Congress of the United States
Washington, DC 20515

June 8, 2022

The Honorable Denis McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, D.C. 20420

Dear Secretary McDonough:

We are appalled by the information presented in the May 31, 2022 U.S. Department of Veterans Affairs Office of Inspector General (OIG) Report, "Failure to Provide Emergency Care to a Patient and Leaders' Inadequate Response to that Failure at the Malcom Randall VA Medical Center (MR VAMC) in Gainesville, Florida." The report details an incident in June 2020 when MR VAMC Emergency Department (ED) nurses and administrative staff prioritized determining the patient's veteran status over rendering him emergency care. Alachua County EMS subsequently transported the patient across the street to UF Health Shands Hospital who admitted the patient. According to the OIG report, the patient was later determined to be an eligible veteran. Shands UF provided emergency care, but the veteran passed away approximately 10 hours after admission. This incident, and potentially others mentioned in the report, call into question the competency, professionalism, and commitment of MR VAMC ED medical providers and staff to our nation's veterans.

The OIG report noted what appears to be "differing accounts of professionalism among EMS and VA staff." The report found that not only did the "[ED] nurses [fail] to provide emergency care access to the patient," but when they conducted their own assessment, they "failed to recognize the criticality of the patient." According to the report, "the nurses' inaccurate visual assessment impeded the patient's access to an emergency medical evaluation and care." This information is extremely troubling for all veterans who trust the MR VAMC. The report and its conclusions should concern anyone seeking emergency treatment at MR VAMC, or is brought to the facility in a condition in which they could not articulate their medical care needs, would not be given timely and proper assessment and treatment.

The OIG report also notes that MR VAMC ED medical providers and administrative staff have repeatedly violated the Veterans Health Administration's Emergency Medical Treatment and Labor Act (EMTALA) policy, which requires an ED to provide a medical screening examination and treatment to stabilize patients with emergency medical conditions. The report included a chart that showed at least seven EMTALA-related incidents involving delays or denials of care from 2018 to 2021 at the MR VAMC. One of incidents on the chart "identified nine additional patient safety reports related to delays or denial of care due to EMTALA-related or patient registration issues." Given these factors, we request that you provide a detailed list of:

- How many incidents of EMTALA-related or patient registration issues took place at MR VAMC during this period;

- How many resulted in the injury or death of a patient;
- Whether any staff received disciplinary or dismissal actions; and
- The average time of delays in care or patient registration.

Please provide similar information for the same period for other VISN 8 medical centers and compare with the Veterans Health Administration's records for this same period.

The OIG report indicated there are questions about 2019 Ongoing Competency Assessments for some ED nurses involved in the incident. Further, the actions of the ED Nurse Educator seem to indicate that individual may have submitted falsified documents regarding the competency assessments of two of the nurses involved in the incident. It also appears the Chief of Nurse Education did not complete required Annual Nursing Competency Certification assessments in 2018 or 2019 prior to the incident. This is unacceptable.

The OIG report stated the Chief of Quality Management and Quality Management Team did not track action items from the Administrative Investigation Board (AIB), provided incorrect information to the OIG, and did not appear to make any significant efforts to provide oversight of action items from the AIB – including the need for an ED EMS Radio and Ambulance Bay Video Camera.

- Who or what office conducts oversight of the Chief of Quality Management and the Quality Management Team?
- What has been done to ensure action items from the AIB are being completed?

Further, we are deeply troubled by the previous MR VAMC Director's decision to rescind recommended disciplinary action against certain ED staff. We also note that the OIG recommended that VISN 8 review this incident to determine if further administrative action and/or reporting to state licensing boards is warranted in this matter. However, the September 30, 2022 completion date on that action is unacceptable. We urge you to ensure these determinations and responses to all OIG recommendations are made by June 30, 2022.

Finally, the VA must demonstrate to veterans and their families in the MR VAMC catchment area, and nationwide, that the MR VAMC ED is knowledgeable, competent, and dedicated to its veteran patients. Our nation's veterans have served their country honorably. They should not have to worry about gross incompetence and negligence when they seek care, especially in emergency situations where timely, efficient, and effective care is vital.

We look forward to your prompt response.

Sincerely,

Marco Rubio	Kat Cammack	Rick Scott
U.S. Senator	Member of Congress	U.S. Senator