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October 2, 2018

The Honorable Robert Wilkie
Secretary of Veterans Affairs

Dr. Richard A. Stone
Executive in Charge
Veterans Health Administration

U.S. Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, DC 20420

Dear Secretary Wilkie and Dr. Stone,

I write to further inquire about the training and supervision of employees of the Department of Veterans Affairs (VA) who have patient care roles. Specifically, I seek clarification of a response I received from former Secretary Shulkin on this topic earlier this year. Although I appreciate the VA's answers to my questions, I am alarmed that the VA's response reveals that it does not ensure that its employees who directly provide care to our veterans receive robust education and training.

In response to an October 2017 letter I sent to then-Secretary Shulkin concerning the death of Vietnam veteran William Nutter, the VA shared several examples of how the agency trains health care workers in patient care roles.[1] Much of the training appears to center around voluntary online workshops, with minimal accountability. Further, there appears to be little structure to, or oversight of, the training of VA employees directly responsible for the wellness and safety of some of our sickest veterans.

This absence of consistent, uniform training is particularly concerning in light of a recent story in the *Boston Globe* and *USA TODAY* alleging disturbing, substandard care at the Edith Nourse Rogers Memorial Veterans Hospital, also known as the Bedford VA.[2] I have met many of the competent and compassionate individuals who care for veterans at the Bedford VA, and it is

[1] Letter from Dr. David Shulkin, then Secretary of Veterans Affairs, to Sen. Edward J. Markey (Jan. 10, 2018).
[2] Andrea Estes and Donovan Slack, *Bed sores, neglect, alleged abuse: inside the Bedford VA nursing home,* Boston Globe and USA Today (Sept. 4, 2018), https://www.bostonglobe.com/metro/2018/09/03/bed-sores-neglect-alleged-abuse-inside-one-lowest-rated-veterans-nursing-homes-country-bedford/9COivG8mpVathjErrrA9nM/story.html.

shameful that these latest allegations cast a shadow on their good work at an institution dedicated to caring for those who have given so much to this country.

We must not allow any maltreatment of our nation's veterans to be accepted as normal, especially when training and educational resources are available to help prevent it from occurring in the first place.

I appreciate that patient care training and enforcement regimes may vary throughout the VA. But I am concerned that the VA does not sufficiently emphasize adequate employee training and oversight. To better understand how the VA applies the education and training standards and manages the related resources that are referenced in then-Secretary Shulkin's January 2018 response to my inquiry, please answer the following questions:

1. In response to my question about the guidance the VA provides to hospitals to ensure that Nursing Assistants are adequately trained and capable of performing their patient-care roles (Question 1.a), the VA stated that the "Office of Nursing Services (ONS) provides guidance to executives, senior leaders, and mid-level nursing supervisors via national standardized training courses." The VA gave the same response to my question about the guidance it provides to hospitals to ensure that supervisors are adequately trained to oversee health care workers in patient care roles (Question 1.b).

   In response to another question about training (Question 2), the VA replied that there are currently 20 online courses designed specifically for Nursing Assistants "relating to the topics of sensitivity training and communication/bedside skills with patients and family members."
   a. Does the VA update these training courses? If so, how often? When was the last time these training courses were reviewed? How does the VA decide when to update training courses? If not, why not?
   b. Does the VA keep records of which facilities access these training courses?
      i. If yes, what percent of VA facilities access them? What percent of these VA facilities have made accessing at least some of these training programs mandatory? Do facilities accessing these courses report to the VA who is accessing them (e.g., nurse managers, registered nurses, licensed practical nurses)?
      ii. If the VA has not made accessing these training courses mandatory, why not? Does VA believe that a baseline level of training and education for direct patient care personnel should be required?
   c. Please provide any available information regarding the Bedford VA's use of these training resources.

2. In response to my question about the guidance the VA provides to hospitals to ensure that Nursing Assistants are adequately trained and capable of performing their patient care roles (Question 1.a), the VA stated that "success is enforced by the inclusion of annual performance plan critical element statements on leading people . . . ."

a. Do any VA facilities specifically require completion of ONS training programs as part of an employee's evaluation or performance measurement plan?
b. Has the VA considered other enforcement mechanisms to ensure personnel are adequately trained? If so, please describe them. If not, why not?

3. In response to my question whether the VA intends to issue uniform federal guidance for the training of Nursing Assistants (Question 1.a.i), the VA responded that the "VA does not issue guidance across the system in response to isolated incidents, and there is currently no plan to do so." The Veterans Health Administration (VHA) does issue national guidance on policy issues, but enforcement is left up to individual facilities.
   a. Has the VHA ever issued a directive on personnel training? If yes, please provide the directive number. If not, please explain why the VHA believes that is unnecessary.
   b. Does the VHA typically cede enforcement of directives to facilities? If so, please explain why.
   c. Please provide examples of VHA directives, if any, that do not cede enforcement to individual facilities.

4. In response to my question about bedside manner and sensitivity training for health care workers directly involved in patient care (Question 2.a), the VA described its 2005 "Civility, Respect, and Engagement in the Workplace (CREW)" voluntary initiative to help improve the workplace atmosphere throughout the VA, with the ultimate goal of improving patient care. While the program's intent is laudable, the VA has not made participation in it mandatory.
   a. According to the VA's response to Question 2.a, more than "1,200 VA work groups" have utilized CREW. How many VA facilities have made it part of their bedside manner and sensitivity training?
   b. Why did the VA decide not to make CREW mandatory?
   c. Have working groups within the Bedford VA used CREW? If so, please identify them and when they did.

5. In response to my question about the VA's engagement with individual hospitals when inappropriate or inadequate care causes a patient harm (Question 1.c), the VA stated that, "[i]f needed, local leadership will call for a Root Cause Analysis process that investigates and develops a plan to resolve the problems."
   a. Are decisions to engage in a Root Cause Analysis process made at the Veteran Integrated Services Network (VISN), the individual facility level, or somewhere else?
   b. How does the VHA ensure that individual facilities comply with plans developed through the Root Cause Analysis process? What enforcement action can the VHA take if there are repeated incidents?
   c. Has the Bedford VA initiated a Root Cause Analysis process in response to the death of William Nutter? Has the Bedford VA engaged in a Root Cause Analysis

process for the incidents involving Russ Bonanno described in the September 4 report in the *Boston Globe* and *USA Today*?

i. If yes, please provide a status update on this process. Will any investigation results and remedial plans be made public?

6. Last year, the VA created the Office of Accountability and Whistleblower Protections (OAWP). Specifically, OAWP "manages all internal affairs and has a broad and expansive mission to protect whistleblower rights and recommend discipline and/or termination of employees due to poor performance or misconduct."[3]
   a. The *Boston Globe* reported instances in which veterans' families were fearful of reporting issues with caregivers and care quality, concerned that the care their loved ones receive would suffer in response.
      i. What resources does the OAWP provide for family members concerned about the care their loved ones receive at a VA facility? If this is beyond the OAWP's jurisdiction, does any other VA entity provide these resources for families?
   b. Does OAWP require, or intend to require, any sort of mandatory employee training related to whistleblower retaliation and whistleblower protections?
      i. If yes, please describe the timeline for this training, including which employees will receive it.
      ii. If no, please describe why the VA believes whistleblower protection training for employees is unnecessary.

7. Please provide a copy of the recommendation made by the Geriatrics and Gerontology Advisory Committee to the Secretary of the VA concerning geriatric competencies discussed in response to Question 5.

Please respond no later than October 26, 2018. Should you have any questions about this request, please contact Nikki Hurt in my office at 202-224-2742. Thank you for your commitment to our nation's veterans and for your prompt attention to this important matter.

Sincerely,

Edward J. Markey

Edward J. Markey
United States Senator

cc: Dr. Joan Clifford, Bedford VA Medical Center Director

[3] VA Office of Accountability and Whistleblower Protection, https://www.va.gov/accountability/ (last visited Sept. 25, 2018).