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SUITE SD-255
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WASHINGTON, DC 20510-2107
202-224-2742

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508-677-0523

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October 24, 2017

The Honorable David J. Shulkin
Secretary of Veterans Affairs
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Secretary Shulkin:

I write in regards to the disturbing details revealed in *The Boston Globe* story around the death of veteran William Nutter and the apparent deficiencies in care he received at the Bedford Veterans Affairs (VA) Medical Center. I join in calls to expeditiously investigate Mr. Nutter's death and rectify the systemic voids in leadership that may have exacerbated the substandard quality of care and inadequate living conditions experienced by some of the veterans at the VA.

While I applaud the VA Inspector General for conducting a criminal investigation into this particular case, the *Boston Globe* story raises significant concerns about whether the VA has and also enforces adequate standards for the training and supervision of health care workers. Specifically, the story makes clear that Mr. Nutter's death was not an isolated incident at the Bedford VA, citing several other concerning observations and situations raised by whistleblowers or veterans' family members. These types of issues are not confined to the Bedford VA. Earlier this year, I raised concerns to you after the *Boston Herald* reported on inaccurate diagnoses of traumatic brain injury at the Boston VA.

Unsatisfactory care and unsafe conditions are an inexcusable transgression against our veterans. There must be robust training and supervision standards in place – and these standards must be enforced – to ensure those providing and assisting with the care of our veterans are appropriately trained and held accountable to the veterans they serve.

To better understand the VA's role in providing uniform and adequate training and supervision standards throughout the VA, please provide answers to the following questions no later than November 17, 2017.

1. What is the role of the national VA in ensuring adequate training and supervision standards for health care workers in individual hospitals? Specifically:

a. What guidance does the VA provide to hospitals to ensure nurse's aides are adequately trained and capable of performing their patient care roles? How is this guidance enforced?
    i. If federal, uniform training guidance does not currently exist, does the VA intend to issue such guidance? What is the timeline and how would this guidance be enforced?

b. What guidance does the VA provide to hospitals to ensure that supervisors are adequately trained to oversee health care workers in patient care roles? How is this guidance enforced?
    i. If federal, uniform supervision guidance does not currently exist, does the VA intend to issue such guidance? What is the timeline and how would this guidance be enforced?

c. How does the federal VA interact with individual hospitals when there is evidence that inappropriate or inadequate care provided by a health care worker resulted in a harmful outcome to a patient?

2. How does the VA ensure that all health care workers who interact with veterans and families communicate clearly and effectively about a veteran's health care conditions or situations that may have caused adverse health outcomes?
    a. Does the VA require bedside manner or sensitivity training to health care workers who may not receive such training as a part of their formal education?

3. Please describe the programs you have initiated to help improve the quality of care provided to veterans throughout the VA system, specifically citing any efforts to ensure uniform training standards and enforcement of these standards across the country.

4. Does the absence of permanent leadership at a VA medical center, specifically at the Bedford VA, impact the quality and consistency of the training and supervision of VA personnel?
    a. What is the agency doing to provide a permanent director at the Bedford VA?

5. Does the VA need any additional resources or authorities from Congress to help the agency address and rectify health care quality and safety concerns raised by whistle-blowers and family members of veterans, particularly as it pertains to appropriately training health care workers and their supervisors?
    a. If so, please provide specific examples of what these resources and authorities would be and how they may have prevented the tragedy like the one that occurred at the Bedford VA.

I appreciate your commitment to holding health care workers throughout the VA system more accountable to our nation's veterans and their unique health care needs. In addition to providing answers to the above questions, I request an in-person update on your efforts to ensure the Bedford VA and VA medical centers across the country are providing the appropriate training

and supervision standards for their personnel. My office stands ready to work with you to improve the quality of care veterans receive throughout the VA system.

Please contact Nikki Hurt (nikki_hurt@markey.senate.gov) in my office with any questions or concerns. Thank you for your prompt attention to this matter.

Sincerely,

Edward J. Markey

Edward J. Markey
United States Senator