Chairwoman Kiggans, Ranking Member Ramirez, and distinguished members of the Committee:

Thank you for the opportunity to testify today on behalf of Healthcare Sterile Processing Association (HSPA) and the 60,000 sterile processing technicians across the United States, including the roughly 3,400 serving in positions within Department of Veterans Affairs (VA) medical facilities. As a veteran, and a sterile processing professional, I am honored to speak in strong support of legislation efforts to improve credentialing and training efforts within VA sterile processing departments.

Sterile processing is not widely understood by the average patient, yet it is the *foundation of surgical safety* and directly influences clinical outcomes. Sterile processing technicians are responsible for the disassembly, cleaning, inspection,

sterilization, and reassembly of every surgical instrument used in patient care. Although many technicians do not hold advanced degrees, they are required to maintain deep technical knowledge of more than 37,000 surgical instruments and to perform their work with a high level of precision under mission-critical conditions.

A hospital with 15 operating rooms performs roughly 13,000 surgical cases annually, which translates to an average of 450 instrument-related steps per procedure or big picture 5 million instruments processed yearly. That level of complexity underscores the need for evidence-based standards, clinical risk mitigation, and high-reliability processes performed by certified professionals.

Many major hospital systems including, Memorial Hermann Health System where I previously served as Regional Director

and University of Virginia Health System where I am currently serving as the Administrator of Sterile Processing, have voluntarily adopted credentialing requirements, and seven states require them at all hospitals and ambulatory surgery centers, however, these standards do not apply to federally operated hospitals like those run by VA.

While VA has made progress within the last couple of years by requiring certain staff, such as VA medical facility Sterile Processing Staff Chiefs, to obtain certification from an accredited institution within one year of appointment, the rest of the sterile processing technicians are only required to complete an online learning management training which can be compared to the online training with minimal oversight, similar to what many experience taking cybersecurity training. These modules lack the rigor, competency-based assessment, and

third-party oversight provided by accredited certification bodies.

Chairwoman's Kiggans draft legislation requires certification from an accredited institution. Accreditation is an impartial, third-party that sets the standards for certification program practices and administration. By holding an accredited certification, you demonstrate to your employer, the community, and to yourself, that you have the skills and knowledge required to complete your job as defined by the leading authority in the credentialing industry.

Similar to many industries, the surgical industry is constantly evolving and so are the surgical instruments. Ensuring a culture of safety means staff are held to high standards like certification and resourced properly through regular on the job training. We

believe all the sterile processing technicians within VA should be certified and trained on a continual basis, which is why we are supporting the legislation drafted by Chairwoman Kiggans.

Contaminated equipment /instruments expose veterans to dangerous pathogens, costly follow-up care, and lengthy delays at a facility when contamination incidents occur. Here are a couple of examples of outbreaks of dirty surgical instruments at VA facilities across the country:

- In January 2022, OIG found that 4,500 veterans who underwent surgical procedures at Carl Vinson Hospital in Georgia in 2021 may have been exposed to HIV and Hepatitis due to improper sterilization procedures.[i] In a follow up report, the OIG found that "Significant training and competency failures existed in the [Sterile Processing Staff] SPS."[ii]

- Residue was discovered on reusable surgical equipment at the Roudebush VA Medical Center in Indianapolis, Indiana, in April 2024. [iii] A 3-month shut-down of on-site sterilization ensued, resulting in significant reduction in procedures. OIG found 468 veterans were affected by subsequent delays and cancellations.[iv]
- Similarly, in May 2024, residue was found on reusable medical equipment at the VA Medical Center in Aurora, Colorado, leading to a surgery stoppage.[v] 608 procedures were postponed or referred to other hospitals and surgeries did not fully resume until mid-August.[vi]

Veterans deserve to have confidence that they are receiving the best care, and their equipment is properly sterilized and serviced. On behalf of sterile processing technicians, I would

like to once again thank you for the opportunity to testify today.

I look forward to your questions.

[i] https://www.infectioncontroltoday.com/view/improper-sterilization-veterans-affairs-hospital-exposed-thousands-hiv-hepatitis

[ii] https://www.vaoig.gov/sites/default/files/reports/2024-03/vaoig-22-01315-90.pdf

[iii] https://www.wthr.com/article/news/investigations/13-investigates/indianapolis-va-hospital-delays-surgeries-concerns-over-sterilization-of-surgical-instruments/531-185e3014-7142-4fc5-9a73-5d766a6a0c06

[iv] https://www.wthr.com/article/news/investigations/13-investigates/indianapolis-va-hospital-patient-surgeries-resume-normal-sterilization-problems-fixed/531-db2fc9d1-8e3b-44e6-8aee-783b91a98d31

[v] https://www.9news.com/article/news/health/residue-surgery-equipment-va-hospital-aurora-colorado-surgeries-halted/73-441db8e5-0e9d-45c3-80e5-a62ab3356799

[vi] https://www.cpr.org/2024/08/09/aurora-rocky-mountain-regional-va-medical-center-resumes-surgeries/