For Immediate Release
Thursday, January 14, 2010

Grassley asks VA secretary about exposure of VA patients to infectious diseases due to health system mishaps

WASHINGTON --- Based on an internal agency memo documenting the incident, Senator Chuck Grassley is asking the Secretary of Veterans Affairs to respond to information about the wrong filter being used in dialysis machines at the VA Palo Alto Health Care System last year, putting 83 patients, and possibly more, who were treated using the contaminated machines at risk for being infected with hepatitis, HIV, or other infectious diseases. Grassley said it's his understanding that all of the patients have yet to be informed.

"This account raises serious questions about the VA's infection control processes and practices," Grassley said. "It comes on top of an independent news report last year about 11,000 VA system patients being told to get their blood checked for possible exposure to infectious body fluids and a similar, incident in 2006. Patients in the VA health care system deserve to be informed promptly of their exposure to risk. And the VA needs to hold its facilities accountable and take prompt action to prevent incidents like these in the future."

Grassley regularly conducts pro-active congressional oversight of the executive branch on behalf of taxpayers and beneficiaries of federal programs.

The text of Grassley's letter to VA Secretary Eric K. Shinseki is below. The enclosed internal memo describing the most recent incident is here.

January 14, 2010

The Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki:

As the senior Senator from Iowa and Ranking Member of the United States Senate Committee on Finance (Committee), it is my Constitutional duty to conduct oversight into the actions of the Executive Branch, including the activities of the Department of Veterans Affairs (VA).

I recently received the enclosed memorandum, which documents that the wrong filter was used in dialysis machines at the VA Palo Alto Health Care System last year, putting 83 patients and possibly more who were treated using the contaminated machines at risk of being infected with hepatitis, HIV, or other infectious diseases. I understand that as of the date of the memorandum, all of these patients had not been informed of the incident.

What is as troubling is that this is not the first incident of contaminated equipment in the VA health system. The *Associated Press* reported that in February 2009 the VA started notifying more than 11,000 patients treated at three VA medical centers to get their blood checked because they may have been exposed to infectious body fluids. It was discovered two months earlier that equipment used for colonoscopies at these three hospitals was not properly cleaned or sterilized. Similarly, in April 2006, the VA issued an alert that a biopsy device used to take tissue samples from the prostate, to test for cancer in VA facilities had not been cleaned adequately, thus potentially exposing patients to infectious agents.

These incidents raise serious questions about the VA's infection control processes and practices. Accordingly, I request that the VA respond to the following questions by no later than January 28, 2010. In responding to this letter, please repeat the enumerated question and follow with the appropriate response and documentation.

1) In light of these recent health care-associated exposures within the VA health care system, what measures does the VA plan to put in place to prevent similar incidents from occurring in the future?

2) What infection control policies, guidelines and practices are currently in place to prevent the development and transmission of disease and infection in VA health care facilities throughout the country?

    a. Please specify changes, if any, to the policies, guidelines, procedures and practices that were implemented by the VA in response to the earlier incidents.

    b. Please also describe any structural changes that were implemented.

3) What office within the VA's Veterans Health Administration (VHA) has primary responsibility for the infection control program?

4) What system does VHA currently have in place to track rates of health care-associated infections in VA health care facilities?

    a. How is the data collected? Please describe in detail.

    b. Is the data made available to VA health care providers?

5) What is VHA's budget for its health care-associated infection control program and how is it allocated among the VHA offices?

    a. Does VHA have specific guidelines for infection control staffing levels? Please describe.

    b. What specific products, resources, or training over the last five years has been made available to VHA health care providers to minimize and prevent health care-associated infections?

6) Has the VA, VHA and/or other government entities or third parties reviewed VA's infection control program in the last five years? If so, please provide a copy of the review(s) and specify whether or not the VA implemented changes to its infection control program in response to any recommendations.

7) If the patients who were treated using the contaminated dialysis machines have not been informed of the potential risk of infection, please explain why they have not yet been notified. If all the patients have since been notified, please specify when they were contacted.

Thank you in advance for your attention to this important matter.

Sincerely,
Charles E. Grassley
United States Senator
Ranking Member of the Committee on Finance

Enclosure