United States Senate
Washington, D.C. 20510

July 8, 2024

Mrs. Sunaina Kumar-Giebel
Network Director
Veterans Affairs Rocky Mountain Network
4100 E Mississippi Avenue
Denver, CO 80246

Dr. Susan Bray-Hall
Chief Medical Officer
Veterans Affairs Rocky Mountain Network
4100 E Mississippi Avenue
Denver, CO 80246

Dear Mrs. Kumar-Giebel and Dr. Bray-Hall:

We write to express our concern regarding veteran patient care within the Eastern Colorado Health Care System (ECHCS) and at the Rocky Mountain Regional Medical Center. In a report released in June, the Veterans Affairs Office of Inspector General (VA OIG) found a "lack of resident supervision, an ineffective teaching environment for residents, and patient harm," in the Intensive Care Unit (ICU) at the Rocky Mountain VA.[1] In addition to the VA OIG findings, there are reports of unidentified residues found on reusable surgical equipment, which has led to over 500 canceled surgeries at the Rocky Mountain VA.[2] [3] Further, our offices have received information from VA employees who highlight ongoing problems related to leadership turnover, budget cuts, and hiring freezes. As problems persist within the ECHCS, we are increasingly concerned about the quality of care Colorado veterans receive, a lack of adherence to the required medical and employee procedures, and how recent leadership changes have impeded the system's effectiveness.

While we appreciate the VA OIG's recent recommendations intended to address issues in the ECHCS between April 2022 and August 2023, it is paramount that you address more recent events at the Rocky Mountain VA.[4] These concerns must be taken seriously and require active oversight by the Department of Veterans Affairs. In light of these issues, we request answers to the following questions and a briefing with our offices in order to identify long-term solutions to improve veteran care in Colorado:

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1 OIG, VA. pp. 1–57, Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora.

2 Tabachnik, Sam. "Unsafe Culture Permeates Aurora VA's ICU, Staffers Allege. The Message? 'Shut up and Do What You're Told.'" *The Denver Post*, The Denver Post, 29 Mar. 2024, www.denverpost.com/2024/03/27/aurora-va-hospital-intensive-care-unit/.

3 Tabachnik, Sam. "More than 500 Surgeries Halted since April as Aurora VA Hospital Still Can't Id Mysterious Residue." *The Denver Post*, The Denver Post, 17 June 2024, www.denverpost.com/2024/06/17/aurora-va-hosptial-residue-surgical-equipment/?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_medium=email&_hsenc=p2ANqtz-_AtEKNFdNOfuTqXvJls7fl1at0jt-W5XwBdxvR2Aq2FVP4oeQ2hpPgPX8CTEwTsCkNWvL2_z4u_mCQMkLoru079eQ8PLqPtB4hOSnXa8oa7-HFrj0&_hsmi=312087416&utm_content=312087416&utm_source=hs_email.

4 Tabachnik, Sam. "Unsafe Culture Permeates Aurora VA's ICU, Staffers Allege. The Message? 'Shut up and Do What You're Told.'" *The Denver Post*, The Denver Post, 29 Mar. 2024, www.denverpost.com/2024/03/27/aurora-va-hospital-intensive-care-unit/.

Patient Safety

1. Does the Rocky Mountain VA track occurrences of patient safety issues? If yes, please provide the number of safety issues that have occurred and how you've addressed them. If not, please explain why these issues are not monitored.

Unidentified residue and resulting delayed care

1. Does the Rocky Mountain VA follow the Centers for Disease Control and Prevention (CDC) Guideline for Disinfection and Sterilization in Healthcare Facilities (2008) to ensure consistency of sterilization practices? If the Rocky Mountain VA does not follow CDC guidelines, please provide the details of the process you follow and confirm adherence.
2. When did the Rocky Mountain VA first become aware of the unidentified residue in its surgical units? When did the Rocky Mountain VA first begin canceling surgeries as a result of this residue?
3. Has the Rocky Mountain VA conducted a full investigation into the cleanliness and sterilization of all medical equipment?
4. How many days, weeks, or months are veterans' surgeries delayed as a result of this investigation?
5. How much advance notice have veterans received before their surgeries are canceled?
6. Have these surgical pauses delayed any additional medical services within the Rocky Mountain VA Hospital?
7. Where are veterans being referred for care in lieu of treatment at the Rocky Mountain VA? Is the VA reimbursing veterans for additional travel incurred to receive surgery at other hospitals?
8. What continuing education requirements are there for sterile processing technicians within the Veterans Health Administration; and when is the last time your sterile processing curriculum and training were updated?
9. Given recent instances of sterile processing issues in Georgia in 2021, Indiana in April 2024, and now Colorado in March 2024, will the Department of Veterans Affairs require sterile processing training and curriculum to be updated on an annual basis?

Staff shortages and organizational culture

1. How do ongoing staff shortages affect the Rocky Mountain VA's ability to provide timely and quality health care to veterans, including mental and dental care?
2. How many surgical and non-surgical divisions within the Rocky Mountain VA are currently understaffed?
3. What is your timeline to address these staffing shortages and is there a timeline to lift the hiring freeze?
4. What is your timeline to replace interim directors in the organization with permanent positions?
5. Veterans across the ECHCS have reported waiting many months for their first face-to-face appointment with a VHA provider. What is the average wait time for a veteran to be seen by their provider upon requesting an appointment? Please provide information for the following visits:
    a. 1st Dental
    b. 1st Mental Health
    c. 1st Primary Care Visit

d. 1st Sleep Care
e. 1st Social Work

6. What is the staff size of a Physician Aligned Care Team (PACT) and how many patients do PACTs have?
7. What steps has the Rocky Mountain VA taken to address pervasive organizational "cultural" problems that disincentivize the ability to identify and resolve problems in procedures, staffing, and medical care?

We share the goal of providing veterans across the country with timely, quality, and consistent health care. The continuous appointment delays and ongoing quality issues at ECHCS undermine this objective. We look forward to receiving your response to these questions by August 10, 2024.

Sincerely,

Michael F. Bennet
United States Senator

John Hickenlooper
United States Senator

Jason Crow
Member of Congress

CC: Secretary of Veterans Affairs, Denis R. McDonough
Under Secretary of Health for the Department of Veterans Affairs, Shereef Elnahal