ms. JOHNSON. Unprofessional conduct.

Mr. CARNAHAN. What do you think that meant?

Ms. JOHNSON. I didn't know. I asked them, because I've always carried myself in a professional manner, always, no matter what they did, no matter what they said, no matter how they tried. I'm an Army brat and it's hard to really break me. So I always carried myself in a professional manner. My daddy taught me that.

Mr. CARNAHAN. Do you still have a pending complaint or case, or has that been resolved?

Ms. JOHNSON. Nothing has been resolved. It's still pending.

Mr. CARNAHAN. Were there other people within your department that discussed these concerns, also, besides the supervisors?

Ms. JOHNSON. I was the only one.

Mr. CARNAHAN. We appreciate your service and especially being here to share your story. And again, we hope this is an important part of getting to the bottom of this, getting answers, so that we can care for those veterans impacted and be sure this doesn't happen again.

Thank you all.

The CHAIRMAN. Thank you.

The CHAIRMAN. Mr. Blunt.

Mr. BLUNT. Thank you, Mr. Chairman.

Ms. Johnson, when did you come to work at Cochran?

Ms. JOHNSON. I left Chicago, Illinois, in December of 2008.

Mr. BLUNT. And when did you go to work here?

Ms. JOHNSON. December the 22nd or the 23rd of 2008.

Mr. BLUNT. Of 2008? Of 2008? Now, did you ever work in the dental sterilization area at all?

Ms. JOHNSON. No, sir.

Mr. BLUNT. And your view is, as I understand it, that all the sterilization should have been done in the Sterile Processing department?

Ms. JOHNSON. Yes, sir.

Mr. BLUNT. And do you know how the dental sterilization was done before February 1, 2009?

Ms. JOHNSON. Processing and Distribution was going to dental to pick up the dirty instruments. That's why I can't understand how this happened. They were going making rounds, picking up dirty dental instruments.

Mr. BLUNT. Even between February of 2009 and March of 2010, they were picking up some of the instruments or were not?

Ms. JOHNSON. From the time I was hired in December of 2008 until the time of my termination of November the 10th of 2009, the Sterile Processing department was picking up dental instruments that needed cleaning and processing.

Mr. BLUNT. And your impression would be, from what we now know, they weren't picking up all the instruments?

Ms. JOHNSON. Yes, sir.

Can I explain one thing?

Mr. BLUNT. Yes.

Ms. JOHNSON. This is why I'm saying that when you hire people in, you need to really know they know their job. This dental clinic is located inside a hospital. It's not located outside somewhere in another building, where the dental hygienists have to know sterilization because they use smaller equipment, tabletop sterilizers and ultrasonic. This clinic is located inside the hospital. Anything that's located inside the hospital, you have a central area for cleaning, and that would be Sterile Processing.

So all these instruments that come to Sterile Processing, they are processed. They are clean. You have people who do just that. They are supposed to know their jobs.

Mr. BLUNT. Right. And you are telling us that your impression is, or your full understanding is that some things, between the period we are talking about here, went to the Sterile Processing area?

Ms. JOHNSON. Yes.

Mr. BLUNT. And we don't think the problem occurred, Mr. Chairman, in Sterile Processing. We think it occurred at the department level. And I see some agreement behind you that that is the case.

I'll be interested—and I don't know that you would know this—but I would be interested to know what happened February 1, 2009, that was different than January, 2009.

And I'm surmising that maybe everything was going to Sterile Processing in January, and for some reason everything didn't go in February.

But at some point I want to know what was different in January and what was different after February 1. And I assume maybe someone on the next panel will be able to tell us that.

And I think those are the only questions I have here, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Costello.

Mr. COSTELLO. Thank you, Mr. Chairman.

Mr. Searle, you've stated in your written testimony that, "The problem exists not in the business process structure of the system, and the system protocols were designed to prevent such exposures, but rather, in the failure of those operating the system to execute those protocols. This can only be overcome by diligent and attentive management and training."

You heard earlier about the incidents, the veterans, over 10,000 veterans that were exposed in the three States, Tennessee, Florida and Georgia. You heard me and Congressman Shimkus talk about what's happened at the VA facility, the hospital in Marion. Those deaths resulted in Marion because of substandard care. Failure to follow standard procedure.

In your position, have you ever heard, either at the Marion facility or any VA facility where anyone was held accountable and actually terminated from employment? Either an administrator or employee?

I can tell you in the case of Marion, as Mr. Shimkus can, the administrator who was in charge of the facility was transferred to be an administrator at another facility and, in fact, we got an Acting Administrator. This happened in 2007 and they just appointed a permanent administrator over at the Marion facility who started this week.

So my question is, do we just shuffle chairs around, or do we hold people accountable?

Mr. SEARLE. The information that the Task Force has brought back is that there is a shuffling of people going on. I've not been told anyone has ever actually gotten fired. I haven't substantiated that. But that people have just been moved.

Mr. COSTELLO. So basically the people that work for the VA, the message is that if you don't follow procedures, you will still have a job. They may transfer you to another facility, but no one really is held accountable.

Mr. SEARLE. That's the trends that we are picking up, yes, sir.

The CHAIRMAN. Good step, Mr. Costello, for a whistleblower.

Mr. COSTELLO. And I was going to get to that.

Ms. Johnson, I can tell you, in your testimony where you state that they wanted you to keep your mouth shut, they did not want employees to give suggestions or to criticize procedures, that is exactly what we found from the employees at the VA facility in Marion.

I have had, and Congressman Shimkus had many meetings with the employees, both at the facility and off the facility after-hours, to hear their complaints and to investigate some of the issues that they raised, and we heard the exact same thing from those employees, that the administration did not want to hear suggestions or criticism and, in fact, there was retaliation and intimidation.

So what you have testified to this Committee today, we have seen not only at this facility that you are testifying about, but we saw it in Marion.

Finally, let me ask, Mr. Searle, examining what has happened here based upon what you know thus far, what should the VA have done as soon as they found out that 1,812 veterans were at risk?

Mr. SEARLE. Well, we would agree that they could have moved faster and put the word out sooner. I think that it goes back to what I read in my original testimony is that rather than waiting until something happens, there has got to be more oversight on a quarterly basis, monthly basis, whatever is set up, rather than—we feel that there is not enough oversight from Central Office. There are many different issues. There are a lot of policies that are put out, documentation put together. But when it gets down to the autonomy at the facility division director, regional office level, there is just too much leeway, in our opinion, that they can manage it as they see fit. And that's where the issue has been, or it wouldn't have come up in the first place.

Mr. COSTELLO. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Shimkus.

Mr. SHIMKUS. Thank you, Mr. Chairman.

As my friend Congressman Costello mentioned Marion, this is a, it's important to understand this stems two administrations. The Marion problem was in a previous administration and this is in the present administration. That's why a lot of us now are boring down on what is it about the Veterans Administration and the culture that's not focused on taking care of our veterans?

And that's why, Mr. Searle, I'm going to be interested in following—I'm a Legionnaire myself and my post is right across the river, Post 365 in Collinsville—not just "A System Worth Saving" but a system worth reforming.

Mr. SEARLE. [Nodded the head.]

Mr. SHIMKUS. And I think we need other eyes on the system. Obviously the current eyes are not identifying things, or it's being squashed.

Now, I know at Cochran when I visited a year or 2 ago, we had a Veteran's Advisory Committee made up of Legionnaires. Made up of VFW's. The only ones who complained to me at that time was the Paralyzed Veterans, based upon a spinal cord facility that we had been fighting and struggling and trying to get access to at Cochran.

I think there must be an issue there, too. If we've got Veterans Advisory Committees and we've got these problems in veterans hospitals, then our Veterans Advisory Committees ought to be speaking up. They ought to be calling us. They ought to be calling the administration. They ought to be using the 1–800 lines. And I would suggest that veterans here who know members on that Committee, that we all do a more diligent job.

And Ms. Johnson—and my colleague Mr. Costello highlighted this—you believe you were fired for doing your job, you were punished, where we have a system that when people don't do their job, they are not punished?

Ms. JOHNSON. Exactly. And that's the way it goes. You see it.

Mr. SHIMKUS. And that's the way it has to change.

Ms. JOHNSON. [Nodded the head.]

Mr. SHIMKUS. That's the way it has to change.

And my question was—and you answered it—this system seems like it's upside down?

Ms. JOHNSON. Yes.

Mr. SHIMKUS. You should be awarding people. When you work on a line, you are building a vehicle and there is a flaw in the vehicle, you pull the cord and you stop the process, because you don't want to sell faulty product. If you let it go on, then there is the whole, the whole system pays. So I apologize.

Let me read something that came out of the St. Louis Post Dispatch on July 7th. And this is for Ms. Johnson. "The cleaning of endoscopes was moved from the Supply Processing department to the gastrointestinal unit after problems surfaced with equipment not being properly cleaned."

Is that—would you view that as proper procedure, based upon your experience?

Ms. JOHNSON. Did the article—I mean they moved the scopes from Processing to what area?

Mr. SHIMKUS. Gastrointestinal.

Ms. JOHNSON. When did they do that? Because Sterile Processing was doing the processing of scopes when I was there.

Mr. SHIMKUS. I just have a snippet from, I know it's a Post Dispatch article. He's probably here, who wrote it.

Ms. JOHNSON. Well, in my opinion, when I was there Sterile Processing was doing the scopes, processing the scopes, cleaning scopes, and they have a machine that do all of this.

And GI, you know, they wanted those scopes and I thought it was proper that GI and their staff clean the scopes if they had well-educated employees in GI to clean the scopes.

Mr. SHIMKUS. Okay. And the only reason why—the story goes on. It says, "A month later, after receiving a complaint about endoscope sterilization, the Veterans Affairs inspectors visited the hospital and found several health and safety infractions. The temperature in the sterilization area was too high, rags and gloves were strewn about, decontamination area filters had not been changed, as required, a technician was not wearing protective gear, chemical test strips were left exposed, emergency exits were blocked, and employees were unsure whether an unattended endoscope was sterile, according to the Inspector Report issued in April by the VA's Office of the Inspector General."

Those would all be errors.

Ms. JOHNSON. They kept me away from that area.

Mr. SHIMKUS. Mr. Chairman, that's all I have. Thank you.

The CHAIRMAN. Thank you.

Mr. Akin.

Mr. AKIN. Thank you, Mr. Chairman. Just a couple of quick questions.

First of all, Ms. Johnson, it sounds like you were in a way a whistleblower, but you really tried to reform things, get things changed from the inside. Of course, that's tricky to do if you don't have enough management support behind you, and sometimes they can isolate you.

One thing, though. Did you write some letters making recommendations, specific recommendations, and saying, if we don't

do this, we are going to have this problem? Did you leave any kind of a trail in that regard?

Ms. JOHNSON. Yes, sir, I did.

Mr. AKIN. And could you make those letters available to the Committee?

Ms. JOHNSON. Yes, I can.

Mr. AKIN. Thank you. Thank you for your testimony.

The next question, is there any kind of—this is for the second witness, Mr. Searle. Is there any kind of a Customer Satisfaction Survey type of thing that people can fill out to say, how has your experience at the hospital been? Do they have any kind of procedures like that so there is a feedback loop that says, hey, we are missing something?

Mr. SEARLE. That's part of our "System Worth Saving." That's part of the investigations that we do. We go in and we look at the facilities, we talk to staff, and we do question patients to see what type of——

Mr. AKIN. And what sort of data do you get from that? Is there a pattern of people not being very happy with the services there, or is it no different than other places, or——

Mr. SEARLE. Quite honestly, we find veterans are very pleased with the health care system overall.

Mr. AKIN. Overall.

Mr. SEARLE. But we hear a significant, that they call it the best care anywhere. I'm sure you've heard that. There are very positive results.

I am a veteran and obviously I'm a product of the Old Square VA in Pennsylvania, and I have nothing but positive things to say about it.

Mr. AKIN. Okay. So now we generalized the question, but are there certain specific facilities where you find that the ratings are low?

Mr. SEARLE. I'm sure there are some that are lower than others. I don't have this year's "System Worth Saving" compiled yet. The team is still putting it together. It will be made available to you as soon as——

Mr. AKIN. Because from your testimony what I thought I heard, because I was interested in kind of the overall system and what's going on.

I got the impression from you that the system is pretty independent. That one Veterans Center may work pretty much differently than another. There is a lot of autonomy.

Mr. SEARLE. That's correct.

Mr. AKIN. Therefore, if that's the case, I would think there might be some that would be shining examples of good care, and some other ones—at least you'd think there would be good ones and bad ones in the system, and a lot of ones partly in between.

Mr. SEARLE. Oh, yes, there are.

Mr. AKIN. If that's the case and you do have those sort of satisfaction surveys, is that the pattern that you see in general, do you think?

Mr. SEARLE. I would think so, yes, sir.

Mr. AKIN. You would think so. But have you noticed that pattern specifically?

Mr. SEARLE. Again, I haven't seen this year's report. I don't know.

Mr. AKIN. I'm not talking about this year's. I'm just talking about in general.

Mr. SEARLE. In general? Yes, sir, we have seen some patterns.

Mr. AKIN. You do see that. And have you seen anything in terms of the data from the people that you have going through, has there been a problem with this particular facility?

Mr. SEARLE. No, sir. As I mentioned before, the last time that we went through this facility was in 2007.

Mr. AKIN. And at that time was there difficulty there, or not particularly?

Mr. SEARLE. No, sir.

Mr. AKIN. It didn't stand out as being worse than some other facilities or something like that?

Mr. SEARLE. No, sir.

Mr. AKIN. Okay. Thank you very much.

That's all the questions I have, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Luetkemeyer.

Mr. LUETKEMEYER. Thank you, Mr. Chairman.

For Mr. Searle, you are an advocate group for veterans with regards to VA treatment and benefits, the care that they get.

How is your relationship normally with the VA? Do they accept your suggestions? Do you have a pretty good working relationship with them? Is it adversarial, or what would you say?

Mr. SEARLE. I wouldn't say it's adversarial. I think we have a good working relationship. I'm sure that at some times we get under their skin, but that's part of the job of being an advocate.

Mr. LUETKEMEYER. You know, during your testimony you were talking they need some increased accountability. What were some areas? Can you define that or explain where you thought it would be? And specifically to this situation.

Mr. SEARLE. Well, again, sir, what we are looking at is that the procedures have been set up for the sterilization and various specifically to that are going on, and we just are not seeing a feedback mechanism going to Central Office, where the facility directors can say, yes, we are following these procedures. This is the training that's being conducted. These are the specifically to that are being done. We are not seeing anything that shows Central Office.

Again, going back to my military, I was a colonel. Retired colonel. The troops do best when the boss checks. And we are just not sure there is a significant feedback mechanism to make sure the troops are doing what they are supposed to be doing.

Mr. LUETKEMEYER. During your testimony I think you made the statement that you hadn't been in this facility for a while, is that correct?

Mr. SEARLE. Yes, sir, that's correct.

Mr. LUETKEMEYER. How can you make accountability suggestions if you haven't been there?

Mr. SEARLE. Again, I came from National Headquarters. We are using the VA system, VHA, in general, not specifically to this facility. It's what we have found across the board at VA, sir.

Mr. LUETKEMEYER. Okay. The suggestions that you have made, have you given those to the Cochran folks at this point?

Mr. SEARLE. No, sir.

Mr. LUETKEMEYER. You have not. Have you had any discussions with them at this point about you are going to give them some suggestions? Or——

Mr. SEARLE. No, sir, we have not.

Mr. LUETKEMEYER. Okay. At what point were you notified, or the American Legion? Or were you notified at all about this situation?

Mr. SEARLE. We, similar to the Committee, we saw it in the newspapers in this case.

Mr. LUETKEMEYER. Okay. Is it normal procedure that you not be notified?

Mr. SEARLE. By VA?

Mr. LUETKEMEYER. Yeah.

Mr. SEARLE. VA would not, has not in the past brought anything in particular to our attention with regard to these kind of issues.

Mr. LUETKEMEYER. Okay. So sometimes they do, sometimes they don't. Generally they don't do it at all?

Mr. SEARLE. I can say that generally they don't let us know these things.

Mr. LUETKEMEYER. Okay. All right. What is your organization doing to assist, or are they doing anything right now to assist the veterans who have gone through this dental program here and have some problems? Are you working with them at all? Do you have any programs in place for them as an individual group?

Mr. SEARLE. No, sir.

Mr. LUETKEMEYER. Okay. Do you anticipate doing it?

Mr. SEARLE. We certainly would look at it any time that we get comments or questions or requests for assistance from veterans. We do so on a daily basis. But in this particular case we haven't really thought about it.

Mr. LUETKEMEYER. Okay. All right. Very good.

Thank you, Mr. Chairman. That's all I have.

The CHAIRMAN. Thank you.

Mr. Miller.

Mr. MILLER. Ms. Johnson, you said there are about 13 people that you worked with in Sterile Processing?

Ms. JOHNSON. It could be a couple more. About 14 or 15.

Mr. MILLER. A dozen or so, thereabouts.

Ms. JOHNSON. Yes.

Mr. MILLER. And I'm just trying to go back to your testimony. You were the only person in that group that had any type of problems or vocalized your issues? Nobody else would do that?

Ms. JOHNSON. Well, they did behind the boss's back. But as far as, you know, changes and what was supposed to be done and suggestions, I was the one that came in and saw that the department weren't being up to par, as far as I'm concerned.

Mr. MILLER. Even if they didn't say anything negative, would you say they agreed with what your recommendations were?

Ms. JOHNSON. Uh-huh. Yes, sir.

Mr. MILLER. Why do you think they wouldn't say anything?

Ms. JOHNSON. Because they would be retaliated on. I mean everyone needs their job now. They wasn't going to say anything. The

only difference is my family goes to John Cochran. My daddy goes there. Vets go there. I did everything out of concern for the veterans. I come from a military background. I opened my mouth.

It was for the best. You see what happened. Eighteen hundred vets now have to go and get blood tested. All they had to do was listen.

Mr. MILLER. Did you say that—and again, I have no medical background—but that dental should have had all of their equipment processed by Sterile Processing, is that correct?

Ms. JOHNSON. May I give you something? And that is correct.

I wanted to give you something and Mr. Carnahan, so you have a better understanding about what I'm saying when you receive this and read it.

And the other half comes from the Department of Veterans Affairs. It comes out of their book. So you will have a better understanding as to what I'm saying.

Is that okay? It will just take a minute. It's right behind me.

Mr. MILLER. Please.

The CHAIRMAN. Go ahead.

This always gets us in trouble when I'm advised not to do it, but the gentleman in the back, did you want to add something to this?

Mr. HUSKEY. Yes. There is a survey and——

The CHAIRMAN. Would you identify yourself?

Mr. HUSKEY. Yes. Bob Huskey. I'm with the Gateway Chapter of Paralyzed Veterans. And we had asked—we had to go to the Freedom of Information Act to get it—for a survey administered by the Veterans Administration of 124 hospitals. John Cochran scored the lowest in three different categories. I have that survey, if you would like to see it. I would be glad to give it to you.

The CHAIRMAN. Okay. You can give it to our staff. We would be glad to look at it. Thanks.

Mr. COSTELLO. Mr. Chairman.

The CHAIRMAN. Mr. Costello.

Mr. COSTELLO. I wonder, before we dismiss this panel, if I could ask two questions?

The CHAIRMAN. Sure.

Mr. COSTELLO. We are not done yet.

The CHAIRMAN. We are not done.

Please, Ms. Johnson.

Ms. JOHNSON. Yes, sir.

Mr. MILLER. Thank you for providing additional material. With your indulgence we will also make it available for all the Committee Members.

[The supplemental information is attached to Ms. Johnson's prepared statement, which appears on p. 73.]

Ms. JOHNSON. Thank you very much, because I didn't want to leave anyone out. No one.

Mr. MILLER. Thank you. I think I heard you say that dental should have had their equipment processed with Sterile Processing, but was okay for GI to sterilize the scopes. Why the difference?

Ms. JOHNSON. The difference was because when I was there, GI had the most experienced person or personnel to clean their scopes.

And another reason I said that was because once the scopes are down in Sterile Processing, it takes away the employees from doing

instrumentation. In other words, you will have about three people over here doing scopes where we need these people over here to be assembling trays. So in the process, everybody is rushing because we are short on this side because they are over here doing the scopes.

Now, we in Sterile Processing, I'm not saying that the people, the staff wasn't qualified to process the scopes. What I'm saying is that those scopes should have been sent to GI because they have the most experienced staff. And you know, it just takes away the work that Sterile Processing is supposed to be doing.

Mr. MILLER. My time has expired, but one other question. You are aware that you can file a complaint under the Whistleblower Protection Act, correct?

Ms. JOHNSON. No, sir, because I don't consider myself a whistleblower. I consider myself someone trying to help the veterans in seeing things that weren't being done that should have been done. I didn't consider myself a whistleblower. I'm not. I just wanted things to——

Mr. MILLER. With all due respect, I would advise you to file.

Ms. JOHNSON. Thank you.

The CHAIRMAN. Thank you.

Mr. Costello, please?

Mr. COSTELLO. Thank you, Mr. Chairman.

And again, Ms. Johnson, I would concur with Mr. Miller. I would recommend that you file, as well.

But you, when Mr. Carnahan asked you about your case, you said it was pending. You also said earlier that the VA had 30 days to appeal but they did not appeal. Can you explain, one, what you meant by that, that they didn't appeal? Apparently there was a finding in your favor?

Ms. JOHNSON. Yes, sir.

Mr. COSTELLO. And when that finding was issued, the VA had 30 days to appeal but they did not?

Ms. JOHNSON. No, they didn't.

That was on my unemployment claim. VA had 30 days to appeal the decision that my termination was not for misconduct. They did not appeal that.

Mr. COSTELLO. But you said that your case is still pending. Can you explain what the status is?

Ms. JOHNSON. I also filed an equal employment opportunity complaint against VA. So that's still pending.

Mr. COSTELLO. And how long has your case been pending?

Ms. JOHNSON. I think I filed in, I guess about 7, 8 months.

Mr. COSTELLO. Thank you.

Mr. Searle, a final question. I'm a little confused as to the American Legion. How often do you visit facilities? You mentioned that you had not been to John Cochran since 2007. Do you visit facilities on a regular basis, or just when you get complaints, or can you explain the procedure?

Mr. SEARLE. No, sir. What we do is we—and again, this year we did 32 facilities. There are 153 different facilities, so we go on a rotation and we select them out of there. That's how they do that.

Mr. COSTELLO. And if you get a complaint, do you——

Mr. SEARLE. Yes, sir.

Mr. COSTELLO. Very good. Thank you very much for your testimony, both of you.

And I thank you, Mr. Chairman.

The CHAIRMAN. Okay. I just want to compliment our visitors here today for their questions. Usually, we think that only those of us on the Committee know what's going on.

But your talk, Mr. Shimkus and Mr. Akin, about the culture and the systems hits the mark. I think Ms. Johnson's testimony illustrates that.

There is a well-known sociological theory that a bureaucracy, almost inevitably, begins to function for itself rather than for who it serves. I think we see that happening in many places. Not every place and not equally. There are still good managers and good people, but the sense of fear and intimidation seems to be an indication that something is wrong.

I had high hopes, I still do, of Mr. Shinseki getting his arms around that. I don't think he has yet. But there are too many examples of the bureaucracy functioning for its own self rather than for the good of the veterans. This is only one example. If they had listened to Ms. Johnson, we might not have been here today.

I could give you hundreds and hundreds of similar things and decisions being made, for example, because somebody will have a better bottom line on their budget, and then not want to spend the money on behalf of a patient so that they will get a promotion.

If things like that happen, there is something going wrong. Again, the fear that people have is evidence itself that something is wrong.

No matter how much you say, we have the best of this or the best of that, if there is fear, something bad is happening. I think you have given us a good illustration of that, Ms. Johnson. We appreciate it. Again we've got to get our arms around this system and this culture.

I think you have to constantly revitalize staff from the top both in working conditions but more, in morale boosters. The Secretary should be seen around the country at the different hospitals inspiring and re-inspiring people.

Almost everyone I have ever met in the VA has joined because they want to help veterans. But somehow that gets lost in order to keep a job and to not rattle the cages. So it's hard. I think, Mr. Blunt would agree that the hardest thing we have in the legislature is getting our arm around these issues, as a bureaucrat from here.

Mr. Luetkemeyer.

Mr. LUETKEMEYER. Yeah. Mr. Chairman, if I may for just a moment.

Not serving on the Veterans' Affairs Committee myself, the report that the gentleman mentioned a while ago, do you, as Members, get that report?

The CHAIRMAN. I think so, yes.

Mr. LUETKEMEYER. Is it something that could be made public so that there is some accountability to the——

The CHAIRMAN. Yes, they are public. And the OIG and others report on their reports.

Mr. LUETKEMEYER. Well, my point is——

The CHAIRMAN. And, on whether or not the recommendations have been carried out.

Mr. MILLER. They are on the Web site.

The CHAIRMAN. As Mr. Miller points out, they are on the Web site. They are public reports.

Mr. LUETKEMEYER. All right. So there could be some accountability for those institutions and those groups that are not providing good service and, therefore, they can be held accountable.

The CHAIRMAN. Theoretically.

Mr. LUETKEMEYER. Okay.

The CHAIRMAN. But as we heard from Mr. Searle and others, they always cloak it in legal matters. We can't talk about personnel decisions.

We've got to figure out a way that we can talk about things that are public policy and that accountability is there. Unless people know they can be fired for withholding information, change doesn't occur.

Mr. LUETKEMEYER. Well, in the business world you go to an Executive Committee whenever you have an issue that you need to talk about personnel. And perhaps that's what needs to happen with this Committee, is at some point have an executive Committee so that they can discuss one-on-one and——

The CHAIRMAN. I will be interested, when we get back to the Hill, to hear your impressions. You know, that would help——

Mr. LUETKEMEYER. Thanks.

The CHAIRMAN [continuing]. This Committee do a better job. I think you are perfectly right.

I thank you, and we will call the third panel. Most Committees have the Executive Branch testify first; however, they tend to leave the room after they testify and never hear what the other witnesses have to say.

We have instituted a policy, under my Chairmanship, where the Administration testifies last. I like to ask them about what they've heard and what they are going to do about it. Usually, they don't have clearance from the Office of Management and Budget to answer my questions, but we try.

Dr. Petzel, I think you are on now.

Anyway, that's why they are third, so they can take into account the views of both the public and the stakeholders and hear things before they leave the premises.

The CHAIRMAN. Our witnesses on the third panel are from the Department of Veterans Affairs. Dr. Robert Petzel is the Under Secretary of Health for the Veterans Health Administration. He is accompanied by Dr. George Arana, the Acting Clinical Quality Assurance Liaison for Field Operations in the VHA. Dr. Andrea Buck is the National Director of Medicine at the Veterans Health Administration. And RimaAnn Nelson is the Acting Medical Center Director at John Cochran. Acting because? How long have you been Acting?

Ms. NELSON. Since October 2009.

The CHAIRMAN. Then we haven't had a permanent director there since then? Is that——

Dr. PETZEL. We actually haven't had a permanent Director there since January of 2009. We are soon going to have a permanent director.

The CHAIRMAN. Why is that, by the way? Why have you gone so long without a permanent Director?

Dr. PETZEL. Well, just briefly, Mr. Chairman, before I give my opening remarks——

The CHAIRMAN. Do they have something to do with this?

Dr. PETZEL. We do not believe so. The previous Chairman—the previous Director was detailed out and we are unable to fill a position if somebody is detailed out of it. Once he was, once he was permanently in his new position, we began the search and we are very close, Mr. Chairman, to filling it.

The CHAIRMAN. What does that mean, you can't do something because he's detailed? Because, you mean he still has the job?

Dr. PETZEL. He still has that job, yes.

The CHAIRMAN. Something is wrong. The average person listening in the back says, what in the hell does that mean? If you can't fill a job because someone left it, what are you administering back in Washington?

Dr. PETZEL. We would be happy if you could change that rule for us.

The CHAIRMAN. What kind of rule is it?

Dr. PETZEL. It's a personnel rule.

The CHAIRMAN. But that comes from you guys, not from us guys.

Dr. PETZEL. Well, it comes from the Office of Personnel Management.

The CHAIRMAN. Well, that just doesn't make any sense. But go ahead.

STATEMENTS OF HON. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GEORGE W. ARANA, M.D., ACTING QUALITY ASSURANCE LIAISON, FIELD OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ANDREA BUCK, M.D., J.D., NATIONAL DIRECTOR OF MEDICINE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND RIMAANN O. NELSON, ACTING MEDICAL CENTER DIRECTOR, ST. LOUIS VETERANS AFFAIRS MEDICAL CENTER, JOHN COCHRAN DIVISION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. PETZEL. Chairman Filner, Ranking Member Miller, and distinguished Members of the Committee, thank you for the opportunity to appear before you today.

I am here to discuss our finding that there was a failure to clean dental hand pieces according to manufacturers instructions and VA standard operating procedures at the St. Louis Department of Veterans Affairs were not followed.

I'm accompanied today by Dr. George Arana, VA's Acting Quality Assurance Liaison, Dr. Andrea Buck, VA's National Director of Medicine, and Ms. RimaAnn Nelson, the Acting Director at the St. Louis VA Medical Center.

We appreciate the opportunity to address this issue in detail and on the record. Simply put, what happened at St. Louis was inexcusable and unacceptable. It's the first responsibility of every government agency to be open and honest to the public and its clients. In our place, those clients are the brave men and women who wore the uniform and promised to defend this Nation.

We at VA have a great privilege and a solemn responsibility to provide quality health care and benefits to this population. That's why every day we constantly monitor and inspect our more than 1,000 hospitals and other clinical sites. That's why we check and re-check the safety and quality of the millions of procedures that we perform each year.

When we discover our care does not meet the high standards we have set, as happened in St. Louis, we take immediate steps to set things right. We notify our veterans, arrange necessary care and hold our people accountable.

Yet we understand that honesty and good intentions are not enough. The risk of infection to our veteran patients in this instance is extremely low, but nonetheless, we deeply regret the emotional and psychological burden, as testified to today——

The CHAIRMAN. Let me—Mr. Petzel, it's not——

Dr. PETZEL [continuing]. That's been placed on our veteran patients——

The CHAIRMAN [continuing]. It's not——

Dr. PETZEL [continuing]. And their loved ones.

The CHAIRMAN. I'm being less than decorous to stop you in the middle of your testimony, but we've gone through this before. You've been there.

You just made several sentences which conflict directly with the testimony you have heard today. Why don't you just stop for a second and either say that it might not have been fast enough for you but we have to do this, or, we didn't even do it right?

You just said, we respond as rapidly as we can. You have heard 2½ hours of testimony where every one of us said it wasn't fast enough. You act as if we didn't say a word here.

Dr. PETZEL. We absolutely, I absolutely agree with you, Mr. Chairman. We did not respond quickly enough.

The CHAIRMAN. But that's not what you just said in your sentence. You said, we acted as quickly as we could.

Dr. PETZEL. We took too long to investigate this.

The CHAIRMAN. Well, you didn't say that.

Dr. PETZEL. Well, it comes later in my testimony. We took too long to investigate this and we took too long to notify. I absolutely agree with you on that, Mr. Chairman. Absolutely agree.

The CHAIRMAN. Thank you.

Dr. PETZEL. The VA is grateful for the sustained confidence in our ability to provide world-class care and demonstrate by our veterans, their families, and the veteran service organizations. We believe our system of quality assurance and safety is second to none. It has been proven time and time again by a wide range of organizations who have testified to the general quality of care within the VA.

My written testimony provides a chronology of the events, and documents our responses to this situation. In the time I have now,

I would like to acknowledge that we recognize there were missed opportunities to uncover this issue sooner.

Not only are we reviewing our experience and our responses to identify lessons learned, our policies for identifying these lessons, these issues earlier and notifying our veterans and stakeholders faster; I will submit a letter describing the improvements in our standards for ensuring compliance by facilities to the Committee on Veterans' Affairs on August 15th. We have reviewed our processes and we have determined that these have to be shortened; that the 108 days that we took to bring this to public notice was far, far too long.

The CHAIRMAN. And now you are going to take another 30 days to notify me by letter? That means you really learned your lesson?

How can you say that? You just said, you are going to notify everybody as quick as you can. You just said, you learned your lesson, and then you say you are going to send a letter about that 30 days from now.

Why not right now? What goes on in the thinking here? You know, you've heard, as I said, 2½ hours of testimony. Respond to it. Give us some sense that you get it. All I hear is the same justifications that "we've been doing." I will let you complete your statement, sir, but we make you sit through the previous testimony so you can respond to it. The frustration, the anger, the hurt, and everything else that you heard—you are not responding to it. People will leave as frustrated as when they came if you continue this way.

You are not showing that you understand the depth of the fear, the hurt, and the loss of trust—I mean all these things are there. You have a chance here to try to begin to build a bridge and are not taking that chance.

Dr. PETZEL. Mr. Chairman, we do recognize, as I said earlier, that this took far too long. That we must find a quicker way to investigate these incidents.

The CHAIRMAN. Give me the letter tomorrow. Why on August 15th?

Dr. PETZEL. To notify—we can certainly send the letter to you long before the 15th, sir.

We are committed to implementing the high quality principles of the ISO 9001. We've talked about this before with you. Therefore, I'm not going to go into the details of it.

But the critical part, the critical part, in my mind, of changing the incidence of events in the SPD is industrialization of the process, and ISO 9001 is that industrial standard by which we need to have our SPD's fully functional.

To respond to veterans' concerns about this issue, the VA has set up a Call Center, beginning to operate 7 days a week, 24 hours a day. Veterans and their families can call this number, 1–888——

The CHAIRMAN. Did you hear what happened when someone called?

Dr. PETZEL [continuing]. Three seven four——

The CHAIRMAN. Respond to that. Don't tell me you've got a 24/7 hotline. You've got new people who don't understand a word of what they are doing. I just called this morning and I will tell you if I was a veteran, I would have just started crying. The person

who answered the phone had no sense of what I was talking about. No sense of what I needed and you heard this earlier, Dr. Petzel. You've heard it and yet you still quote, "24/7, they are always there."

It doesn't work. Besides, they've had so much experience with the 1–800 numbers and nobody answering them that they don't even bother to call any more.

We've tried this 800 number, and I don't know what you do there, but nobody seems to be there. You can wait for an hour before it gets to be your turn. So, they say, the hell with these 800 numbers. They don't have any confidence in this.

You say it's working. We just heard everybody say it's not working. It's not an acknowledgment that we've got a problem. That's why we have the problem.

You said industrialization is the answer. That's not the answer. The answer is caring people who understand the veterans, and who can make changes and recommend solutions to their supervisors without getting intimidated and somehow the bureaucracy responds to the real needs of people. All you keep telling me is that bureaucracy comes first. We've got the industrialization. We are working as hard as we can.

It's not working.

Dr. PETZEL. Then we will go back and make it work, Mr. Chairman. It's appropriate to have a 24-hour, 7-day-a-week call——

The CHAIRMAN. Not with 50 people who were hired yesterday.

Dr. PETZEL. No. I absolutely agree with you. They need to be answered by compassionate, understanding people who understand what the issues are and are able to talk and respond directly. If those aren't the kinds of people that are manning that call, then we will have those kinds of people there.

The CHAIRMAN. You just heard that there weren't, and you didn't even acknowledge that there were those complaints.

Mr. MILLER. Mr. Chairman, will you yield?

The CHAIRMAN. Mr. Miller.

Mr. MILLER. I think part of the problem is, Doctor, that you've got approved testimony that you have submitted that obviously has been reviewed by somebody, because you keep going back to it. And I understand with testimony that's the way that it normally works.

I think the thing that bothers us is the fact that the Chairman does ask the administration officials to wait until the end so they can hear from those that are testifying before the Committee in hopes that you will deviate from your written remarks, go off-script, if you will, and show some compassion yourself; that you heard the people who poured out their hearts as best they could in a public forum.

And I read this last night. I read it this morning. I read everybody's testimony. But my feelings for the testimony changed when I heard them actually give it personally. It would for any human being.

But I'm not hearing your testimony change. And I would just ask if you could fold up your testimony and speak from the heart. Because we know that VA cares about their people but what you are showing is that VA cares more about the script that's been prepared for this hearing today.

Dr. PETZEL. Yes. I hear you, Congressman Miller.

The CHAIRMAN. I thank the Ranking Member for making me more eloquent.

Dr. PETZEL. So let me review, if I may, if I could, then, before the questions begin.

First of all, we are shocked, appalled at this unacceptable incident. I think I want to make that very clear that we do not condone what happened. We do not believe it was appropriate. And, number one, we are, I am personally embarrassed by the length of time that it took the organization to respond in two ways, one, to get the investigation done and, two, to notify the patients.

And Mr. Chairman, as I said before, I promise you that we will outline for you a rapid procedure for both identification of the issues and problems, and notification and a new process for notifying families.

As you heard before, we have traditionally used this letter phenomena. Clearly, in listening to what was going on today, that failed to meet the needs of these patients. Absolutely failed to meet the needs of these patients. It's clear that we need to do a personal, on-the-phone, qualified professional's initial call. There may be letters to follow up with at some future date, but it's clear that this was not the appropriate way to notify people.

And it's also clear that we don't have the kinds of experienced people that we need to have answering our phone calls and leading our patients through the process. And those things, as we will outline in the letter to the Chairman, need to be changed. Absolutely need to be changed.

The CHAIRMAN. Thank you.

Dr. PETZEL. This process did not demonstrate the kind of compassion that I know people at St. Louis feel for these patients, and we will change that process.

[The prepared statement of Dr. Petzel appears on p. 78.]

The CHAIRMAN. Thank you.

Dr. PETZEL. Yes, sir.

The CHAIRMAN. Mr. Carnahan.

Mr. CARNAHAN. Thank you, Mr. Chairman.

My question is for Dr. Petzel. And first, with regard to this incident, you heard the description from Ms. Johnson about her being retaliated against and the culture of really suppressing people speaking out when they see problems, large or small.

And I want to know, what is going to be done from the VA to affirmatively tell employees that they are not only able to speak up, but encouraged to in a safe way, without retaliation?

Dr. PETZEL. I promise you, Congressman Carnahan, that we will, at the John Cochran, have a program to do exactly as you implied. To encourage employees to come forward, tell us about issues, tell us about problems, or to set up a safe system whereby they can do that. Where they can anonymously, if you will, present their problems to the management.

I don't, I don't condone retaliation.

Mr. SHIMKUS. Will my colleague yield for a second on this point?

Mr. CARNAHAN. Yes.

Mr. SHIMKUS. This needs to be system-wide. This is the same problem we had at Marion. This has to be system-wide. See, the

employees need to feel open to be able to air their concerns and their problems. And the patients need to be able to complain without fear of retribution.

If there is fear of retribution, either by an employee or veterans, there is failure. So I would ask that you take back to the Secretary these comments and say, we've got to clean this up.

Thanks to my colleague.

Mr. CARNAHAN. No, I appreciate that.

And that was my point, as well, that can we learn from this incident? Because this does not seem to be restricted to Cochran. And in any kind of an organization where you are striving for quality, you have to reward people. Not punish them. Reward them. You know, Ms. Johnson should have been promoted, not fired. And reward them for speaking up about quality and how to make those improvements.

I don't think that exists, not at Cochran, and it doesn't seem to exist in the VA. And their needs to be a system in place to do that. That, to me, has to be the critical part of continuous improvement within an organization like the VA.

Dr. PETZEL. I absolutely agree with you, Congressman. We need to have a culture where, as you say, people are willing to speak up and become a part of a continuous improvement process in the hospitals. I absolutely agree with you.

The CHAIRMAN. If you will yield for a minute, I want to get unanimous consent from my colleagues. I like the group here today.

I want to come back in 6 months. Dr. Petzel, we appreciate your promises. We appreciate your effort. Let's see what's gone on in 6 months.

Mr. SHIMKUS. No objection. No objection.

The CHAIRMAN. I suggest that to my colleagues because of the frustration here as we see this again and again and the changes don't get made. I want to see some changes even if it's in one place. If it has to start here, fine.

You have all shown a real sensitivity and a real empathy, so maybe VA can report back to us.

Anyway, I'm sorry.

Mr. CARNAHAN. No. Thank you, Mr. Chairman. I wholeheartedly concur.

And the other question I had, Dr. Petzel, was the use of the Administrative Investigation Board versus the Inspector General of the VA, what's the rationale for that? What's the precedent for that?

Dr. PETZEL. For using an Administrative Investigative Board to look at the incident at Cochran?

Mr. CARNAHAN. Yes.

Dr. PETZEL. Well, we wanted to get an unbiased, outside-of-the-institution, outside-of-the-network view of why this happened.

We know what happened and we want to be absolutely certain about why this happened. And when we are, then we can decide who was responsible for this and we can decide who needs to be disciplined and who needs to be held accountable. So that is our mechanism for gathering the information to find out who is accountable.

Mr. CARNAHAN. And you got to my last point, and that is, how important it is at the end of the day, when we have discovered exactly what happened, who was responsible, that somebody is held accountable and we can begin to tell our veterans that any of their confidence that has been shaken in the system, that it's been taken seriously, that the shortfalls are being addressed, and in going forward, we are going to have a better system?

Dr. PETZEL. Absolutely agreed, Congressman. I absolutely agree.

Mr. CARNAHAN. Thank you. I give it back.

The CHAIRMAN. Thank you.

Mr. Blunt.

Mr. BLUNT. Well, thank you, Chairman, and thank you for coming to Missouri today. You know, you and I have talked about these issues many times but I've never got to sit on a Committee on this topic with you. And the intensity and the commitment you bring to this issue is important.

And Mr. Miller, you, as well. And you and I have talked about these veterans issues over the years.

And I think what you can see, Doctor, is the frustration of hearing the same answers over and over again to the same problem. And so I'm—how long have you had your job?

Dr. PETZEL. I was sworn in in February, the middle of February, 2010.

Mr. BLUNT. And what did you do before that?

Dr. PETZEL. I was the Network Director in Minnesota, Minneapolis, Minnesota, for Network 23.

Mr. BLUNT. So how long have you been with the VA?

Dr. PETZEL. Approximately 37 years.

Mr. BLUNT. So you bring your career-long background to this. And I would hope that if anybody could figure out how to solve this, somebody who had been working in this for 37 years would be able to do it.

Dr. PETZEL. I do have many ideas that we are just beginning to implement, yes, sir.

Mr. BLUNT. Well, it will be interesting to see, 6 months from now, if you've implemented them or not.

I will say that, you know, I have people from southwest Missouri, from my district, that are among these 1,800 and I believe 1,812 people. People from a significant number of States, because of the uniqueness of this particular facility, are among the 1,800 people. And on July the 1st, I sent a letter to the Secretary and, like others here, I have great hopes for his leadership of the VA. I was pleased to see, just a few weeks ago, that he had done some things long overdue to try to cut the paperwork, to try to cut all of the application process to get this done.

But this is a time when we need to get to the bottom of some of these problems and use all of the new things available. You know, we've got a new Veterans Clinic in Branson that I walked through the other day. They have a doctor there just for traveling veterans. And that doctor for traveling veterans can pull up any veterans' health records because the VA is ahead in this.

But we need to figure out, okay, we are ahead in that. What else can we, how can we use the time we used to spend looking for records—because all those records are on Health IT now—how do

we use the time we used to spend looking for records to get ahead somewhere else?

And I would charge you to do that. And I would hope—you know, the six questions that I asked on July 1, the day after I heard about this problem, are the six questions we've been asking today. Now, if I can figure out these six questions within 24 hours, it is amazing to me that it would take, you know, months to decide how are we going to, are we going to notify people? And then even more months, up until today, to figure out that we've notified these people in the wrong way, the VA has.

That when you get that letter, you know, we heard Ms. Odom say that she just fell to her knees. And I tell you, a lot of people would fall to their knees if they got that letter, wondering which of these things they might have and why they've got this letter that, as she described it, was like getting a notification that the parking lot was going to be repaved on the south side next week, instead of the reaching out. As the Chairman said the very first thing, why don't you find 1,800 people that can be assigned to each of these people until the problem is solved?

And you know, I've got several questions here. Look at the six questions I asked you, line one. And we've answered some of them today, but I would like an answer and I would like it before next July 1.

And surely after this hearing somebody can sit down and just write a letter that answers these six questions so that I know that at least somebody there is responding to what we are asking.

Now, what was different? I think the Acting Director of the hospital is here, or of this facility is here, is that right?

Ms. NELSON. That's correct.

Mr. BLUNT. How long have you been the Acting Director?

Ms. NELSON. Since October, 2009.

Mr. BLUNT. Of this? Now, are you the Acting Director of the John Cochran VA Medical Center?

Ms. NELSON. Yes, I am.

Mr. BLUNT. And you've done that since October of 2009?

Ms. NELSON. Yes.

Mr. BLUNT. Tell me what you were doing different in January of 2009 than they were in February of 2009. Why is this a problem that only goes back to February 1, and what changed between January 31 and February 1 that makes this problem start on February 1?

Ms. NELSON. Well, and I started in October 2009. But what happened——

Mr. BLUNT. Well, surely you know the answer to that question. Surely this is a question you asked somebody when they said this started February 1. I don't care when you started. Surely you asked that question.

What was the answer?

Ms. NELSON. What happened prior to February 1, 2009, was that we had an inspection of the dental clinic area, which showed that we were following cleaning procedures per manufacturing guidelines.

After February 1st, 2009, we are not sure that those procedures were followed and so we wanted to make sure that we took care

of all veterans seen in the dental clinic, so we chose February 1st, 2009, as the date because we did not have any evidence after February 1, 2009, that the procedures were still being followed.

Mr. BLUNT. So are you telling me that this routine inspection that I asked about in the letter—according to information provided by VA staff, this situation was discovered during a routine inspection conducted by the National Infectious Diseases Program Office.

Dr. PETZEL. Congressman Blunt, let me explain. Prior to February of 2009, all of the instruments were going down to Sterile Processing and being both washed and sterilized in Central Processing.

Mr. BLUNT. All of the—okay.

Dr. PETZEL. All of the instruments.

Mr. BLUNT. Now, is that—do you agree with that answer? I don't know why you didn't say that.

Dr. PETZEL. I think she didn't quite understand the question.

Then after February of 2009 the dental service, because they weren't getting back all of the instruments in the right packets that they wanted, said, we will do the washing. They didn't say it but they started doing the washing, they packaged the instrument packets, and then they went down to be sterilized.

And our problem with that and everybody's problem with that is that they weren't doing the prewash in exactly the right fashion.

Therefore, even though the instruments were pre-washed, in a way, and were indeed sterilized in the sterilizer, we cannot definitively say that they were sterile. That's the issue that was discovered, then, on March 10th of 2010.

Mr. BLUNT. All right. So now let me be sure I understand this. Did they change the process just because, right after an inspection, and they, why did they——

Dr. PETZEL. They changed the process, as I am led to believe——

Mr. BLUNT. Was there an inspection in January of 2009 or not?

Dr. PETZEL. No.

Mr. BLUNT. Now, I thought you just said there was an inspection in January of 2009 and it didn't come around again until—and that's why you picked the day, is that not right?

Ms. NELSON. We did an internal audit where we walked through the dental clinic and saw that the procedure was being followed at the time of the audit. This was our own audit conducted by our Quality Management Department.

Mr. BLUNT. And the procedure at that time was everything was going somewhere else to get sterilized?

Ms. NELSON. Yes. It was going down to the Sterilized Processing Area.

Mr. BLUNT. And you believe that changed, but it didn't change any earlier than February 1, 2009. Sometime after that they decided they weren't getting their equipment back in the order they wanted it in?

Ms. NELSON. That's correct.

Dr. PETZEL. That's right.

Mr. BLUNT. All right. So that's why it starts on that date. And you are confident it couldn't have been earlier than that? I'm hearing maybe it might have been a few days later than that, but you

are confident it couldn't have been earlier than that, is February 1, 2009?

Ms. NELSON. Yes, we are confident that February 1, 2009, is the risk period and would capture all the patients that were seen in dental that would have potentially been exposed.

Mr. BLUNT. And the 1,812 of them, can somebody give me an idea how long these people—could it possibly be 20 years before you know whether this is still a problem or not?

Dr. PETZEL. I would like to turn to Dr. Arana, who is prepared to answer that question for you, Congressman.

Dr. ARANA. Mr. Blunt, in response to that question, the issue of the window of exposure, that is, if you get exposed to hepatitis B or hepatitis C or HIV on July 1st, you don't know whether you have those or you've essentially gotten infected until 6 months later. So that's a 6-month window of time that we have to wait and make certain that we've captured every single vulnerable vet in terms of infection.

So the, right now we have notified all the veterans. We have tested approximately 950 of those. To date we have the number, the latest number from yesterday close of business is that 826 of those veterans were negative on all three illnesses: HIV, hepatitis B and hepatitis C. Up to yesterday's close of business, 261 of them were notified.

Mr. BLUNT. And then they are outside the 6-month window, the ones you are notifying?

Dr. ARANA. Some of them are. Some of them aren't.

Mr. BLUNT. All right. Well, once you get outside the 6-month window, 6 months from the last person impacted here, which would be March the 10th, 6 months from then, if that last person that was seen on March 10th has a test and it comes back negative, do they have to worry for the next 20 years that it may not be negative or not?

Dr. ARANA. No, sir. They only have to worry until September, when they get re-tested at that time. The 10-year, 20-year number that we heard somebody mention is usually the period of time that it takes for some of these illnesses to manifest. But in terms of testing and being certain that they have been infected, that is a 6-month period of time.

Mr. BLUNT. So, okay. Let me be sure. This is one point I want to make and I'm sure the people have other questions. And they will be questions I might have asked, but let's let them ask them.

The one point I want to be sure I'm clear on here is 6 months from the last time you were in this dental clinic, if you are not testing positive, you are not positive. And if you are testing positive, it could be a long, sometime in the future before hepatitis C or whatever manifests itself.

But if you are not positive 6 months later, you don't have to worry about 10 years from now.

Dr. ARANA. You don't have to worry about—at 6 months if you are testing negative, you are finished worrying.

Mr. BLUNT. Okay. Susan and Julie, does that help? At least in 6 months.

But then if you say, okay, you are testing positive for it, you've got the hepatitis C positive test——

Dr. ARANA. Right.

Mr. BLUNT [continuing]. At that point you do have to continue to be concerned, but only if you are told that at that point?

Dr. ARANA. Yes.

Mr. BLUNT. Is that right, Dr. Arana?

Dr. ARANA. That's true.

Mr. BLUNT. All right. That's helpful to me. And it's not, it's obviously not as good as if this didn't happen, and it's obviously not as good as if all of the people we hope test negatively.

But whoever has the sense that you won't know for 20 years whether you've got this or not, that's not true. You won't know for 20 years, if you've got it, whether it might manifest itself or not.

Dr. ARANA. Correct.

Mr. BLUNT. Is what——

Dr. ARANA. That's a correct statement. That is that if you end up testing positive, then you can, over time, convert to having the illness. But at that point what you have is you have evidence in the blood of exposure, but you don't have the disease.

Mr. BLUNT. But 6 months from the last day you were in that dental situation, you should be able to know one way or another whether this is over for you, or you have to continue to worry, right?

Dr. ARANA. Yes.

Mr. BLUNT. And if the last day you were there was 6 months ago and you took the test tomorrow, you would know tomorrow——

Dr. ARANA. Yes.

Mr. BLUNT [continuing]. Or whenever the test is reported back, you would know one way or another that you have to worry about this or you don't?

Dr. PETZEL. That's correct.

Mr. BLUNT. All right. Did somebody else want to answer a question there? Any time I see somebody grab a microphone, I don't want to not let you ask a question, if you want to.

Do you have anything else you want to say?

Dr. PETZEL. No. You've got this exactly right, Congressman Blunt.

Mr. BLUNT. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Has anybody in those latest tests, tested positive in anything?

Dr. ARANA. No.

The CHAIRMAN. So far it's zero.

VOICE. That's not true.

Dr. ARANA. No. No. We have, what we have is we have some that have tested positive, but we have to go back and verify exactly when they were in the clinic in terms of the risk.

So the evaluation is not complete until we have checked back when they were actually seen in the clinic. So although we have found some positives, we don't know that they are positive until we verify——

The CHAIRMAN. Of course you wouldn't "no" treat them.

Mr. BLUNT. Mr. Chairman, there is somebody back there saying that's not true. Can you ask her what she means by that?

The CHAIRMAN. Some people are yelling. Ma'am in the red.

Ms. HENRY. Yeah, my father was——

The CHAIRMAN. Identify yourself, please.

Ms. HENRY. My name is a Lisa Henry. I wasn't planning on speaking today. I'm sorry.

My father was in the dental clinic in May and several times after that, and he was in full liver failure at the VA in January, hepatitis B. They had to transfer him to Barnes for a workup for a liver transplant. He was seen in the VA dental clinic four times. He had normal liver function tests prior to being diagnosed with hepatitis B.

So I don't know 100 percent this is where he got it, but a 72-year-old man who doesn't have any other risk factors——

The CHAIRMAN. By the way, they are going to argue that he was not tested in this program, so they don't still have any positives.

But you had better understand what happened to that man.

Dr. ARANA. Absolutely.

Ms. HENRY. He almost died.

The CHAIRMAN. Thank you. One or two more. We shouldn't do this but—in the back, please?

Mr. HART. Yes, my name is Richard Hart. And at the VA they overdosed me with botulism. You was talking about tests being run. Well, they gave me 1,000 units in 45 days. It almost killed me. They did a Doppler on my leg and they said I was fine for blockage, but later I go to the Social Security doctor——

The CHAIRMAN. We need to look at that, sir, but that's a little bit different problem than what we are discussing.

If you would let our staff know about your situation, we will look into that, please.

Mr. HART. What I'm saying, their test comes up different than what everybody else's test comes up.

The CHAIRMAN. Okay.

Mr. HART. I had three different tests and it came up good for them. But when I went to a different facility, they found out something different.

The CHAIRMAN. Okay. Thank you.

Dr. PETZEL. We will follow up with that, as well.

The CHAIRMAN. One more question in the back. Go ahead, please, ma'am.

Mrs. SHANDS. I've got one quick comment for the Committee.

Please get a board certified hepatologist with experience in dealing with all the different forms of hepatitis, from A through G, who knows about C, who knows that, one, you cannot always find it that easily, and two, just because you test 6 months later and you come up negative, it doesn't necessarily mean it's not there.

For example, in the case of my husband, who died at John Cochran of hepatocellular carcinoma, which is hepatitis C related liver cancer, he tested negative in his serum until the day before his death.

Dr. Chenowitz called me the day before, because VA doctors did not believe he had cellular carcinoma, he said, Mrs. Shands, please, may we do a biopsy and confirm it? I gave my permission. They found it, once the biopsy was done, in the tissue but it never showed up in the blood. So please, get a board certified hepatologist and get the facts.

Thank you.

The CHAIRMAN. Thank you.

The CHAIRMAN. Mr. Costello, please.

Mr. COSTELLO. Mr. Chairman, thank you.

Mr. Chairman, let me applaud your approach to Mr. Petzel's testimony. I almost said, take the testimony, turn it over, and tell us what you know and what you are going to do about it. What's the action that we are going to take from here on out.

We realize you've only been in your position a very short period of time, your current position, and I'm sure that you have every intention of trying to make the changes that are necessary to be made here, but I've got to tell you, based upon my experience and the track record of the Agency, I'm very skeptical that the change will take place.

You know, I talked about the Marion facility. That was in 2007. We talked about what happened to veterans who were exposed in Tennessee, Georgia and Florida. And this Committee, at my request and Mr. Shimkus' request, held a hearing on the VA facility in Marion.

And I've got to tell you that it was most troubling that after 2 years, we requested that the Inspector General take a look at the Marion facility to see what improvements were made. After 2 years of discovering the problem and nine veterans dying, that the Office of the Inspector General discovered in 2009 that Marion had not improved on their procedures. That's the Inspector General, 2 years after it was discovered that nine veterans died because of substandard care.

So I would just suggest, Mr. Chairman, as you have, that this, the only way that action is going to be taken and the only way the change will come about is if this Committee provides aggressive oversight to make certain that the VA is doing what they tell us they are going to do.

It's my experience, in Chairing the Aviation Subcommittee, that the Federal Aviation Administration has all of the good intentions in the world, but unless the Subcommittee keeps pressure on them, they do not act. And that is my fear with John Cochran.

So I'm pleased to hear you say that in 6 months or whatever the time period, there will be another hearing of this Committee, and I think that's an excellent suggestion. It puts the VA on notice that someone is looking over their shoulder and will continue to.

I personally, and Congressman Shimkus and Senator Durbin, have met on a regular basis at the VA facility since the Inspector General's report came out in 2009. We are starting to see some improvements, but it's because they know that someone is looking over their shoulder and we will expose it if they are not taking proper action.

Having said that, let me ask just two quick questions for Dr. Petzel.

Dr. Petzel, my understanding is that on June 26th of 2009, the VHA directed, has a directive that states that VHA policy requires each facility to have standardization and oversight plans for reprocessing reusable medical equipment according to the manufacturer's instructions.

Number one, who approves those plans and ensures that they are followed?

Dr. PETZEL. There are several mechanisms, Congressman Costello. One is that each one of the networks has an oversight board for Supply Processing and Distribution. And that board is responsible for doing both announced and unannounced inspections of each one of the facilities within that network to ensure that they are indeed following those processes.

Number two is that we ask the facility directors to certify to the effect that they are indeed following all of those processes and procedures.

Does that catch this every time? Does that mean that I can say definitively that we are never going to have another incident in another Supply Processing and Distribution area or in another dental clinic? It doesn't. Unless we've got good surveillance and good oversight, as you were about to point out, to ensure that these things are being done, we can't make those kinds of assurances.

Mr. COSTELLO. If, in fact, the second part of your procedure that you explained—did, in fact, the Acting Director at this facility sign a certification that those procedures were followed?

Dr. PETZEL. I believe so, they were signed just before she became the Acting.

Ms. NELSON. They were signed prior to my arriving.

Mr. COSTELLO. And when would that have been?

Ms. NELSON. This would have been prior to October 2009.

Mr. COSTELLO. I would request, Mr. Chairman, that that documentation, not only the certification that was signed before you became the Acting Director, I would like to see if in fact a certification was signed, and the dates for the last few years. The last 2 years.

Dr. PETZEL. We will do that, sir.

The CHAIRMAN. And how often do you have to sign one? Every year or every 2 years?

Dr. PETZEL. This was a result of the——

The CHAIRMAN. No? When did she have to sign one?

Dr. PETZEL. She would have been signing as a result of—she wouldn't have to sign one independently, Mr. Chairman. She would, someone had to sign the certification at the time that we sent that out.

Now, if we have to find out, I don't know who was the Acting here or whether the previous Director was here, but that's the individual that would have certified that.

Mr. COSTELLO. Well, what does the, what is the procedure? Does the procedure say that a certification has to be signed every month, every 6 months, every year? What's the——

Dr. PETZEL. That was just a one-time event associated with the publication of that new directive, as I remember it.

Mr. COSTELLO. So if I understand you correctly, the Acting Director had to do the certification one time and that's it?

Dr. PETZEL. The certification was a one-time that they have looked at, inspected all of the facilities and we, then, are indeed following all those procedures that was in that directive. That was just a one-time event associated with the issuance of that directive.

Now, there are a number of inspection groups that go and look at our Supply Processing and Distribution centers. Some of them come out of the network, some of them come out of Central Office,

Infection Control. There is also a national group, now, of Supply Processing and Distribution that reviews and inspects our procedures in each one of the medical centers. That's the external methods for accounting.

In addition to that, the Joint Commission every 3 years comes in and looks at these things. The Inspector General, in their Combined Assessment Program visits, comes in and looks at our Supply Processing and Distribution and we have Systematic Ongoing Assessment and Review Strategy, an internal group that also looks at it.

Mr. COSTELLO. My understanding is that the letters that were sent out to the 1,812 veterans, that in the letter that the Center says between February 1, 2009, and March 10, 2010.

Why did it take this long to go undetected?

Dr. PETZEL. I don't know the answer to that, Congressman, to be honest with you. That's part of what we are trying to find out with the Administrative Investigative Board. Who should have known that this was not proper and appropriate? Why didn't they know and why didn't we know?

Mr. COSTELLO. Are there procedures in place now? I mean for a year this went on. Are there procedures in place now that inspections have to take place or a review has to take place on a regular basis?

Dr. PETZEL. What we've done first to assure that this doesn't happen with dental is that we now require, and we have certification from every one of the medical centers, we require that all processing of dental equipment, the prewash and the sterilization, must occur in the Supply Processing and Distribution central center. That's our mechanism for being certain that we are not doing what happened before.

In addition to that, there should be walking rounds that occur in a medical center to ensure periodically that indeed that process is being followed.

Finally, the Supply Processing and Distribution people are alert now to the fact that they are supposed to be receiving the unwrapped dental instruments. If that should not happen, if they should be coming down wrapped, then that's a red flag to say this is not happening correctly.

Mr. COSTELLO. Finally—the last question because I'm out of time here—what did the Agency learn from the incidents that happened in Tennessee, Georgia and Florida that should have happened here with the notification of the 1,812 veterans? I mean surely the Agency learned something from those incidents.

Dr. PETZEL. I think we did. It's very interesting, Congressman. We notified by letter all of the people, and we received absolutely no feedback or pushback about the way that happened. So clearly, we didn't learn from that that the method of notifying was not sensitive to the patients' needs and was not, didn't recognize the seriousness of this event in the lives and minds of the patients. So that's a lesson we didn't learn.

We did learn how to go about organizing ourselves for an event like this. We did learn that we need to have counseling available. We did learn that we need to have professionals available.

The things that we did not learn were, number one, the time and the implications that it was going to have on both Congress and the public in terms of the time it took us to discover this, and the reaction that the patients would have to the letters that we sent out. In retrospect, it's obvious.

Mr. COSTELLO. Would you agree with the Chairman's statement earlier that all 1,812 should have a caseworker or someone assigned to them so that they can have a contact, and ask the caseworker questions throughout this process?

Dr. PETZEL. Yes. I believe that each one of those people should have a contact person that they can go to, that they know will answer their questions, that they know is available, and help them with whatever issues they might have.

It's interesting, though. Most—not most. Some of the people are going to reject that. When we called after we sent the letters out, there are numbers of people who don't want to be tested, don't want to be involved.

Mr. COSTELLO. How soon do you intend to implement that so each one who wants a caseworker has a name and a phone number of an individual to call?

Dr. PETZEL. We can start that tomorrow.

Mr. COSTELLO. We can or we are going to?

Dr. PETZEL. We will start that tomorrow.

Mr. COSTELLO. Thank you, Mr. Chairman.

The CHAIRMAN. As long as every one of the 1,812 doesn't have the same caseworker.

You have to figure out how to ask these questions with these guys.

Mr. Akin.

Mr. AKIN. Thank you, Mr. Chairman.

First of all, Secretary Petzel, you are not, you haven't been assigned specifically to your job but you've been in this business a long time, so just first of all, do you have, across the Nation, do you have any sort of a feedback loop, first from the employees, if they want to talk to you about something? If somebody is going to be a whistleblower, are they a legitimate whistleblower and do they have legitimate concerns? And do you have some sort of a feedback loop from your own employees?

And second of all, do you have a feedback loop from the veterans that are getting service, so that you have any way of knowing or monitoring whether you've got problems in certain locations? Is there anything like that?

Dr. PETZEL. Well, there is a system within the VA of what we call incident reporting. Every medical center has suggestion boxes, which are places that people can put complaints, where people can put suggestions that they have for making improvements.

I think we have some work to do in terms of providing a mechanism for employees to provide us with feedback, to provide us with information in a completely and totally, an atmosphere that's free of reprisal or intimidation.

We are—and I have been in a medical center as a chief of staff. I was a network director. And I can tell you that in those positions, you are a victim of what you don't know. And these people can pro-

vide you with valuable information about events that may lead you to an incident, say, such as what happened at Cochran.

So I think we have work to do. I have not got a specific idea of how it should be done, but I think it's something that needs to be addressed.

Mr. AKIN. Probably, I would think, after the last couple of hours you would probably have gotten sensitized to the fact that the people here, that are just to some degree outside observers, have a sense of frustration.

And part of the sense of frustration is not so much that we don't trust that you would like to make things better, or that you, if we put pressure on you, will say, it will be better. The question is, can you make it better? And do you have a plan to make it better, and are you going to be able to execute that plan?

It seems like, to me, the front end of that plan might be that, better than suggestion box, you have an organized system that works across your veterans' hospitals to give you feedback to let you know if you've got problems.

And it would seem like that one of the things that you are desperate for is feedback from veterans as to what kind of quality service do they think they have. If you really care about the service you are providing, then you are going to need to have that sort of feedback loop. And also, you need to have it better than a suggestion box. Obviously that's not a very reliable system. So it would seem like that might be the front end.

I'm an engineer by training. I don't mind being critical, but I always want to say, hey, here are some ideas. The first thing is you'd better get some feedback as to where you are going to go. If you don't have that loop in place, you are not going to convince any of us that you are going to change anything. First of all, you have to be collecting some data.

It seems—and second of all, I wanted to ask this question in a general sense. You put your hat on and go to work each day. There have to be some—what are a couple of the biggest challenges you have in your job? All of a sudden you've got this new job. You are in charge of all these things and you are going to be there for some period of time. What are some of the challenges that you face?

We have heard several things that sound to me like they would be really serious challenges. The first is we have a lot of trouble with turnover. The second one is we don't have enough staffing. Are those two things that keep you up at night? Are those things that you are worried about? If those things are true and I were in your position, I would be worried about that. Are those the sort of things you are worried about?

And the, part of where I'm going with this question is do you have the capability of changing it even if you wanted to? Do you have—the authority that you've been granted, can you deal with the cost of how much it costs? Because my understanding—I don't serve with the Chairman. He seems like a pretty good Chairman, by the way.

But my understanding of veterans stuff is there is tremendous demand for your services and fairly limited resources to try to provide those services. So just like a lot of medical places, it costs a

lot of money and it's hard to try to provide that level of service for the funds and the people. Is that something that you struggle with?

Dr. PETZEL. Well, first of all, let me address the turnover issue that you mentioned. That is something that I feel I have control over. I can control. I can do the things, or I can help the organization do the things that contribute to less turnover. A more satisfying working environment, things such as that. So I do.

In terms of resources, I believe that across the country this organization has the resources that it needs. I believe, also, that there probably are places where those resources are being used better than there are places, than at some other places. And if——

Mr. AKIN. Do you have a mechanism to know?

Dr. PETZEL. I do. I do. We do have a way of looking at the efficiency, the effectiveness, et cetera, of the money that's being spent. We have very detailed ways of looking at, again, how the money is being spent. Changing that may take a lot more effort, et cetera, but knowing what's going on, yes, we do. Yes, we do.

Mr. AKIN. I would think that—I won't speak for everybody on the Committee, but I would be skeptical if you are telling me that you are going to change some of the patterns that we've seen, particularly what appears to be a pretty casual attitude towards the veterans you are supposed to be serving on the part of many staff people. I would be skeptical.

You would say, we are going to change it tomorrow, Congressman Akin, but I would be skeptical that you could do that unless you have some plan in place, which is going to take a look at the overall situation and figure out what you've got to change, and analyze it, and how you are going to solve the problem.

And I would think that some type of report back to the Members of this meeting today, and the Committee, would make a lot of sense and would give us a sense of, hey, they've got 10 things they are going to do. And we've got three of them done. We are working on the fourth. That type of thing would give us the sense that there is some, some forward progress.

Dr. PETZEL. I hear you.

Mr. AKIN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Luetkemeyer.

Mr. LUETKEMEYER. Thank you, Mr. Chairman.

I've got a constituent or two of my district here today who is listening to the testimony, and one of the questions that they've got is what recourse/restitution does the veteran who has been diagnosed as positive or had positive tests done, what do they have? What kind of restitution do they have?

Dr. PETZEL. Well, it's my understanding, first of all, we would provide them with whatever medical care they need.

Secondly, they can file a tort claim and if we are held to be responsible for having created that condition, let's say hepatitis C or HIV infection, they can be compensated for that through the tort claim process.

Mr. LUETKEMEYER. What about the individual that were to find out who this person is, or this group who are responsible for doing this? Are they being held liable at all? Personally liable?

Dr. PETZEL. Financially liable?

Mr. LUETKEMEYER. Well, either you are financially liable or you go to jail. One or both of them.

Dr. PETZEL. Well, the Federal Tort Claim Act would protect them from financial liability if they were acting within the scope of their job, but they certainly can be disciplined, punished.

Mr. LUETKEMEYER. Yeah, but if it's negligence on their part, just simply criminal negligence, are they protected by Federal law then? I would think not.

Dr. PETZEL. If it's criminal negligence, they would not be protected. But if they were acting within the scope of their job, then they would be protected.

Mr. LUETKEMEYER. Okay. Are you looking at other procedures? I mean we will talk today about this, about the dental situation, but obviously if this is going on, there may or may not be other things.

Are you looking at all at other procedures that are going on in this particular facility that may be improper——

Dr. PETZEL. We are not only looking at all the procedures in this particular facility, we are looking across the country.

As I said, we brought all the dental processing into our Central Processing Unit. And we are bringing everything into, eventually, the Central Processing Unit so that we don't have any reprocessing or processing of reusable medical equipment occurring anyplace but in our Central SPD units. So yes, we are.

Mr. LUETKEMEYER. What are you doing for the folks, or do you have a program in place if somebody tests positive? What about their spouse, or their partner, or other people who they come in contact with? What are your plans to take care of those people?

Dr. PETZEL. Certainly we would provide them with counseling. We would provide them with testing. And quite frankly, Congressman, I cannot answer your question about what our legal responsibility is, but I will get back to you.

[The VA subsequently provided the following information:]

> During the oversight hearing on July 13, Dr. Petzel was asked if VA had in place a program for the spouse or partner of an affected veteran. Unless the spouse is eligible for CHAMPVA care (38 U.S.C. 1781), VA has no legal authority to extend such an offer to the spouse of a veteran. If the intimate partner of a patient who has been newly diagnosed with a viral infection is also found to have positive test results, the intimate partner could file a tort claim with the Regional Counsel seeking damages, including the cost of past and future medical care. The decision on whether such a claim would be payable would depend on whether the supporting evidence showed that the patient's infection was more likely than not associated with the dental equipment and not other possible causes.

Mr. LUETKEMEYER. Okay. Well, I just want to close with just a remark. I mean as we have said here today, and I think you've heard the Chairman and all of the individuals, the Congressmen here that testified.

You know, I think that as I listened to your testimony—and this doesn't apply, it applies not only to you, Dr. Petzel, but to other members of the panel. I don't hear the concern for the veterans. I don't hear the angst over what happened. I don't hear the empathy for the people who have been harmed by this.

In my world, as a former businessman and now as a Congressman, I always try and put myself in the place of the person across the table from me and try and say, how do they feel? How can I help them? What are their real concerns? I don't see that from this group today and that concerns me, because that's exactly what you should be doing.

Yours is not a job. Yours is a responsibility of care. And we don't see that, the understanding that there is a responsibility on your part to take care.

And if you look at what happened, it took a year to find it, 13 months to find it. It took 90 days to notify the people, or more. One hundred eight days to notify the people. That is, that shows there is nothing there of concern, or that the process and programs in place are not working, the bureaucracy is not working, and that can't happen because you are in a people business. You have to understand that.

With that, Mr. Chairman, I give it back.

The CHAIRMAN. Thank you, Mr. Luetkemeyer.

Let me make a suggestion along those lines. I think you hit the nail on the head. You said you would try to get some case managers by tomorrow?

Dr. PETZEL. Yes.

The CHAIRMAN. May I suggest, in a very humble way, that the Acting Director take a dozen, you take a dozen, the Secretary of Veterans Affairs take a dozen.

Let's show that we care by talking to these people directly. Don't leave it to the person that was hired yesterday. Find out what's going on with these people. Just call six of them up. See how they are doing. What don't you understand? If you were affected you would want someone to show compassion. You are administrators and you have someone else making these calls when you ought to be doing it.

Dr. PETZEL. Good idea.

The CHAIRMAN. I just make a modest proposal. If the Secretary says, "let the Chairman do it," I will be happy to. Just give me some names and phone numbers.

I think we ended when Mr. Carnahan asked you some quick questions.

You may not be able to answer this, but do you know when the Secretary was notified about this incident?

Dr. PETZEL. I don't.

The CHAIRMAN. That bothers me. I didn't understand this Administrative Investigative Board. Who are they and why isn't the OIG brought in?

Dr. PETZEL. Why wasn't the OIG brought in? Because we wanted to do an administrative evaluation that we can use for disciplinary actions if need be, and the OIG's business is not available for that purpose.

The CHAIRMAN. That's the first time I've ever heard it.

Dr. PETZEL. These are people from across the country, a team of about four people.

The CHAIRMAN. Is it private and you hire them?

Dr. PETZEL. No. These are VA employees.

The CHAIRMAN. VA employees?

Dr. PETZEL. VA employees who are going in and looking at what happened there.

The CHAIRMAN. And why would they be independent?

Dr. PETZEL. Well, because——

The CHAIRMAN. We just heard is Ms. Johnson still here?

Ms. JOHNSON. Yeah, I'm here. I'm here. I'm listening to everything you are saying, Mr. Chairman.

The CHAIRMAN. I want you to——

Ms. JOHNSON. It's my business.

The CHAIRMAN. I want you in court, to use what Dr. Petzel said about what should happen at all the Central Offices. He said exactly what you said, exactly. Except you had premature sensibility to this, so you were fired.

But he said it exactly the way—that all the cleaning and the sterilization should take part in——

Ms. JOHNSON. In your department.

The CHAIRMAN [continuing]. In your, in that department.

Ms. JOHNSON. May I say something?

The CHAIRMAN. I just don't understand. How is it independent with employees? Don't they care? Aren't they worried about their next job and everything else?

Dr. PETZEL. Well, don't you think that they are able to rise above that? They are concerned about what happened?

The CHAIRMAN. They are able to rise above it if you guys are able to rise above it. I mean we've had people fired for saying stuff, so how can they rise above it?

Dr. PETZEL. I do believe that they are capable, they are capable of looking independently and without bias at what the circumstances were in this incident.

The CHAIRMAN. Well, I would hire some people from the Congress rather than from the VA, then. I would trust any one of our offices to do that better. We are sitting here for 2½ hours talking about intimidation and fear, and now you are telling me you are going to have the independent investigation from the very employees who fear for their jobs? That doesn't make any sense to me.

Dr. PETZEL. I don't think these employees fear for their jobs, that are going to be doing this investigation.

The CHAIRMAN. Oh, so it's just the ones that are already up there. So why should I trust them, then?

Dr. PETZEL. Well, Mr. Chairman, are you implying that we can't do an unbiased investigation?

The CHAIRMAN. I'm not implying. I'm saying it. You said you wanted an independent investigation. Now I find out that it's VA employees that are going to do it.

Even if they could rise above it, the perception is that they can't. Now you are telling me that the Inspector General is not independent or something. I don't know what you are telling me about that, but that's been our traditional approach. I've got to look into what the Administrative Investigative Board is.

One last question. Why, from your perspective—and I'm sure you have a justification for it—why did it take 2 months for this Board to be set up to investigate this? And why did it take 2 months, after they decided that people should be notified, to be notified?

What is going on with the bureaucracy that puts the process above the people?

Dr. PETZEL. I have absolutely no justification for that, Mr. Chairman.

The CHAIRMAN. What's going on? They couldn't find a date for a meeting so they kept putting it off and they all got together or somebody was on vacation so they couldn't meet then? I mean what's going on there?

Dr. PETZEL. I think there were probably a number of different things, all of which were inappropriate.

The CHAIRMAN. All right. You will get that in your letter to me.

Mr. Carnahan, you have been on top of this from day one. You get the concluding questions.

Mr. CARNAHAN. Thank you. I just have a couple of quick follow-ups.

Specifically, Dr. Petzel, how is the VA going to advise employees that they are not only encouraged to step up and speak out about this specific case, but cases and any problems going forward? How are they going to be advised of that to sort of break this culture of real or perceived retaliation?

Dr. PETZEL. I can't tell you, Congressman Carnahan, exactly what we are going to do, but it needs to be in the nature of a campaign. It needs to be written notification to employees. It needs to be setting up—just as was pointed out by another Congressman, that we need to set up a mechanism for them to bring their concerns forward in a completely un-intimidating, no-fear-of-reprisal kind of atmosphere.

And I'm not, I'm not prepared to say exactly how that can be done. I do know what needs to be done but I don't know exactly how we are going to do it.

Mr. CARNAHAN. Well, we are going to need, we are going to need to know exactly how that's going to be done.

Dr. PETZEL. I can appreciate that.

Mr. CARNAHAN. Because I think that's going to be critical to going forward. And I'm assuming the process of evaluating those kind of concerns that have come up at Cochran before.

Is there a process in place if—and I direct this to Ms. Nelson. Prior to this incident, was there a process in place at Cochran to take complaints or suggestions and be evaluated for implementing them?

Ms. NELSON. Yes, there is a process in place. Employees are notified through New Employee Orientation exactly what it is that they can do if they discover problems. We also have an annual reminder for employees to remind them of what they can do.

We have informed them that they can contact the Joint Commission or the Inspector General at any time if they feel that the quality and safety of the patients, the veterans in the hospital isn't up to the standard. And that's exactly what happened in the OIG report.

Mr. CARNAHAN. And based on what you've heard here today and other conversations, do you think that system is sufficient?

Ms. NELSON. It sounds like we need to do some more work to improve it, based on what we've heard today.

Mr. CARNAHAN. Okay. Now, and then lastly I want to ask, we heard Ms. Johnson here today and her reference to conversations she had, but also a copy of an e-mail from August 24th of 2009 and the title, "Here is an outline of improvements for Sterile Processing." This is from August of 2009.

Was this brought to anybody's attention, that you are aware of?

Ms. NELSON. No, I'm not aware of that.

Dr. PETZEL. We've looked, we've looked for e-mails in both of our e-mail systems from Ms. Johnson to anybody in the organization during her employment, and we cannot find but one. That was not one of them.

Mr. CARNAHAN. Well, we will want to hear more about that, as well.

Mr. Chairman, thank you.

The CHAIRMAN. Thank you. I want to thank my colleagues. I have not served on a Committee with most of these gentlemen, but I think you helped us get to some really important things here.

I want to assure those of you in attendance, especially those who are veterans who are affected, this is not just a hearing for show. We are going to look at all 1,812 and take care of you until you are assured there is no problem. We want to make sure you know that.

You heard me and Dr. Petzel have some, or me, at least, have some exchange. He knows, and I've said in public how much I respect him. I feel like I'm talking to someone who can understand it.

We are going to come back with the same group in 5 or 6 months. We may have a different Chair or we may not have a different Chair. I don't know yet. But we are all committed to seeing that some of the issues that came up today have real follow-through. We may find out Dr. Petzel was fired because he raised too many questions, and the next guy will say, I don't know what he promised, so we are going to start over again. I hope that doesn't happen, but I've seen it too often.

We take this hearing very seriously. We have every word written down and we are going to hold people accountable. And I think we have found both a Republican and Democrat community of interest here and that is going to ensure we continue our follow-up. I assure all of you we are going to do that.

I especially thank the Missouri delegates for joining us.

Dr. Petzel you look like you want the last word. I will give it to you.

Dr. PETZEL. Thank you, Mr. Chairman.

I look forward to joining you back here in 6 months to demonstrate some progress on the issues we've discussed today.

The CHAIRMAN. Fantastic.

This hearing is adjourned.

[Whereupon, at 4:33 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs

This hearing will now come to order.

I would like to thank everyone for attending, especially the veterans who are with us today. I would like to thank the staff of Thomas F. Eagleton U.S. Courthouse for their generosity in providing a space for today's hearing.

Today, I join my colleagues Mr. Miller, Mr. Carnahan, Mr. Costello, Mr. Blunt, Mr. Shimkus, Mr. Akin, Mr. Clay, and Mr. Luetkemeyer in examining an incident involving reusable dental equipment at the John Cochran VA Medical Center. As a result of the lapse in the protocol for cleaning dental equipment, more than 1,800 veterans have been put at risk–possibly having been exposed to hepatitis B, hepatitis C, and HIV.

The purpose of today's hearing is to get to the bottom of the events leading up to the lapse in protocol for cleaning dental equipment. We need to examine the steps that VA officials took once they learned of this incident, and evaluate whether they were effective in providing timely information to veterans. I am also concerned with VA's lack of transparency. Members of Congress did not receive appropriate information to allow them to relay information to their constituents in a timely way. When mistakes are made, honesty and truthfulness are the only way to begin to rebuild trust with the public.

We need to explore how best to deal with the aftermath of this shameful incident. First, we must affirm that VA properly identified all potentially affected veterans and that these veterans get tested for hepatitis and HIV. Most assuredly we must deal with the issues of accountability when standardized procedures are not followed and veterans are put at risk, along with again reviewing VA's oversight policies to ensure that mistakes like these will not happen again. Finally, today's meeting presents us with the opportunity to hear directly from veterans and better understand the questions and fears they face while dealing with this incident.

My biggest concern is that we've been here before. In December 2008, I was notified of improper reprocessing of endoscopes which put thousands of veterans in Murfreesboro, Tennessee, and Miami, Florida, at possible risk of hepatitis and HIV. And in February 2009, another one thousand veterans in Augusta, Georgia, received notifications that they were at risk for hepatitis and HIV because of improper processing of ear, nose, and throat endoscopes. And just last week, the Department notified 79 additional veterans in Florida, whom they failed to notify previously, that they were also at risk. Clearly, VA has had issues with ensuring the sterility of reusable medical equipment in the past and clearly they have yet to resolve these problems, as evidenced by the most recent incidents in St. Louis and Miami.

Most veterans–and Members of Congress—are getting their information from news outlets. These are just some of the headlines that we have been reading in the last couple of weeks:

- Washington Post, "HIV Scare Causing New Problems for Veterans Affairs";
- New York Times, "Veterans at St. Louis Center Are Told of Exposure Risk";
- CNN, "VA Hospital May Have Infected 1,800 Veterans with HIV";
- St. Louis Post-Dispatch, "Faulty Dental Sterilization in St. Louis."

In the July 2 issue of the St. Louis Post-Dispatch, the Chief of Dental Services at the John Cochran VA Medical Center is quoted as saying that, "Things are done to get votes, and that's a shame"—implying that this hearing here today is for show. Frankly, I am angered by this comment. By blaming politics, this is simply an attempt to shift the attention away from the incident and minimize the mistakes that were made.

Instead, I challenge the Chief of Dental Services—in fact, *I challenge the entire leadership of the Department of Veterans' Affairs*—to take responsibility for this disgraceful incident and show America and our veterans what they are doing to better

understand why and how this inexcusable lapse in dental sterilization occurred. Already facing an uphill battle, VA now must work harder and longer to improve training, implement standardized procedures, and regain the trust of the veterans it serves.

I look forward to hearing today's testimonies.

Prepared Statement of Hon. Jeff Miller

Thank you, Mr. Chairman. And, thank you for calling this important hearing.

I want to thank my fellow Members of Congress from the neighboring states of Missouri and Illinois for joining us today—my good friend Roy Blunt—John Shimkus—Todd Akin—Blaine Luetkemeyer, and—from the other side of the aisle—Lacy Clay, Russ Carnahan, and Jerry Costello. I know Congressman Blunt has already sent a letter to Secretary Shinseki on July 1st with some very specific questions that need to be answered, and I hope this hearing will answer at least some of those questions. I also know other Members also wanted to be with us today, but were unable to attend. In particular, Congresswoman Jo Ann Emerson asked me to give you her best regard and express her regret that she could not attend. JoAnn has sent a member of her staff to listen and participate and many of the Missouri and Illinois delegations have done the same.

We are all here because we share a deep concern for our veterans and the quality of care they receive in VA facilities.

The problem that has come to light with the cleaning of dental equipment at the medical center in St. Louis is unfortunately a disturbing symptom of a system-wide breakdown in patient safety.

Over the past 2 years, we have been confronted with the discovery of the improper cleaning of various types of reusable medical equipment in locations such as Murfreesboro, Tennessee; Miami, Florida; Augusta, Georgia; and San Juan, Puerto Rico. After each incident, Congress and the country were assured that VA was addressing these serious threats to patient safety and that our veteran's trust would not again be compromised. After each incident, the VA assurances proved hollow.

Today, we are here because it is clear that VA does not have effective processes in place to ensure proper reprocessing of reusable medical and dental equipment.

It is well and good for VA to talk about changes that are taking place to address these problems, but these are repeated failures of senior leadership and management. I am going to ask today what is being done at the highest levels in VA to hold Veterans Health Administration leadership and management accountable. And, what is it going to take to get actual results?

Time is past due for VA leadership to take charge to eliminate ongoing quality care issues and adopt an aggressive and effective action plan to monitor compliance with device-specific standard operating procedures for sterilizing medical equipment. At risk is no less than the health and well-being of our most revered citizens.

Patient safety is and should continue to be our very highest priority. The 1,812 men and women who may have been exposed to any infection as a result of improper cleaning at the John Cochran VA medical center served our country honorably. The very least that we can offer them in exchange for their bravery and sacrifice is health care that is safe and effective.

With that said, I want to thank all of our dedicated VA health care workers for the care they provide our veterans. It is your compassion, experience, and expertise that is bettering the VA health care system each and every day. However, as with everything in life there is always a need to continue to strive for improvement in every aspect of chosen work. And, I hope today's hearing will encourage staff to be diligent and always report any and all concerns they feel should be addressed. You will be heard.

It is the obligation of Congress to oversee the quality of health care VA provides to our veterans and to ensure that they and their families can have the utmost confidence that VA really is the "best and safest care anywhere."

In closing, and most importantly, I want to thank every veteran present for their service. I want you to know that I will not rest until situations like the one that brought us here today are fully resolved. You have earned and deserve the best and safest care our Nation can provide. And you can be certain that I will continue to do all I can to bring it to you.

Mr. Chairman, I yield back my time.

Prepared Statement of Hon. Russ Carnahan

Mr. Chairman, thank you for holding this necessary meeting to discuss the risk created by a breach of standard operating procedures in the John Cochran VA Medical Center's dental clinic and other non-compliance issues.

Since we learned earlier this month that veterans throughout the St. Louis and Illinois area could have been exposed to blood borne pathogens such as Hepatitis B, Hepatitis C, and HIV while receiving dental care at John Cochran VA Medical Center, I have heard from many constituents, veterans, and their families who are gravely concerned about this matter.

From where I stand, there are five issues that need to be addressed here today:

1. We need to make sure that the 1,821 veterans who have been directly impacted by this—and their families—are getting the special care they need, including any mental health care.
2. We need clear answers as to exactly what happened, how it could have gone on for as long as it did and how it was uncovered.
3. I am determined to get to the bottom of whether an employee of the Medical Center was terminated in part because she raised concerns about the sanitization procedure. In addition, I want to know what concrete steps the Cochran Center and the VA are taking to *proactively* reach out to current and former employees in order to seek information that may be relevant to this investigation. When employees see coworkers who speak up lose their jobs, it can have a chilling effect, and a thorough investigation depends upon witnesses who feel safe and secure in their ability to be candid and forthright, without fear of retaliation from supervisors. We must make sure employees who have information that is relevant to this matter are aware of their rights and feel comfortable coming forward.
4. I want to determine whether this latest incident in the dental clinic—in conjunction with prior safety and sanitization problems at Cochran—represent a larger systemic problem at this facility. This is not the first time John Cochran VA Medical Center has been cited for serious infractions, which leads me to suspect that there may be broader issues that need to be addressed at this facility. In April 2010, the Veteran Affairs' Office of Inspector General conducted an inspection to "determine the validity of allegations regarding ongoing issues with the Supply, Processing and Distribution departments related to reprocessing gastrointestinal endoscopes." The inspectors found that the SPD department did not have defined clean and dirty areas and there were severe communication breakdowns between staff regarding proper reprocessing procedures. Moreover, in 2009 Survey of Health Expectancies of Patients—a VA approved patient satisfaction survey that tracks satisfaction responses from inpatient and outpatient veterans—showed that John Cochran VA Medical Center scored the lowest score out of the 128 VA hospitals around the country in inpatient services. A score of 46 percent is unacceptable in when it comes to providing much needed health care services to our veterans.
5. And most importantly—we need to determine what next steps must be taken in order to restore and rebuild the faith of our veterans—and the public—in the quality of care being delivered by the VA Health System generally and Cochran VA Med Center specifically.

Let me be clear—this is *not* and should not be an excise that broadly paints a negative picture of our VA Health Care system.

The fact is, I have been encouraged by the VA's response to our inquiries, and I have no doubt that the leadership at the VA and Cochran care as deeply as I do about providing the best quality care possible for our veterans.

And certainly, many of the vets I have met and spoken with tell me that they have been extremely pleased with the care they have received through the VA—even veterans who received the letter advising them of their risk from the Dental Clinic.

In fact, just last Thursday, I met with a group of about 30 veterans from throughout the area after touring the Cochran facility. TELL INDIVIDUAL STORY FROM VETS MEETING

But at the end of the day, it is critical that the VA identify and rectify any existing problems, make sure this never happens again, and take whatever steps are needed to rebuild our veteran's confidence in the VA health care system.

To all the witnesses before us today—thank you for taking time out of your busy schedules to appear before us. I look forward to hearing your testimony.

Prepared Statement of Hon. Jerry F. Costello

First, I would like to thank Chairman Filner for responding to our request on short notice to hold today's field hearing to examine the U.S. Department of Veterans Affairs (VA) actions in failing to comply with standard operating procedures and the possible risks our veterans were exposed to from inadequately cleaned and sterilized dental equipment at the John A. Cochran Veterans Medical Center (VAMC).

As we now know, 1,812 veterans were notified on June 28, 2010 that they were at risk, the same day Congress was made aware of this situation. Of the 1,812, 370 of these veterans reside in the congressional district I am privileged to represent. I am outraged at what happened, which is particularly egregious as it is not the first time the VA has jeopardized the health of veterans by improperly cleaning medical equipment. In 2009, an investigation by the Office of Inspector General discovered that 10,320 veterans were exposed to Hepatitis B and C, or HIV because VA hospitals were not properly cleaning endoscopic equipment in Murfreesboro, Tennessee; Augusta, Georgia; and Miami, Florida.

In my Congressional district in Southern Illinois, we are dealing with similar inabilities to follow basic, routine procedures and quality management standards at the Marion VAMC. These events led to the unfortunate deaths of nine veterans in 2007 and caused a lack of confidence in patients receiving care from the Marion Veterans Medical Center.

Equally troubling, this committee has previously investigated failures in VA procedures, including basic sterilization processes, and assured these problems were resolved. The evident inability of the VA to ensure these procedures are implemented is shocking. I am eager to hear from the VA if our existing Veterans Integrated Service Network (VISN)—which is charged with maintaining oversight at the facilities—and its review processes are capable of addressing inefficiencies in a timely and effective manner. Simply issuing guidelines is not sufficient and the VISN and facility leadership are responsible for ensuring those guidelines are successfully followed. It is fair to ask if the VA can effectively institute system-wide standards—and provide the necessary oversight to make certain that the standards are being followed.

Hopefully, none of the 1,812 veterans contracted a disease because of this breakdown in procedure. The VA must explain how they will handle the matter if any veteran does contract a disease. At the same time, the VA will not be vindicated if all remain healthy—the key question here is the VA's ability to follow their own routine procedures. I want to know why such a time lapse occurred between the breakdown in procedure and when veterans were notified. I also want to know the exact dates of when regional and Washington D.C. officials were notified of this breakdown. I think we must follow this timeline closely to determine if the VA's reaction to this situation was slow and ineffective.

For everything that our veterans have sacrificed for us, we must ensure that the health care they receive at VA facilities is of the highest quality care. I look forward to hearing from our witnesses regarding these questions and how the VA will assure patient safety moving forward.

Prepared Statement of Hon. John Shimkus

Thank you, Mr. Chairman. We are all appalled that dental instruments were not properly sterilized at the Cochran VA Dental Clinic here in St. Louis. Unfortunately, this is a sign that serious problems affecting the health of our Nation's veterans have not been corrected—even after the recent tragedies at the Marion VA Medical Center in my state and the temporary closing of the supply processing department here just months ago.

This is quite an egregious situation, given that it was more than 1 year before it was determined that the proper procedures were not being followed. And the proposed solution—turning over sterilization to the supply processing department—raises even more questions. According to the July 7, 2010, St. Louis Post-Dispatch, "the cleaning of endoscopes was moved from the supply processing department to

the gastrointestinal unit after problems surfaced with equipment not being properly cleaned.

"Hospital leaders closed the department for two weeks in December and January to train staff and to sterilize all endoscopes, which are used in colonoscopies and other procedures.

"A month later, after receiving a complaint about endoscope sterilization, Veterans Affairs inspectors visited the hospital and found several health and safety infractions. The temperature in the sterilization area was too high, rags and gloves were 'strewn about' in the decontamination areas, filters had not been changed as required, a technician was not wearing protective gear, chemical test strips were left exposed, emergency exits were blocked, and employees were unsure whether an unattended endoscope was sterile, according to an inspection report issued in April by the VA's Office of Inspector General."

I hope that the precautionary tests being given to veterans who were treated during the time in question reveal no adverse health conditions. This is certainly traumatic for those men and women who had dental work done at the clinic.

My colleagues and I are asking Secretary Shinseki to follow through on investigating the actions that led to this critical safety lapse and to take steps to ensure patient safety standards are upheld at all VA facilities, including dealing with infected patients. We urge Secretary Shinseki to make sure promises are kept to strengthen VA oversight of sterilization practices and enhance regulations to protect veterans from infection and reduce the chance of such a lapse happening in the future.

As we have learned from the situation at Marion, problems such as these do not occur overnight and are not solved overnight. This is a corporate culture issue that must be solved. And without follow-up, they will continue to occur. While we are now fired up to show our concern, let us not leave here and forget our veterans one more time. I have a long, established relationship with Secretary Shinseki and am biased in my belief in and support of him. He has a big job, and if he needs help separating the wheat from the chaff, let us give him the tools to do so.

I welcome my colleagues to the bi-State area and thank you for taking the time to come to St. Louis for this important discussion.

Prepared Statement of Hon. Wm. Lacy Clay

Thank you Mr. Chairman, Ranking Member Buyer and members for holding this timely hearing and for inviting me to take part in this field hearing regarding the John Cochran St. Louis VA Medical Center which I represent in Congress.

We will examine, and hopefully, learn the truth about the improper processing of dental instruments, including a failure to clean dental equipment with a special detergent before it is sterilized.

According to reports, on June 28, 2010, the St. Louis VA Medical Center distributed a disclosure letter by certified mail to thousands of Veterans which notified them of the possible exposure of Hepatitis B, C and HIV.

Those exposed to this potential risk received dental treatment from February 1, 2009 to March 11, 2010.

It is unacceptable that procedures were conducted from February 1, 2009 to March 11, 2010 without proper safeguards in place to protect the health of veterans receiving treatment.

Making matters worse, the VA knew about the possibility of exposure in March 2010, yet veterans were not notified of the problem until June 2010.

That is shameful, and there is no excuse for withholding that information.

This country owes an enormous debt to the brave men and women who served our country with courage and honor.

The care and treatment of military veterans has always been one of my top priorities, and President Obama and this Congress shares that essential commitment.

On July 10, 2009, the House of Representatives passed H.R. 3082, which provided a total of $45.1 billion for the Veterans Health Administration (VHA).

That bill also provided $48.2 billion in advance appropriations for VHA to be available in FY 2011.

The $48.2 billion advance appropriation is for medical services, medical support and compliance, and medical facilities accounts, to be available in FY 2011.

Mr. Chairman, I outline that legislative history to point out that this situation is not about a shortage of money.

This is about a failure to follow proper procedure;

A failure of supervision;

And a failure to keep faith with all the brave Americans who have defended freedom.

Thank you for your attention, and I look forward to today's testimony.

Prepared Statement of Susan Maddux, Festus, MO (Veteran)

My name is Susan Maddux. I am a 40-year-old Gulf War era veteran. I served in the United States Air Force from 1988 to 1998 as an Aerospace Propulsion Specialist. I am married to another service-connected disabled veteran and we are the parents of 4 teenage boys.

On June 29th I received a certified letter from the John Cochran VA Hospital stating I may have been exposed to Hepatitis B, Hepatitis C and HIV. I found this letter to be very impersonal. In fact there was little difference in the contents of this letter than from any other communication from the VA. It just may have read like an appointment cancellation letter if not for the signature required to receive it.

I was very angry with the Veterans Administration after reading this letter. For something as significant as this it should have warranted a more delicate approach than a form letter. The VA has advised us that there is a minimal chance of being infected by these diseases, however I feel that any chance of instruments becoming contaminated is unacceptable within a modern medical facility.

The veterans that are eligible to use the dental services at the VA hospital are not normal veterans, rather they are among a select population and are also the most susceptible to harm due to being previously compromised by other illnesses. Those of us that are approved to use the dental service are 100% service-connected, service connected for dental health or are P.O.W's. Then there are some veterans that have been hospitalized for more than 120 days that also have access to the dental clinic.

To hear that there are some who think that the reaction to this incident is solely political angers me significantly. Hospital employees are not political appointees, but rather are employed to perform a job and that is to care for our nations veterans. It is their directive to follow the policies and procedures of their respective profession to ensure they do no harm.

As an aerospace propulsion specialist it was necessary to perform tasks following procedures and policies. This allowed the aircrew to have confidence that I had installed or repaired their aircraft engines properly. If I didn't follow those procedures accurately I put their lives at risk. In the same sense, the VA employees should strive to instill our trust in that they are doing everything the appropriate way since our lives are in their hands. In this instance, instead of strengthening our trust, the St Louis VA has weakened our confidence by potentially risking over 1800 veterans lives.

On June 1st, 2005 I was admitted to the intensive Care Unit at the John Cochran VA Hospital with bacterial meningitis. This was several months after having neurosurgery at this VA facility. Two forms of bacteria were found in my cerebral fluid. One of the infections is normally found in the gastro-intestinal tract. I nearly lost my life due to this infection. After recovering from meningitis I was just happy to be alive and I didn't think to ask more questions as to how this happened. After the disclosure by the VA over the sterilization failures at the Dental Clinic, it brought me concerns that the VA's sterilization issues are not just confined to this one clinic. It also raises questions in my mind as to how long these failures in sterilization policies have been truly going on. I would also like to express my concerns about the length of time it took for the VA to notify us about this incident. It makes me speculate if there was an attempt to conceal this from the veterans. It is also taking an extended amount of time to get the testing results back to us. They need to realize that we have put our lives on hold while we wait for these results.

I would ask that VA employees speak out about policies and procedures that are not being followed. That it should be their duty to ensure our safety first and the managers and administrators should be willing to listen when informed about these issues. I would request that VA administrators and managers look beyond saving money and follow your own motto by "***Putting Veterans First***".

I would like to express my thanks to Miss Earlene Johnson for attempting to advocate for the safety of the veterans even at the risk of her own livelihood. By her saving all of the communications with management in regards to this issue, she has exposed the grave injustice that the St Louis VA was knowingly allowing to happen. If only there were more VA employees that had the same courage and conviction of Miss Johnson to stand up for what is right.

Thank you for allowing me to testify today, not only for myself but also as a voice for all veterans that use VA Medical Centers.

Prepared Statement of Terri J. Odom, Imperial, MO (Veteran)

My name is Terri J. Odom. I am a disabled veteran and am one of the 1,812 veterans that were exposed to Hepatitis B, Hepatitis C, and HIV at the St. Louis VA Hospital Dental Clinic, John Cochran Division. I was informed via certified letter of the error on behalf of the VA. I suffer from severe chronic Post Traumatic Stress Disorder from Military Sexual Trauma while serving in the Navy. So with my panic attacks and anxiety level already on over-drive, this terrible mistake by the VA has made me even more anxious.

The phone number attached to the certified letter was a joke. The people answering the telephone were rude and knew nothing more than I did. I even called to verify my blood test, which was scheduled for July 6, 2010 at Jefferson Barracks VA hospital. I called the 24/7 manned phone line on July 5, 2010 and the nurse actually laughed at my concerns. She said it was such a "low risk," and that I had nothing to worry about. I asked her if the blood test being offered was because of"zero risk" or "risk."

Looking back, now I realize something in the dental department was wrong. After my first oral surgery, I had severe pain for 28 days straight. We were taught in the military to suck it up and keep going. That strive and toughness is still embedded in us veterans today. I had another oral surgery later and some teeth filled. I did receive partial dentures from the VA, but after three visits they still do not fit, and my speech is bad with them. I also remember when the dentist reached for the metal molding piece to make impressions for my partial plates; they appeared dirty and rusty.

In February of 2010, I was scheduled for a colonoscopy at the St. Louis VA JC division, but had a severe panic attack on the table with extreme rapid heart rate and elevated blood pressure. I looked around the room, and it was beyond filthy. I didn't want the equipment being used on me. Thankfully I was taken to the Emergency Room, and the procedure was canceled.

While on a hospital stay at the St. Louis VA John Cochran division in 2009, I was unable to shower due to the moldy and unsanitary condition of my bathroom. The nurses were very nice and just said, "No honey, you don't want to dare use the dirty nasty shower." I did offer to clean it.

There must be a change in the VA. What has recently happened in St. Louis with the exposure is third world treatment, if not less. And yes, we are angry and have every right to be. The VA put our health at great risk! There has to be some accountability! This issue must not be just swept away like it never happened!

I already have major trust issues due to my disability, and now I feel that the very people who are supposed to have my back are trying to put me in harms way. WHY? We deserve better than this. We are not just veterans but human beings. People make mistakes; I understand that. But when you are dealing with lives, there is no room for failure. I am outraged at the lack of seriousness the St. Louis VA seems to want to put on this horrible issue. How would any of them like to wait in horror for test results and then again in 6 months to do it all over again?

Prepared Statement of Earlene Johnson, St. Louis, MO
(Former VA Dental Employee)

My name is Earlene Johnson. I left Chicago, Illinois, to take care of my mom and dad who are veterans and live on the outskirts of St. Louis, Missouri. I took a medical technician position at John Cochran VA Hospital. I have almost 30 years of experience in my field of Processing and Distribution (P&D), in which the private sector calls this department Sterile Processing (SPD). I am also an operating room scrub technician, *obstetrician* technician, and I am also a Phlebotomist. I was a manager in Oregon and supervised in Chicago, Illinois. I was called by CEO's when they were having situations with Sterile Processing. In some cases, when employees were trying to form a union, sometimes I would find management at fault due to poor management skills.

The supervisor of P&D at John Cochran knew I was a supervisor of SPD and a manager, but what she didn't know was that I was a trouble shooter for hospitals.

I have always carried myself in a professional manner and her staff had a problem with this; even the supervisor and her boss had a problem with my professionalism.

I saw a lot, and I knew the department was not being run by an experienced supervisor. In fact, I believe she is a lead technician, and everyone called her a supervisor.

Sterile processing is a very important area in every hospital. The staff goes to school or takes a home study course to become certified in cleaning, decontamination, infection control, disinfectants, etc.

I warned management that they needed to go to every auxiliary department to ensure no one was sterilizing any instrument or anything that pertains to Sterile Processing. I was told that it was her department, and that she can do what she wants. I left that situation alone until she did something to me, and I set an appointment up to see a higher boss. I was told the same thing by her boss. Her boss asked me if I have other issues, and I sent her an e-mail of some of the improvements needed for the department.

Afterwards I started being harassed and intimidated because of my warning. I was told I was not coming back to her department with a disability and all sorts of harassment. She fired me while I was under doctor care for a torn tendon that occurred on the job.

SUPPLEMENTAL MATERIAL PROVIDED DURING THE HEARING BY MS. JOHNSON

[Notes made by Ms. Johnson of submitted documents are bracketed. ***Bold-italics*** text indicated highlighted text by Ms. Johnson.]

Excerpt from the "Central Service Technical Manual," 6th Edition International Association of Health care Central Service Materiel Management

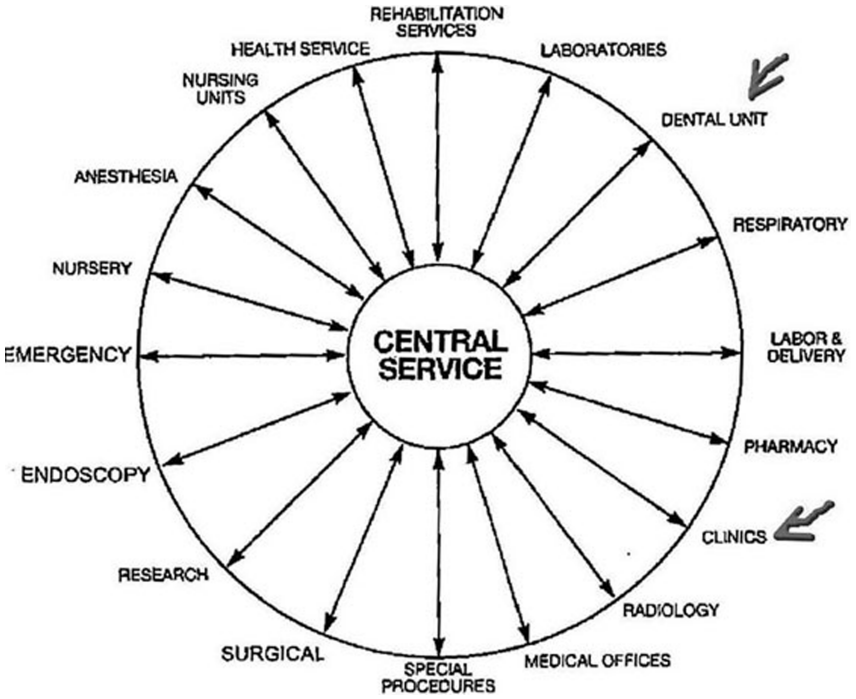
Chapter 1—The Profession of Central Service

THE IMPORTANCE OF CENTRAL SERVICE

One can think of the central processing area as a manufacturing and production unit within the health care facility. The functions of recycling, decontamination, processing, inspection, assembly, packaging and sterilization are production activities. In essence Central Service is a manufacturer of sterile products. While these production and sterilization activities are usually considered its primary responsibility, Central Service is also responsible for other associated materiel management functions such as procurement, inventory control and distribution.

The term *Service* is key. Central Service personnel must always remember that they are an integral part of a service entity. These vital services contribute greatly to the quality of patient care. Due to the impact Central Service has on operational functions, it is often referred to as the hub around which other departments revolve. Virtually all areas of the facility that require processed sterile supplies, equipment and materials depend upon Central Service (see Figure 1.1).

Figure 1.1: Central Service: Hub of the Health care Facility



The term Central implies that the services are centralized. ***Activities of reprocessing soiled goods and sterilization are conducted in one centralized location under the direction and management of one individual.*** Many facilities find an increased demand for reprocessing services partially as a result of a growing trend: the use of more reusable products. In addition, many facilities have expanded to clinics, surgical centers, professional offices and the like, some of which may be remote from the main site of the facility. In response to the growing demand for reprocessing services, many institutions have established satellite processing units with centralized management. Others have consolidated (centralized) services for an entire integrated system (IDN-integrated delivery networks). Still other organizations outsource required services to specialized businesses. Regardless of where reprocessing activities are conducted, quality practices must be standardized in compliance with Central Service policies and procedures. (The standards of practice and resulting care must be consistent!)

Centralized management helps assure uniform standards of practice and provides for maximum utilization of human and material resources. This eliminates the costly duplication of utilities, processing equipment personnel efforts and space. Educated and skilled technicians must be knowledgeable about the complexities, precautions and techniques of their job. ***They must carry out tasks in a manner that protects the welfare and safety of the patients, workers and the community.*** Proven material handling techniques are employed to provide high levels of efficiency.

Today, greater volumes of materials can be processed in less time by fewer people. This helps to address the problem of increased workload in today's health care operations.

[The Supervisor of P&D gives this Test to the Employees of P&D.]

U.S. Department of Veterans Affairs

"Supply, Processing and Distribution Training Manual"
Level One Training
PAGE 2–1

[VA TEST BOOK]

Section Two: Microbiology

Estimated Contact Time:
40–45 minutes

This module covers:

- The basics of microbiology and why it is important in the SPD environment
- the threat of disease, infection, and cross contamination in the medical center environment
- preventative infection control measures

Following instruction, you should be able to perform the following:

✓ Identify and define terms associated with microbiology.

✓ Recognize the threat of infection and cross contamination in the medical center environment.

- Identify the significance of spores.
- Diagram the chain of infection.
- Identify the four conditions required for disease transmission.
- Define direct and indirect contact.
- Define nosocomial infection.

✓ Identify preventative measures

- Detail hand washing requirements.
- Define Universal Precautions.
- Identify disinfection and sterilization principles.

Why is Microbiology Important?

It is imperative that SPD technicians understand what *microorganisms* are and how they spread so they can be effectively controlled, contained, and killed. ***SPD's objectives are to provide centralized supply support of the medical center's patient care programs, while assuring appropriate aseptic conditions, economy of operation, and consistency in processing,*** storing, and distribution, all under strictly controlled conditions. In order to accomplish these objectives, SPD must control the number of . . .

VA HANDBOOK 7176
AUGUST 16, 2002

1. Open Drawers.
2. Sharps and Needle Sticks.
3. Carelessly Stacked Washer/Sterilizer Baskets.
4. Automatic Cart Washer Doors.
5. Lifting Heavy Objects.
6. Slick/Wet Floors.
7. Automatic Loaders/Unloaders and Doors of Washer Sterilizers.
8. Hot Items.
9. Improper Use of Chemicals.
10. Operating Equipment Noise.

6. 606 SOILED SUPPLY COLLECTION PROCEDURES

a. One of SPD's primary functions is the collection of contaminated supplies and equipment. All contaminated supplies and equipment will be collected in cov-

ered conveyances or containers, such as waterproof plastic bags, tote-boxes with lids, or closed or covered carts. Collection containers for holding soiled reusable supplies should be made of material that can be properly decontaminated or discarded. Care must also be taken to protect the environment when transporting contaminated items to SPD. ***All nursing units and clinic areas will have a dedicated soiled utility or "dirty" room.*** Enclosed carts or containers should be provided in these rooms, and all ward procedure trays and reusable equipment should be placed in them. These containers will be exchanged at each pickup location. Containers will be cleaned between each use. It is the user's responsibility to dispose of sharps appropriately and to remove or dispose of gross soil from items being returned to SPD.

b. The decontamination attire for picking up contaminated items from soiled pick-up areas will consist of:

1. Cover Gown—may be used to protect the uniform and must be removed after completion of pickup.
2. Exam Gloves—will be changed after each pickup. Gloves should not be worn when transporting items back to the decontamination area. This prevents the contamination of elevator buttons, light switches, doorknobs, etc. Changing to clean gloves for transporting items back to the decontamination area is not required and should not be a practice that technicians use. If the technician feels that the items being picked up are soiled, e.g., IV pump & poles, commode chairs, then they should be covered and transported to the decontamination area.

Prepared Statement of Barry A. Searle, Director,
Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's views on this pressing issue brought to light by recent developments at the John Cochran VA Medical Center (VAMC).

The American Legion from its inception has been both a strong advocate for veterans and a proponent for an effective federal entity whose mission is to care for those veterans. In fact, it was following a recommendation from The American Legion's 1920 National Convention that the Dawes Committee with The American Legion representation, advocated for and was instrumental in the development of the predecessor of today's Department of Veterans' Affairs. Throughout this long history with The Department of Veterans' Affairs The American Legion has worked hard to develop a relationship of trust and mutual respect.

Central to The American Legion's efforts is a program called "A System Worth Saving." This Task Force, first established in 2003, annually conducts site visits at VA Medical Centers nationwide to assess the quality and timeliness of VA health care. In preparing for these visits, The American Legion team researches General Accountability Office (GAO) reports, VA's Office of Inspector General (VAOIG) reports, and news articles relating to potential breakdowns in a system that we consider, "The Best Care Anywhere." This task force, we believe, has identified some issues contributing to the issue at hand.

In March of this year, during a routine inspection of the John Cochran VAMC by VA's Infectious Disease Program Office, it was determined that dental instruments were not being cleaned in accordance with specifications of the manufacturers, or in accordance with VA's own procedures for proper sanitations and sterilization. These instruments were being cleaned without proper detergent, potentially putting veterans at risk for blood borne illnesses such as HIV and Hepatitis. VA Central Office (VACO) convened a special committee to determine an appropriate response. The Committee could not determine that the risk to the approximately 1,800 patients treated during this period could be assessed as an absolute zero chance of infection; therefore the decision was made to notify all affected veterans.

These 1,812 veterans, notified through certified mail, will be provided with free testing for HIV and the B and C strains of Hepatitis, and they will be provided with whatever follow up care is deemed necessary. As of this time, no veteran is known to have contracted any of these diseases through this exposure.

The American Legion feels that VA showed great responsibility and demonstrated an act of good faith to bring this issue to the attention of the veterans and the public. Placing patient safety before "good publicity," deserves to be acknowledged.

Nevertheless, The American Legion National Commander Clarence Hill recently stated, "This is an extremely serious problem that has happened before and will happen again unless VA ensures strict adherence to proper sanitation and sterilization protocols." To expose trusting veterans to blood borne illness through routine medical treatment because of avoidable errors in sanitization of medical equipment is inexcusable.

The medical protocols to prevent such occurrences were already in place; however a lack of compliance with those protocols has led to a situation where veterans' confidence in their health care system is being eroded. Simply put, a veteran should never have to fight misgivings about seeking health care from what is overall an excellent system for the delivery of their earned health care benefits. The problem exists not in the business process structure of the system, as the existing protocols were designed to prevent such exposures, but rather in the failure of those operating the system to execute those protocols. This can only be overcome by diligent and attentive management and training.

This event is not the only reported occurrence of failure to follow procedures within the VHA system. A Department of Veterans Affairs Office of Inspector General (VAOIG) report from 21 April 2010, concerning suspected issues in the Supply, Processing, and Distribution (SPD) department relating to endoscope reprocessing and communications at the St. Louis facility, substantiated alleged cleaning issues of equipment. In its findings the VAOIG identified turnover in several key staff positions. The American Legion believes that turnover and shortages in staffing are contributing factors in these serious events.

During the 2010 "System Worth Saving" Task Force visits to 32 VA Medical Centers across the country, a commonly repeated theme was the shortage of personnel, especially nurses and personnel with specialty training. It is the opinion of the American Legion that turnover of personnel and the shortage of personnel at most facilities require renewed emphasis on standardized procedures, quality review and individual training, as well as documentation of that training. If an emphasis on training is subverted to day to day operations, dedicated people will make mistakes. Further, The American Legion believes that VACO must maintain proper oversight of medical care, utilization of facilities and resources in order to ensure veterans receive the highest quality of care.

In a May 2010, VAOIG report concerning the review of Brachytherapy Treatment of Prostate Cancer at Philadelphia, PA and other VA Medical Centers, a recommendation was made for VHA to "standardize to a practical extent, the privileging, delivery of care, and quality controls for the procedures required to provide treatment." As technologies continue to change and treatments and procedures continue to develop, it is critical that VA staff delivering care be properly trained and held accountable. The American Legion supports training and the accountability highlighted and also the standardization of all patient care delivered across the VHA system.

In an April 28, 2010, *PITTSBURGH TRIBUNE–REVIEW* article, after a reported incident at the Pittsburgh VAMC in 2007, it was noted that the Food and Drug Administration had cited the VA facility for not doing a routine blood type confirmation test, a violation of standard procedure. This resulted "in the patient receiving 6 units of the wrong blood before he died." It was reported that, "VA officials told the FDA the error stemmed from "a heavier than usual workload in the blood bank."

We believe, and it has been supported by our visits, that the VA Health care system does in fact have SOP's and procedures in place. However, The American Legion understands that policies developed at VA Central Office, with the best of intentions, are for the most part executed at the discretion of the Veterans Integrated Service Network (VISN) Director or even Facility Director level and therefore, vary in local implementation. As was testified by The American Legion during a 1 July Subcommittee hearing, we believe there is a breakdown in the lack of follow-up and accountability by Central Office to insure procedures are being followed. This autonomy of the facility directors is a function of the over decentralization of the VA structure. It is in no means unique to VHA. It is, we believe, systemic to VA's mode of operation. For example, in VBA we have seen and, in fact, been told by VA personnel themselves that, "When you see one Regional Office, you have seen One Regional Office." The implication is that there is no standardization in VA.

It appears that only when a significant issue is identified such as this unfortunate breakdown in what appears to be cleaning procedure training is action taken on the part of VACO to rectify the lack of follow-up.

Again, one of the rising concerns of The American Legion, as stated in testimony over the last few months, has been that VA needs to do a better job in training its people more effectively and making sure they understand and follow the correct pro-

tocols that have already been established. There is also a need to enforce central oversight of the regional Veterans Integrated Service Networks (VISNs) thereby insuring consistency and accountability nationwide. It is not enough to simply move people to different facilities doing the same job. Unfortunately, at times accountability means negative impact on the individual who is responsible. VA has undoubtedly turned their attention to addressing this matter, and is treating it with the seriousness it deserves. With the correct and effective accountability, there is hope for continued faith in the veterans' health care system. However, we must always be mindful of the fact that this has happened before, and unfortunately, it has happened again.

The American Legion is committed to working with the Secretary to ensure that this situation is successfully resolved and that incidents such as this do not become an ongoing issue with the otherwise excellent VA Health Care System.

Mr. Chairman and Members of the Committee that concludes my testimony.

Prepared Statement of Hon. Robert A. Petzel, M.D.,
Under Secretary for Health, Veterans Health Administration,
U.S. Department of Veterans Affairs

Chairman Filner, and distinguished Members of the Committee: thank you for the opportunity to discuss our finding that there was a failure to clean dental handpieces according to manufacturer instructions and VA standard operating procedures at the St. Louis Department of Veterans Affairs (VA) Medical Center. We understand our Veterans, the public, and Congress are deeply concerned about this revelation, and we appreciate the opportunity to address this issue in detail and on the record. Simply put, what happened at St. Louis was unacceptable.

It is the first responsibility of every government agency to be open and honest with the public and its clients—in our case, the brave men and women who wore the uniform and promised to defend this Nation. We at VA have the great privilege and solemn responsibility to provide health care and benefits to this population. We strive every day to improve the quality of health care for our Veterans. We constantly monitor and inspect more than 1,000 VA clinical sites performing millions of procedures each year. We are dedicated to taking immediate steps to set things right whenever we discover problems.

We understand that honesty and good intentions are not enough; public confidence in government is equally important in delivering quality health care to our Veterans. Every employee of the Department of Veterans Affairs understands that incidents like what happened in St. Louis can lead Veterans and their families to question the care we provide, delay needed health care or seek it from another source. We deeply regret the emotional and psychological burden that we have placed on our Veteran patients and their loved ones. Even though the risk of infection to our Veteran patients is in this instance statistically low, the psychological consequence of the error is a high price to pay for those men and women who have already paid so much on behalf of this Nation.

VA is grateful for the sustained confidence in our ability to provide world class care demonstrated by our Veterans, their family members and the Veteran Service Organizations. We believe we have a system of quality assurance and safety that is second to none. This belief is buttressed by the findings of a range of independent investigations that have reported health outcomes are better for Veterans seen in VA facilities than those seen in other settings. We know that public confidence is a resource not to be esteemed lightly or taken for granted. Following setbacks in the quality of care we delivered in several of our endoscopy programs, and now this issue in St. Louis, we have to demonstrate with actions and not words that we continue the care and safety of our Veterans as a priority. When our care does not meet the high standards we have set, we notify our Veterans and arrange the necessary care to alleviate their concerns and restore their confidence. But we also must hold our people accountable. I have always believed that accountability is a two-way street: leaders must provide clear expectations and the resources necessary to meet them, and employees must use those resources carefully to achieve our objectives. Accountability can take many forms. In some cases, errors are made because of a lack of training or information, and in these cases, it is our duty to provide our front line staff with what they need. In other cases, disciplinary action is warranted. We have convened an Administrative Investigation Board to review the issues we identified in St. Louis to determine what further action we need to take as an organization to ensure the protection of our Veterans, and we will keep Congress informed as this Board makes its recommendations. In the rest of my testimony, I will outline

the chronology of events at St. Louis and our response to this incident, and provide information that every potentially affected Veteran needs to know.

Chronology

In March 2010, the National Infectious Diseases Program Office (IDPO) conducted an announced site visit of the St. Louis VA Medical Center. During this inspection several issues concerning the proper processing of dental instruments were identified, including a failure to clean dental handpieces according to manufacturer instructions and VA standard operating procedures. VA procedures call for the instrument to be cleaned with a detergent before it is sterilized, and the facility was not doing this. It is important to note these instruments received additional cleaning prior to use, but VA cannot establish conclusively their sterility because of the precleaning deficiency. Upon learning of these findings the Acting Medical Center Director immediately suspended Dental Services until the identified issues could be fully addressed and resolved.

Coinciding with the IDPO inspection findings, VA officials immediately initiated and completed an in-depth review of the program, including staff training and direct observation, ultimately resulting in a redesign of dental equipment cleaning processes. On March 18, 2010, the Oral Surgery and Dental Hygienist Clinics reopened with corrected procedures in place, and on March 26, 2010, the General Dentistry Clinic was reopened.

On May 6, 2010, VA convened a Clinical Risk Assessment Advisory Board (Board) at VA Central Office. This Board's membership is comprised of many VA national program leaders representing both clinical and non-clinical expertise. The Board thoroughly reviewed the findings related to the dental issues. While the Clinical Risk Assessment Advisory Board identified the risk of infection to be extremely low, in keeping with VA's commitment to informing Veterans about issues related to their care, the Board recommended notification of 1,812 St. Louis patients receiving dental care between February 1, 2009 and March 10, 2010 of the possible risk through disclosure information letters and that serology testing for hepatitis B, hepatitis C and HIV be offered. Between May 10 and 12, 2010, the National Director of Medicine and the Acting Executive Manager of the Supply, Processing and Distribution Program with a team from VA Central Office conducted a new site visit of St. Louis and found that all issues at the dental clinic had been resolved. VA sent disclosure letters to 1,812 affected Veterans, offering testing for hepatitis B, hepatitis C and HIV on Monday, June 28, 2010.

Response

Upon learning of the identified issues, the Acting Medical Center Director took immediate action to temporarily suspend St. Louis Dental Services until the issues identified could be fully assessed and resolved. All Veterans with appointments were given the option to reschedule at the St. Louis dental clinic, or to receive care in the community at VA expense during the suspension.

St. Louis VAMC is contacting all potentially affected Veterans through certified mail. Additionally, VA staff members are working with local Congressional offices and Veteran Service Organizations to ensure Veterans know of this issue and receive the care they have earned. We appreciate the opportunity to participate in a forum like this where Veterans can see our commitment to their care and can hear directly from us what we are doing to address this issue. More importantly, this forum offers us an opportunity to hear from our Veterans, to address their concerns directly and to answer their questions honestly.

We recognize there were missed opportunities to uncover this issue sooner. We have implemented safeguards system-wide to prevent a similar situation from happening again. We are reviewing our experience at St. Louis and our response to it to identify lessons learned, and I can promise you that our policies for identifying these issues early and notifying our Veterans and stakeholders promptly will change to create a faster response system. We hear too often that VA is too big a ship to respond quickly, but I will not accept this as an excuse. I will submit a letter describing the improvements and our standards for ensuring compliance by our facilities to the Committees on Veterans' Affairs by August 15, 2010.

One of the safeguards we have already identified involved elevating the Supply, Processing and Distribution program to the level of a stand-alone national program. This alignment will allow for improved oversight of the program and specific dedication of additional resources. Supply, Processing and Distribution Boards are being created at all 21 VA Networks to review local facilities and their compliance with VA policies and procedures.

VA also is in the process of standardizing the operating procedures for the cleaning of all reusable medical equipment to reduce variation and errors. VA has committed to implementing industry principles (in the form of International Organiza-

tion of Standardization, or ISO 9001 standards) system-wide, in its ongoing efforts to reduce variation. No other health care system in the country has adopted the industrial practices that ISO requires, and VA will lead the way in this area as we have in so many others before. Moreover, VA has arranged for the International Association of Healthcare Central Service Material Management, a nationally recognized organization promoting excellence in the sterile processing of reusable medical equipment, to intensively train all VA Chiefs of Sterile Processing and Distribution in state-of-the-art techniques for sterile processing.

VA has set up a St. Louis Dental Review Call Center that is being operated 7 days a week, 24 hours a day. Veterans and family members with questions or concerns can call **1–888–374–3046** to speak to our health care staff who will be available to answer any questions and to assist with scheduling an appointment and obtaining the necessary blood tests. A Dental Review walk-in clinic opened on June 29, 2010 at the John Cochran Division at the St. Louis VA Medical Center (hours of operation Monday through Friday 8:00 am to 6:00 pm and Saturdays 8:00 am to 4:00 pm). Blood tests can be obtained at the Jefferson Barracks Division, St. Louis Community-Based Outpatient Clinic (CBOC), Belleville CBOC or St. Charles CBOC (a full list of addresses and contact information is available at the end of this statement). For Veterans and family members located outside the St. Louis area, the St. Louis VA Medical Center will arrange for them to receive service at the most conveniently located VA facility. Wherever Veterans receive services related to this issue, there will be no co-payments associated with the necessary appointment or testing. Through July 7, 2010, 778 Veterans had accepted testing, and 615 have scheduled appointments in the St. Louis Dental Review Clinic.

Finally, we are strengthening our system of accountability for compliance with national directives. These directives are developed and promulgated after careful review by clinicians with years of experience, and it is essential that they be followed. We have a rigorous system of monitoring in place to determine if these directives are being implemented, and employee performance is assessed based upon success in attaining the standards we set. We will reinforce the importance of these principles so that new policies and procedures are adhered to when they are issued.

What Veterans Need to Know

It is important for our Veterans and their families to know that VA has attempted to contact every Veteran seen and possibly exposed to a blood-borne disease between February 1, 2009 and March 10, 2010. If you are a Veteran and you were seen in the St. Louis VA Medical Center Dental Clinic during this time and you have not received a letter from the Department, or if you know a Veteran who was seen during this time who has not received a letter, please call 1–888–374–3046 to notify us so we can arrange testing and monitoring.

It is also important to know that while the risk of exposure is extremely low, it does exist. It is imperative that our Veterans be tested, both for their health and for the health of their loved ones. For Veterans who are worried about being seen in a VA facility, we will arrange for these tests to be done by another party at no cost to the Veteran.

VA has long had staff members known as patient advocates who are available in each of our major medical facilities who can help Veterans with whatever concerns they have. If Veterans need counseling or advice or have any concerns with the quality of care or the nature of our response, VA strongly encourages them to please contact the patient advocate at the facility and discuss these issues with that person.

Conclusion

In the past 18 months, VA has implemented more stringent oversight of the existing safety guidelines for reprocessing of reusable medical equipment in all of its medical facilities. It is this more rigorous standard that directly led VA to identify and address problems at the St. Louis VA Medical Center. The St. Louis VA Medical Center provides quality health care services to more than 50,000 Veterans a year, and employs more than 2,600 individuals from the community. The Veterans potentially affected are their neighbors and friends.

VA, from the Secretary to the staff at the St. Louis VA Medical Center and in every VA facility, has expressed a deep commitment to preventing this, or any similar situation, from happening again, and has taken steps to accomplish that goal.

We deeply regret that this situation occurred and VA is taking all the necessary steps to make certain that testing is offered quickly and that results are communicated in a timely manner. We understand the responsibility and trust Veterans place in us and we want Veterans and our stakeholders to know that the staff at

the St. Louis VA Medical Center is doing everything possible to address this situation and prevent it from occurring again.

Thank you again for the opportunity to appear before you today. My colleagues and I are prepared to answer any questions you may have.

List of Facilities in the St. Louis Area

VA Medical Centers

John Cochran Division

915 North Grand Blvd.

St. Louis, MO 63106

Phone: 314–652–4100 or 1–800–228–5459

Jefferson Barracks Division

1 Jefferson Barracks Dr.

St. Louis, MO 63125

Phone: 314–652–4100 or 1–800–228–5459

VA Clinics

Belleville Clinic

6500 W Main St

Belleville, IL 62223

Phone: 618–398–2100 or 800–228–5459 ext. 56988

Salem Clinic

Hwy 72 North

Salem, MO 65560

Phone: 573–729–6626 or 1–888–557–8262

St. Charles Clinic

7 Jason Ct.

St. Charles, MO 63304

Phone: 636–498–1113 or 1–800–228–5459 ext. 56988

St. Louis Clinic

Missouri Veterans Home—VA Clinic

10600 Lewis and Clark Blvd.

St. Louis, MO 63136

Phone: 314–286–6988 or 1–800–228–5459 ext. 56988

Statement of Hon. Phil Hare,
a Representative in Congress from the State of Illinois

I would like to thank Chairman Filner and Ranking Member Buyer for calling this important hearing to investigate the failure to comply with sterilization procedures at the John Cochran VA Medical Center in St. Louis, MO.

People in the armed services routinely risk their lives so that we do not have to live in fear, and yet because of medical *negligence* at the St. Louis VA Medical Center, many veterans are currently doing just that. There are over 55,000 veterans living in my district, and it pains me to think that any one of them received a letter warning them that they may be infected with HIV, the Hepatitis B and C viruses or other blood-borne diseases from potentially contaminated equipment used during dental treatment.

According to best practices for infection control, sterilization, disinfection and cleaning of medical equipment and instruments, also known as reprocessing, should be performed in a centralized area. However, over the course of a year, employees

at the St. Louis center disregarded these guidelines. And seemingly, no supervision was taking place to ensure the medical guidelines for centralized sterilization of medical instruments were being followed by the dental staff at John Cochran.

On July 1st, I sent a letter to Secretary Shinseki expressing my sincere concern and frustration about the mismanagement at John Cochran and the risk of potential exposure to hundreds of veterans in my district. In this letter, I asked the Secretary to immediately investigate and take steps to ensure that patient safety standards are upheld. I also urged the VA Secretary to strengthen oversight of sterilization procedures and enhance regulations to protect our vets from infection.

I am pleased that the Secretary acted quickly to ensure health care workers are complying with effective sterilization processes. Secretary of Health Robert Petzel's call for an independent, national Administrative Investigation Board to see what went wrong here is a step in the right direction. Re-training all hospital personnel and standardizing washing procedures is a step in the right direction. Placing the Chief of Dental Services on administrative leave until the outcome of the investigation is determined is, again, a step in the right direction.

But our efforts must not stop there. The VA must also take steps to implement these changes agency-wide and restore our veterans confidence in the VHA. I am sure we all remember the failure to sanitize colonoscopy equipment just a little over a year ago. In addition, audits conducted by the Office of Inspector General in the past year have often found issues with sterile processing areas at other VA facilities. The frequency of contaminated instruments cited in OIG reviews suggests an ongoing problem with equipment sterilization within the VA system. Let us once and for all standardize cleaning practices throughout all medical departments and enforce compliance with regular audits at all VA Medical centers to take human error out of the equation.

After all our veterans have done for us, it is our responsibility to do all that is necessary to prevent this kind of occurrence from happening again.

Again, I thank the Chairman for his leadership on this issue and hope that today's testimonies will help us provide our veterans with the best care possible.

Statement of Hon. Claire McCaskill,
a United States Senator from the State of Missouri

Chairman Filner, Members of the House Committee on Veterans' Affairs and panelists, I applaud you for holding a hearing to review the vitally important issue before the Committee today—the consequences to the health and safety of our Nation's veterans following revelations of safety non-compliance at the John Cochran Veterans Administration Medical Center (VAMC) in St. Louis, Missouri. I am sorry that I could not appear before you in person today because of the Senate voting schedule, and I appreciate your accepting my written statement.

As we all now know, approximately 1,812 St. Louis-area veterans were potentially exposed to blood-borne pathogens, including hepatitis B and C and HIV, as a result of possibly being treated with improperly cleaned dental devices at the John Cochran VAMC dental clinic between February 2009 and March 2010. I know that I—and I would venture to say all Americans—were deeply saddened and disappointed by this revelation. My colleagues Senators Bond and Durbin and I made that clear in our June 30, 2010 letter to Veterans Affairs (VA) Secretary Eric Shinseki, which I am providing today and request that you include in the record of this hearing. Veterans are our Nation's heroes—men and women who risked their health and safety for our freedom—and it is disturbing to learn that their health and safety could have been endangered in any way, even if by accident. As we all know, such mistakes simply cannot be allowed to happen.

In addition, our veterans' trust and confidence in the VA medical system and, particularly in the John Cochran VAMC, is badly damaged by incidents like this one. It is going to take time to get that trust back, but I believe the VA can and must do so, and I know today's hearing will be part of that process.

We all agree that veterans receiving treatment at John Cochran deserve the best quality care available, including absolute assuredness that the hospital is meeting the most basic and critical professional standards of cleanliness and conduct. This one incident is disturbing enough, but unfortunately John Cochran VAMC has been the source of other violations and low customer service ratings in the past. In April 2010, the VA Inspector General released a report outlining reprocessing problems with endoscopes used at John Cochran VAMC. Prior to that, John Cochran received some of the lowest customer service satisfaction ratings of any VAMC in the country. I know that efforts have been made to address these problems by the VA, but

the latest revelations about the improper dental device sterilization pose a significant setback to progress.

Further, many veterans groups have expressed concern to me about John Cochran VAMC, including the Paralyzed Veterans of America Gateway Chapter, which has strongly opposed a move of the spinal cord treatment unit to John Cochran VAMC. I have written to Secretary Shinseki about this move because I understand their concerns. I ask that the letter to Secretary Shinseki also be included in the record of this hearing.

I am also deeply concerned that the VA took 4 months (from March until the end of June 2010) to notify veterans who may have been endangered by the flawed procedures at John Cochran VAMC, as well as to notify the area Congressional delegation so that we might assist our constituents, many of whom have called my office worried and outraged about this incident. I appreciate that the VA acted quickly to remedy the flawed cleaning procedures, but the failure to share information in a timely fashion about the situation is unacceptable. In addition, a follow up visit to John Cochran VAMC by VA Headquarters staff was not conducted until May 2010, some 2 months after the initial inspection revealed problems with the cleaning of the dental devices. When a significant failure in procedures occurs, like those discovered at the John Cochran VAMC dental clinic, I would expect a more timely response and more aggressive oversight. There must be an evident and palpable sense of urgency from the VA. It is clear the VA now has such a sense of urgency and it must continue.

The VA has decided to dedicate $5 million in funding to make infrastructure and other improvements at the John Cochran VAMC in light of this troubling incident. While I applaud the VA's efforts to address aggressively underlying problems, including infrastructure problems that could have contributed to the failures in the dental clinic, I and the other members of the Missouri and Illinois delegations want to be kept closely apprised of how the $5 million in renovations will be prioritized and spent. I ask today that the VA keep me, the rest of the congressional delegation and all interested veterans and veteran service organizations, regularly informed about any follow up actions that the VA takes to train staff and improve standard operating procedures in the dental clinic and elsewhere in the hospital.

As John Cochran VAMC staff go about the task of evaluating each of the 1,812 veterans who have received letters from the VA about potential exposure from improperly handled dental devices, I ask for a full and complete accounting by the VA of any health irregularities identified and attributed to the exposure—I cannot stress enough how *any* exposure would be a truly tragic outcome to this case. I know that Secretary Shinseki and the staff at John Cochran VAMC value the health and safety of each and every veteran, and I strongly urge him and the John Cochran VAMC leadership to make sure that no veteran's health goes unchecked in this exposure case.

The incident at John Cochran VAMC is a sad chapter that leaves a stain on the VA system. I abhor that it happened, and I join the Committee and all Americans in demanding a full accounting and assurance that such an incident will not happen again. Because of the challenges John Cochran VAMC has continued to face, I also call for a redoubling of efforts to make improvements at the facility.

I am committed to working with the VA to provide veterans with the resources they need to heal—resources that they have earned through their great service to this country. There is much to be proud of in the work the VA does for America's veterans and there are many skilled, patriotic, selfless employees on the VA team caring for our veterans. I want to thank the VA and its staff for all it does to honor and care for America's veterans and urge everyone who is part of the VA to persevere through challenges like that which this incident poses. The men and women who receive care at the VA know a thing or two about hardship and about perseverance. They will carry on and the VA will, as well.

Thank you, once again, Mr. Chairman for accepting my statement for the record today and for holding this hearing on this important matter.

United States Senate
Washington, DC.
June 30, 2010

General Eric Shinseki
Secretary of Veterans Affairs
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

Please note our deep disappointment and concern that 1,812 St. Louis area veterans were potentially exposed between February 2009 and March 2010 to dangerous blood-borne diseases, including Hepatitis B and C and HIV, through possible contact with improperly cleaned dental devices at the John Cochran VA Medical Center (VAMC) in St. Louis, Missouri. In light of other recent revelations by the VA Inspector General regarding problems with reprocessing of endoscopes at John Cochran and frequent customer service satisfaction problems reported at John Cochran, we are concerned about VA management of the facility. Veterans receiving care at John Cochran deserve the best quality care available, including absolute assuredness that the hospital is meeting the most basic and critical professional standards of cleanliness and conduct.

We are also deeply concerned that the VA took 4 months to notify veterans who may have been endangered by the flawed procedures at the John Cochran VAMC, as well as to notify the area Congressional delegation so that we might assist our constituents. We appreciate that the VA acted quickly to remedy the flawed cleaning procedures but the failure to share information in a timely fashion about the situation is unacceptable. In addition, a follow up visit to John Cochran by VA Headquarters staff was not conducted until May, some 2 months after the initial inspection revealed problems with the cleaning of the dental devices. When a significant failure in procedures occurs, like that discovered at the John Cochran VAMC dental clinic, we would expect a more timely response and more aggressive oversight.

The VA has decided to dedicate $5 million in funding to make infrastructure and other improvements at the John Cochran VAMC in light of the troubling incident. While we applaud the VA's efforts to address aggressively underlying problems, including infrastructure problems that could have contributed to the failures in the dental clinic, we must be kept apprised of how the $5 million in renovations will be spent and prioritized. Please keep us informed about any follow up actions that the VA takes to train staff and improve standard operating procedures in the dental clinic and elsewhere in the hospital.

In closing, as you evaluate each of the 1,812 veterans who have received letters from the VA about potential exposure from improperly handled dental devices, we ask for an accounting of any health irregularities identified and attributed to the exposure. We know you value the health and safety of each and every veteran and strongly urge you to make sure that no veteran's health goes unchecked in this case. We are committed to working with you, Mr. Secretary, to provide veterans with the resources they need to heal-resources they earned through their great service. The repeated failures to follow simple rules and regulations, however, is wholly unacceptable, and we want to know the measures you plan to implement in order to ensure this catastrophe never happens again.

We thank you for your immediate attention to this matter and look forward to your reply.

Should you have additional questions please feel free to contact us directly or to have your staff contact Tressa Guenov in Senator McCaskill's office, Bo Prosch in Senator Bond's office or Gabe Chavez in Senator Durbin's office.

Sincerely,

Claire McCaskill
United States Senator

Christopher Bond
United States Senator

Richard Durbin
United States Senator

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
July 29, 2010

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing entitled "Veterans at Risk: The Consequences of VA Medical Center Non-Compliance" on July 13, 2010, I would appreciate it if you could answer the enclosed hearing questions by the close of business on September 10, 2010.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

MH:ds

Questions for the Record
The Honorable Bob Filner, Chairman
House Committee on Veterans' Affairs
and
The Honorable Wm. Lacy Clay
"Veterans at Risk: The Consequences of VA Medical Center Non-Compliance"
July 13, 2010

Question 1: As of today, what is the total number of Veterans identified by the Veterans Health Administration as being at risk of exposure to Hepatitis B, C, and HIV/AIDS virus?

Response: The data below reflects the most current notifications, testing, and results and can be found at: http://www.va.gov/HEALTH/rme/stlouis.asp.

Numbers of Potentially Affected Patients as of September 7, 2010*	
Number of Patients	**St. Louis**
Potentially Affected Risk Pool)	1,812
Notified	1,769
Responded to Disclosure Letter or Called VAMC for Appointment	1,750
Declined Testing or Appointment	74
Notified of Test Results	1400
Total Calls to Toll Free Hotline or Call Center	2,523

Numbers of Potentially Affected Patients as of September 7, 2010*	
Number of Patients	**St. Louis**
*These numbers are based on the most current analysis of test results and notifications as of the date stated above. While every effort is made to provide exact numbers, the nature of medical science may result in shifts of this data as new results are determined. Note: 43 Veterans were deceased at the time of initial notification. VA does not routinely send notification letters to deceased Veterans.	

Newly Diagnosed and Have Been Notified**	
Test	**St. Louis**
Hepatitis B Virus	2
Hepatitis C Virus	2
HIV	0
**These results are not necessarily linked to any reusable medical equipment issues. VA is performing extensive epidemiological testing to determine the time period and to the extent possible, source of known infections. Regardless of time period or source of known infections, VA will provide all related health care at no cost to infected Veterans. We are continuing to notify individuals and are working with homeless coordinators to reach Veterans with no known home address.	

Question 2: How can the Veterans Health Administration be assured that no health risks existed at the St. Louis VA Medical Center before February 1, 2009?

Response: The St. Louis VAMC Quality Management office reviewed the process in the Dental Service in February 2009. That review did not indicate any failures to follow proper procedures for handling reusable medical dental equipment. During the time period from February 2009 to March 2010, there were no indications that pre-cleaning of reusable dental equipment was occurring in the dental service. Additionally all instruments were being sterilized in central Supply Processing and Distribution (SPD). On May 6, 2010, the Clinical Review Board (CRB) met to review the information from the St. Louis VAMC to determine the risk to patients and identify if disclosure was needed. The Board is comprised of experts in infectious disease, public health, specialty care services, patient safety, and quality management. Based on the review of clinical information presented to the Board, it was determined that the risk to Veterans was from February 1, 2009 to March 12, 2010. The Administrative Investigation Board (AIB) is reviewing all facts and circumstances surrounding the case, and will provide an additional check on the validity of this information. Based on additional review, the Under Secretary has requested that the CRB revalidate this information.

Question 3: How many Veterans, who are residents of the First Congressional District of Missouri, are at risk of exposure to Hepatitis B, C, and HIV?

Response: There is no ongoing risk of exposure; 545 Veterans who were identified as residents of the First Congressional District (FCD) were treated at the Dental Clinic during the period identified and may have been exposed prior to the shutdown of the service.

Question 4: How many of these Veterans have been tested? Also, are there any plans to do to compensate victims for this error?

Response: As of September 7, 2010, 477 of the 545 Veterans who reside in the FCD of Missouri have been tested. Testing and care associated with this event is provided at no-cost to the Veteran. Regarding compensation, Veterans have been provided with education, written materials and contact information regarding claims they may file with VA Regional Offices for Veterans' disability benefits designed to compensate persons injured by medical care, and regarding claims under the Federal Tort Claims Act that they may file with VA Regional Counsel Offices.

Question 5: Considering that it took a full year to discover the error that put Veterans at risk, what changes would you suggest in improving the inspection process to ensure any future problems are discovered and reported earlier?

Response: Nationally, the Supply, Processing and Distribution (SPD) Program function has been realigned within VHA with the goal of providing enhanced leadership, oversight and resources. Each Veterans Integrated Network (VISN) has established an SPD Management Board, which has prescriptive changes and comprises multidisciplinary subject matter experts. The Boards are responsible for policy enforcement and oversight. Various tools, including announced and unannounced inspections of SPD areas are used to accomplish their duties. The standards developed for each SPD area are exacting, down to the citation of applicable codes, and self-diagnostic tools are designed with specificity against those standards.

The Veterans Health Administration (VHA) acknowledges that it took excessively long to notify the affected patients in this case. We have directed targeted improvements to streamline the CRB process by involving the clinical experts initially. Also, the communication process has been redesigned to be able to alert Veterans much more rapidly. By shortening this time, we will improve our ability to discuss these issues, consistent with Federal privacy laws, with Members of Congress so that they have the information they need to perform oversight responsibilities and explain events to their constituents and offer assistance. VHA officials are committed to ensuring that this SPD realignment and additional actions discussed will make VA responsive across all VISNs.

Question 6: What measures have the Veterans Health Administration established to ensure that such errors will not occur again?

Response: St. Louis VAMC has removed all packaging supplies in the dental clinic so instruments can no longer be packaged prior to being sent to Processing and Distribution for sterilization. The Acting Medical Center Director established an Executive Action Telephone Line so employees can report to the Director's Office concerns or issues related to patient care, quality and safety. The facility reassessed staff competencies and provided re-training. Additionally, facility leadership reviewed and standardized procedures to comply with manufacturers' guidelines and to prohibit the cleaning of equipment outside of the SPD. Ongoing staff education and competency assessments are in place, and ongoing quality reviews and inspections continue. The medical center activities are reported to the VISN SPD Review Board quarterly, who conduct unannounced reusable medical equipment (RME) review inspections on an annual basis or as needed.

Several National VA Teams and the Quality Management staff at the VAMC have reviewed areas in the facility where RME is used as part of the clinical care. Their goal is to assure that proper procedures are in place for both pre-cleaning and sterilization.

Additionally, VA has taken the following actions to improve oversight and reduce variation:

- VA elevated the SPD program to the level of a stand-alone National program (from under the infectious disease program office) that reports directly to the National Director of Medicine. This realignment will allow for improved oversight of the program, and dedication of additional resources.
- All 21 VISNs created SPD Review Boards to review local facility compliance with VA SPD policies and procedures.
- VA is in the process of standardizing SPD processes related to all RME to reduce variation and errors.
- VA has committed to implementing industry principles (in the form of International Organization of Standardization, or ISO 9001 standards) system-wide, in its ongoing efforts to reduce variation.
- VA has arranged for the International Association of Health care Central Service Material Management, a nationally recognized organization promoting excellence in the sterile processing of reusable medical equipment, to supplement existing training of all VA Chiefs of SPD in state-of-the-art techniques for sterile processing.