Congress of the United States
Washington, DC 20515

May 14, 2018

The Honorable Mark Meadows
Chairman
Subcommittee on Government Operations
Committee on Oversight & Government Reform
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Jack Bergman
Chairman
Subcommittee on Oversight & Investigations
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Meadows and Chairman Bergman:

We write to request a joint hearing in the House Committee on Oversight and Government Reform Subcommittee on Government Operations and the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations to examine the critical deficiencies at the Washington, DC Veterans Affairs Medical Center (DC VAMC).

On April 12, 2017, the VA Office of Inspector General (VAOIG) took the unusual step of issuing an interim report detailing critical personnel vacancies, unsanitary conditions, and inventory management issues at the DC VAMC. The interim report warned that the hospital's practices put "patients at unnecessary risk" and led to the eventual firing of the medical center's former director Brian Hawkins.

On March 7, 2018, the VAOIG issued its final report highlighting that leadership failures and pervasive understaffing underpinned widespread issues in inventory management, sterile processing, and patient safety. The VAOIG found that the DC VAMC has for many years suffered a series of systemic and programmatic failures that made it challenging for healthcare providers to consistently deliver timely and quality patient care. The VAOIG also found continual mismanagement of protected information and significant government resources, putting them at risk for fraud, waste, and abuse. The report makes it is clear that these problems have persisted for the better part of a decade.

Following the final report's release, officials from the U.S. Department of Veterans Affairs (VA) briefed House Veterans Affairs Committee staff that delays in patient care and supply shortages were no longer occurring as of January 2018. Yet, recent reports show that seven procedures were canceled due to supply shortages in February and March of this year, contrary to the Department's claims.

We have a sacred obligation to ensure that the men and women who sacrifice so much to defend our freedoms receive the highest quality care and services. The VAOIG's yearlong investigation revealed that the DC VAMC has at times fallen far short of that standard. Such poor performance is simply unacceptable. We owe it to our veterans to not only address these problems, but also to understand how they were allowed to arise in the first place.

Our committees can play a critical role in highlighting these issues at the DC VAMC and ensuring that such abhorrent conditions never occur again. We respectfully request that you convene a hearing on these matters.

Sincerely,

Gerald E. Connolly
Ranking Member
Subcommittee on Government Operations

Ann McLane Kuster
Ranking Member
Subcommittee on Oversight and Investigations

Elijah E. Cummings
Ranking Member
Committee on Oversight and Government Reform

Tim Walz
Ranking Member
Committee on Veterans Affairs