



**THE SECRETARY OF VETERANS AFFAIRS  
WASHINGTON**

August 12, 2013

The Honorable Jeff Miller  
Chairman  
Committee on Veterans' Affairs  
U.S. House of Representatives  
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letter to President Obama regarding patient care at Department of Veterans Affairs (VA) medical centers. VA is committed to providing the highest quality care our Veterans have earned and deserve. Like you, I am saddened at the occurrence of any adverse consequence that a Veteran might experience while in or as a result of care at one of our medical centers. When they occur, the Veterans Health Administration (VHA) is committed to identifying, mitigating, and preventing safety risks within the VA health care system.

Each year, over 200,000 VHA leaders and health care employees provide exceptional care to approximately 6.3 million Veterans that is consistently recognized by The Joint Commission and dozens of other internal and external reviews. In 2012, 19 VA medical facilities from across the Nation were recognized by The Joint Commission as top performers on key health care quality measures. We value transparency; VA's Office of Quality, Safety, and Value publishes an extensive annual Quality and Safety Report that details all aspects of our health care quality and safety by facility. We rigorously conduct patient satisfaction surveys that consistently show that our patients experience a level of satisfaction comparable to the private sector. The preponderance of evidence affirms that at the system level, Veterans are being well-served through a highly-effective integrated health care system that is administered by a caring and effective workforce.

VA has established a record of safe health care, and, while it is our goal, no health care system can be free of inherent risks and adverse patient incidents. In the incidents mentioned in your letter, and where other challenges occur, VA takes direct action to review each incident, and put in place corrections to improve the quality of care provided. We work hard to incorporate lessons learned so that future incidents in identified areas can be avoided or mitigated. As a specific example, VA identified the improper use of single use insulin pens at the Western New York Healthcare System. Following that discovery, VA reviewed the issues systemwide and found a few staff at two other VA facilities had improperly used the pen. Disclosures were made and testing was completed. In January 2013, VA took direct action to prohibit the routine use of insulin pens on inpatient units and expanded this to include all multi-dose pen injectors. Other patient safety organizations have since followed VA's lead.

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VA embraces a patient safety culture that allows staff to feel safe to report patient safety risks. Such an environment is characterized by increasing reporting and monitoring; resulting in an informed health care system that learns from past incidents in order to mitigate future adverse events. This commitment requires constant vigilance, self-reporting, openness, and accountability.

VA will continue to ensure accountability and seek continuous improvement as it delivers high quality health care to our Nation's Veterans.

Should you have any questions or concerns, please have a member of your staff contact Ms. Jill Snyder, Congressional Relations Officer, at (202) 461-5774 or by e-mail at [Jill.Snyder@va.gov](mailto:Jill.Snyder@va.gov).

Thank you for your continuing support of our mission.

Sincerely,

A handwritten signature in blue ink, appearing to read "Eric K. Shinseki". The signature is fluid and cursive, with a large initial "E" and "S".

Eric K. Shinseki