DEPARTMENT OF VETERANS AFFAIRS
Robert J. Dole
Medical and Regional Office Center
5500 East Kellogg
Wichita KS 67218-1698

5-30-2014

Dear

Thank you for your interest regarding Veterans access to care in Kansas at the Robert J. Dole VAMC in Wichita, KS. We have completed a review of our access for Veterans in Primary Care at Wichita and our CBOCs in Kansas. I can assure you all available resources are utilized to provide the highest quality primary care to Veterans served at the Robert J. Dole VAMC.

The Office of Inspector General (OIG) interim report of May 28, 2014, concerns all of us; Veterans, Veteran advocates, and those in the Department of Veterans Affairs. That 1700 Veterans were placed on an unauthorized Primary Care wait list in Phoenix, along with another 1400 waiting over 90 days for Primary Care, places Veterans at risk.

At the Robert J. Dole VAMC, we are very clear about our mission; we treat Veterans, not numbers or performance measures. As part of our operations, we seek to fix problems and eliminate placing Veterans at risk of being "dropped" in our scheduling practices.

Two aspects of the Phoenix OIG report are significant; wait times greater than 90 days for access to Primary Care and the presence of unauthorized lists, sometimes called "secret wait lists".

1. The Network Office reviewed the waiting times for Primary Care in VISN 15 (VA Heartland Network) for Veterans waiting over 90 days for Primary Care appointments.
2. For the entire network of seven medical centers and one healthcare center in Evansville, IN, the data on May 28, 2014, revealed 96 Veterans waiting over 90 days. For each medical center, the specific numbers are Marion IL/Evansville IN (8), Poplar Bluff, MO (14), St Louis (26), Columbia, MO (19), Kansas City (12), Eastern Kansas HCS (8), and Wichita (9).
3. The Network Office queried each medical center director on May 28, 2014, for unauthorized lists. The directors reported 10 such lists in the network; eight of these lists served to complement authorized lists to more fully support Veteran

care and access. Staff using unauthorized lists in these cases was educated about more appropriate techniques while continuing to enhance Veteran care.

4. The other two lists placed Veterans at risk. The Network Office notified the OIG through the Hotline process. The medical centers involved terminated the practice, corrected the gaps in access, and investigations for accountability are ongoing. One of the lists belonged to Wichita. The practice was immediately discontinued and a report made to our VISN 15 leadership who referred it to the VA OIG via the Hotline process. In the interim, Veterans are being contacted to ensure they are receiving the correct level of care.
5. Medical centers in VA Heartland Network will be calling the 96 Veterans this week to schedule appropriate access to Primary Care.

If you have any further questions, please have a member of your staff contact Mr. Jeremy Tevis, Public Affairs, at (316) 685-2221 x57886 or by e-mail at Jeremy.Tevis@va.gov.

I appreciate your continued support of our mission.

Sincerely,

Francisco Vazquez
Medical Center Director

VA Heartland Network (VISN 15)
1201 Walnut Street
Kansas City, MO 64106

5/29/2014

Dear

The Office of Inspector General (OIG) interim report of May 28, 2014, concerns all of us; Veterans, Veteran advocates, and those in the Department of Veterans Affairs. As Network Director for VISN 15 I have been very clear about our mission; we treat Veterans, not numbers or performance measures. As part of our operations, we seek to fix problems and to eliminate situations that place Veterans at risk of being "dropped" in our scheduling practices.

We reviewed two aspects of the Phoenix OIG report this week; wait times greater than 90 days for access to Primary Care and the presence of unauthorized lists, sometimes called "secret wait lists". Our findings are:

1. For the entire network of nine hospitals, one healthcare center in Evansville, IN and fifty one community based outpatient clinics, the data on May 28, 2014, revealed 108 Veterans waiting over 90 days. For each medical center, the specific numbers are Marion IL/Evansville IN (8), Poplar Bluff, MO (14), St Louis (26), Columbia, MO (19), Kansas City (12), Eastern Kansas HCS (8), and Wichita (21). This review included our specific CBOC operations located in Vincennes, IN; Owensboro, KY; Hansen, KY; Paducah, KY; Mayfield, KY; Paragould, AR, and Pocahontas, AR, that fall outside the state where the parent medical center is located.
2. The Network Office queried each Medical Center Director for unauthorized lists. The Directors reported ten such lists in the network; eight of these lists served to complement authorized lists to more fully support Veteran care and access. Staff using unauthorized lists in these cases were educated about more appropriate techniques while continuing to enhance Veteran care.
3. The other two lists placed Veterans at risk. The Network Office notified the OIG through the Hotline process. The Medical Centers involved terminated the practice, corrected the gaps in access, and investigations for accountability are ongoing.
4. Medical Centers in VA Heartland Network will be contacting the 108 Veterans this week to schedule appropriate access to Primary Care.

If you have any further questions, please have a member of your staff contact me directly at (816) 701-3000 or by e-mail at William.Patterson@va.gov or Mr. David Isaacks, Deputy Network Director, at (816) 701-3022 or by e-mail at David.Isaacks@va.gov.

I appreciate your continued oversight and support of our mission.

Sincerely,

William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)