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

June 19, 2009

Dear Secretary Shinseki,

I am writing to you today to express my concern over the Department of Veterans Affairs (VA) Inspector General (IG) report released on June 16, 2009. This report, entitled "Use and Reprocessing of Flexible Fiberoptic Endoscopes at VA Medical Facilities," highlighted a number of widespread lapses in hygienic standards of endoscopy equipment.

In response to the December 2008 discovery of lapses in hygienic endoscope procedures at the Alvin C. York Veterans Affairs Medical Center (VAMC) in Murfreesboro, and the subsequent March 2009 discovery of similar problems at the Bruce W. Carter VAMC in Miami, the VA IG instituted this investigation to determine whether such lapses were common throughout the VA. Unfortunately, they were.

During May 13-14, the IG conducted surprise inspections of a random sample of 42 VHA facilities, including the VA Nebraska Western Iowa Health Care System in Omaha. In all, 38 High-Level Disinfection (HLD) colonoscope reprocessing units and 37 Ear, Nose and Throat (ENT) endoscope reprocessing units were examined. The IG report concluded that "Facilities have not complied with management directives to ensure compliance with reprocessing of endoscopes, resulting in a risk of infectious disease to veterans." The report further concludes that "The failure of medical facilities to comply on such a large scale with repeated alerts and directives suggests fundamental defects in organizational structure."

I am particularly concerned with the significant deficiencies in VA employees' knowledge of and compliance with proper flexible endoscope cleaning and reprocessing procedures. The IG's inspection in May found that out of the sampled colonoscope reprocessing units, less than half – 47.4 percent – were in compliance with both Standard Operating Procedures (SOP) display and staff competence regulations . Based on this sample, the report estimates that 42.5 percent of colonoscope reprocessing units throughout the Veterans Health Administration (VHA) are in compliance with both sets of regulations. Endoscope reprocessing rates were similarly poor, with an examined 48.6 percent compliant with both sets of regulations and an estimated 47.3 percent throughout VHA.

I understand that proper standard sterilization procedures are extensive. They begin with pre-cleaning and disinfection by immersion in a disinfecting liquid and end with the application

of alcohol and equipment storage in a proper environment, as directed by the manufacturer. At least, they are supposed to be.

I am deeply troubled that American veterans are being put at risk of deadly infection because of unhygienic VA procedures. Such risk is unacceptable for ~~those~~ the brave men and women who have protected our nation in the past. In light of the results of the IG's conclusion regarding VA organizational problems, and especially since past directives have been ineffective, how will VA ensure that proper procedures are followed in the future?

I am also concerned about the timeliness of any potential remedial action. Nebraska is a rural state, and many veterans cannot easily go to a different VA medical facility if the closest one is unhygienic. Since choice for rural veterans is limited, the VA must move rapidly to ensure that all of its facilities are clean, following proper guidelines, and have staff practicing correct procedures. When do you expect your corrective action to be complete and achieve a positive, desired result? How will you verifiably measure results to ensure remedial action is effective and not short-lived?

Thank you for your time, and I look forward to your prompt response.

Sincerely,

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Mike Johanns
United States Senator

United States Senate

WASHINGTON, DC 20510

June 19, 2009

The Honorable Tom Vilsack
United States Department of Agriculture
14th and Independence Ave, SW
Washington, DC 20250

Dear Secretary Vilsack:

We write to support the request of Nebraska Governor Dave Heineman and Nebraska Agriculture Director Greg Ibach for additional assistance from the U.S. Department of Agriculture to address the recent discovery of bovine tuberculosis (TB) in Nebraska.

The importance of beef production to the region cannot be overstated. In order to preserve the economic vitality of the industry, the TB incident must be addressed as aggressively and immediately as possible. As you know, this involves an epidemiological investigation, testing of quarantined herds, and depopulation of effected herds. The need for personnel and resources is significant, and we urge you to provide additional veterinarians and indemnification funds.

As you know, there are currently 15,000 head of cattle that have been quarantined for testing, with TB exposure risk across Nebraska, Colorado, and South Dakota. This is not just a Nebraska issue or a Midwest issue. Considering the significant amount of beef produced in the Midwest, this problem could affect the beef industry nationwide. The scope and seriousness of this problem demand a federal response.

We appreciate the support USDA has already provided in the form of additional veterinarians and indemnification funds, and we are grateful for your continued attention to this matter.

Sincerely,

Senator Mike Johanns

Senator Ben Nelson

Congressman Jeff Fortenberry

Congressman Lee Terry

Congressman Adrian Smith