Congress of the United States
Washington, DC 20510

July 15, 2022

Dr. Taquisa K. Simmons
Executive Director
Hampton VA Health Care System
100 Emancipation Drive
Hampton, VA 23667

Dr. Simmons:

We write to reiterate our serious concern over the recent report by the Department of Veterans Affairs (VA) Office of Inspector General (OIG), titled *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia.*[1]

We are appalled and disheartened to learn that a series of avoidable failures at the Hampton VA Medical Center (VAMC) led to a veteran's cancer diagnosis being delayed. According to the report, "[t]he OIG identified multiple providers' failures to communicate, act on, and document abnormal test results from July 2019 to April 2021." The report delineates several stages during this veteran's care where providers at the VAMC should have responded more diligently and promptly to provide a thorough and appropriate level of treatment. The findings also indicate a breakdown in a number of processes that should have prevented the gaps and missed hand-offs in care for the patient. Ultimately, the OIG findings suggest a series of careless, dangerous, and unacceptable care coordination and communication failings, both at the individual and systemic levels.

As you know, veterans and their families must be able to trust that they are receiving high-quality, comprehensive, and timely health care whenever they turn to the VA. They should also be confident that every health care professional they encounter in a VAMC will make every effort to provide such care. The OIG has outlined a series of recommendations for the Hampton VAMC to address issues revealed by the report. The identified failings cannot be allowed to persist, and it is crucial that these recommendations are quickly and fully implemented.

As such, we ask that you submit a detailed plan and briefing to our offices with timelines on how the Hampton VAMC intends to meet each of the OIG's recommendations. This plan should also detail actions taken to date, proposed processes and safeguards to prevent similar future cases, oversight to ensure safeguards will be enforced, and any steps – planned or already taken – towards accountability.

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[1] "Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia." *Department of Veterans Affairs Office of Inspector General, Office of Healthcare Inspections.* Report #21-03349-186. 28 June, 2022

Given the importance of the Hampton VAMC to thousands of veterans, we will continue to engage with your team in the coming weeks and months as you work to remedy these issues. Please know that we also expect regular updates to flow from your team to our staffs in the interim.

Sincerely,

MARK R. WARNER
United States Senator

TIM KAINE
United States Senator

ROBERT C. "BOBBY" SCOTT
Member of Congress

ELAINE G. LURIA
Member of Congress