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January 30, 2013

Hon. Eric Shinseki
Secretary
Department of Veterans Affairs
810 Vermont Ave. NW
Washington D.C. 20420

Dear Secretary Shinseki,

RE: Hospital Acquired Infections in the Buffalo VA Hospital

I write further to my concern about the revelation that over 700 veterans and their families may have been exposed to deadly pathogens at the Buffalo VA Hospital due to negligently administered insulin pen injections.

As you know, hospital acquired infections are largely avoidable through the implementation of proper training and nursing techniques. In fact, in 2009 the Veterans Administration (VA) began working with the Department of Health and Human Services and the Department of Defense to develop strategies to eliminate hospital acquired infections. In 2010 they created the *Hospital Acquired Infections Action Plan* to provide recommendations and best practices to begin addressing these issues.

So the VA was clearly well aware of the issue when, in March 2009, the Food and Drug Administration issued an alert about the potential for spreading blood borne pathogens when administering insulin pens improperly. That warning came after a military hospital in Texas had to alert over 2,000 patients that may have been infected from 2007-2009 because of poor handling of multiuse insulin pens.

On January 5, 2012 the Center for Disease Control (CDC) also issued a clinical alert spelling out specific high risk practices that would lead to additional hospital acquired infections if they were not addressed. The specific recommendations were as follows.

- Insulin pens containing multiple doses of insulin are meant for use on a single person only, and should **never** be used for more than one person, even when the needle is changed.

- Insulin pens should be clearly labeled with the person's name or other identifying information to ensure that the correct pen is used **only** on the correct individual.
- Hospitals and other facilities should review their policies and educate their staff regarding safe use of insulin pens and similar devices.
- If reuse is identified, exposed persons should be promptly notified and offered appropriate follow-up including blood borne pathogen testing.

What is troubling is that despite the VA's involvement in a multiagency effort to combat hospital acquired infections, when asked about the 2009 FDA alert and the 2012 CDC alert the Buffalo VA spokeswoman responded, "we do not have a record of receiving the FDA alert or clinical reminder."

It gets worse. A report from the Department of Veterans Affairs Office of the Inspector General in 2008 "identified unsafe injection practices which placed patients at risk for exposure to blood borne pathogens" at the VA Southern Nevada Healthcare System. And in testimony before the Committee on Veteran's Affairs on May 3, 2011 Michael Bell, the Deputy Director of the CDC for Healthcare Quality Promotion, said, "recent infection control lapses, such as those at VA facilities in Dayton OH, St. Louis MO, and Miami FL, demonstrate the need for constant vigilance."

Furthermore the VA is a member of Clinical Outreach Communication Activity or COCA. This group seeks to educate clinicians on the newest treatments and procedures to ensure patient safety and medical effectiveness. In March of 2008 COCA held a conference call which focused chiefly on the goal of eliminating hospital acquired infections specifically from unsafe injection practices. This conference call illustrated the continued challenge to address preventable infections from the misuse of needles, syringes and multiuse insulin pens. Dr. Arjun Srinivasan on the conference call commented on the findings at the VA healthcare facility in Nevada and the ongoing efforts to educate providers. "Another question that's come up a lot particularly with the recent publicity of the episode in Nevada; are these recommendations new? And I think this is, again, an important point to emphasize that the answer is no, these recommendations are definitely not new; they're parts of established guidance. It's a well-established practice to never use the same syringe or needle for more than one patient. And not to enter a medication vial with a syringe or needle used for one patient if that vial is going to be used for another patient."

In addition to federal warnings and recommended procedures the CDC in NYS has had a well-funded campaign to address the needs of providers in improving their patient care safety known as the *One & Only Campaign*. The program seeks to raise awareness amongst patients and support reeducation to providers in order to prevent further exposure to blood borne pathogens through unsafe injection practices. The campaign cites data that over 150,000 patients have been notified since 2001 because of accidental exposure to disease while undergoing care.

A reading of these facts would lead one to conclude that the VA was already aware of the potential for infection from negligently administered injections when it received warnings from the VA Inspector General in 2008, the FDA in 2009, and the CDC in 2011 and 2012, and yet these communications were either not received or were ignored by the Buffalo VA.

When the alerts issued by the federal agencies charged with setting public health policy are not being received by the federal government's largest health care provider, we have an unacceptable breakdown of communication. There is a structural deficiency in how the VA is receiving these warnings from its sister agencies, or in how the VA is communicating these warnings to its hospitals across the country. Either is unacceptable.

The sad truth is that this lack of attention and action on the part of the VA has resulted in poor care for our veterans and will continue without action. Therefore I ask that you undertake an evaluation of this breakdown in communication and identify why these alerts were missed and what is being done to improve communication and coordination between the VA and the FDA, CDC and other public health agencies.

Sincerely,

A handwritten signature in blue ink that reads "Brian Higgins". The signature is stylized with a large, sweeping initial "B" and a trailing flourish.

BRIAN HIGGINS
Member of Congress