Congress of the United States
Washington, DC 20515

February 16, 2016

Secretary Robert A. McDonald
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonald:

We are writing you to express our disappointment and concern over a potential Tuberculosis (TB) exposure at the Department of Veterans Affairs (VA) Palo Alto Medical Center. According to information provided by the VA, as many as 177 veterans and 53 employees were potentially exposed to TB late last year, leading to the subsequent exposure of those who assist and provide services to veterans, including congressional staff. This is unacceptable.

In October 2015, an employee at the VA Palo Alto hospital tested positive for TB and continued to work at the facility until management was notified in January 2016. It is troubling that the employee failed to alert any direct supervisors of their health status, yet shared the TB results with colleagues. And although we respect the privacy of those who may be affected and the need to prevent undue alarm, we find the speed at which information is released to be troubling.

The VA failed to follow public health protocol and notify anyone who may have come into contact with exposed veterans or employees. The lack of notice to not only VA visitors, but also our staff, who regularly came into contact with veterans who were exposed, is also deeply concerning.

The VA has been contacting the veterans who may have been impacted by this incident via phone call; these veterans will need to take additional tests to determine if they have TB, and will need to return for a follow-up exam 6-8 weeks after the initial test. The VA also plans to inform veterans about their right to use legal avenues against the VA as a result of this incident.

An independent assessment of the Veterans Health Administration as required by the Veterans Choice Act, detailed the massive undertaking needed to improve care at VA facilities across the nation. The report noted that, "While VHA exhibits a deep commitment to serving Veterans…VHA's health care facilities provide strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency."

The Palo Alto Health Care System is a leader in quality of care and innovation not only in VA health facilities, but for medical facilities across the U.S. VA health facilities in Pittsburgh, PA and Loma Linda, CA have also dealt with TB exposure, further underscoring the need for a uniform policy and training across the system. A lack of uniformity system-wide and a culture that requires overhaul in many respects have proven problematic. The VA must have protocols in place for notifying management in instances of exposure to a particular disease or infection.

We know that you, your staff, and VA employees are committed to caring for veterans, and that you will take all necessary steps to protect patients, visitors, and staff system-wide. To that end, we request an update on the potential TB exposure situation and have enclosed a list of questions. Please send us your response as soon as possible. We appreciate your attention to this urgent matter.

1. Is the VA implementing a plan to ensure more unified operations and reporting at its medical facilities? When will this be implemented, if not done so already?
2. What are the current protocols for supervisors throughout a VA health facility to share information throughout the VA health system, from employee through the Secretary?
3. What are the current protocols for the VA to notify veterans when they are potentially affected by an illness or disease caused by medical equipment or personnel? Are there established timelines for the VA to notify veterans in these instances?
4. Is the VA developing a communications outreach plan to all those – including visitors – who may be affected by TB?
5. Does the VA compensate veterans for additional medical services that are required as a result of a potential exposure? What are the steps taken by the VA should a veteran become infected?
6. What are the consequences for employees who fail to report potential medical improprieties?
7. What is the VA doing to assist the employees who were exposed to their co-worker? Are they being compensated for additional medical care needed as a result of the exposure; is the VA providing paid leave; are they eligible for legal action against VA?

Sincerely,

Jerry McNerney
United States Representative

Jeff Denham
United States Representative

Mark DeSaulnier
United States Representative

Mike Honda
United States Representative

Zoe Lofgren
United States Representative

Cc: Dr. David Shulkin, Undersecretary for Health
Elizabeth Freeman, Director of the VA Palo Alto Health Care System