United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

June 5, 2014

The Honorable Sloan Gibson
Acting Secretary
Veterans Affairs Department
810 Vermont Ave., N.W.
Washington, D.C. 20420

Dear Secretary Gibson:

As you assume Secretarial leadership of the Department of Veterans Affairs in the wake of these founded, disgraceful practices impacting veterans at VA facilities around the country, we hope to build a relationship with you based on trust and a mutual interest in giving veterans the care they deserve and a department worthy of their service. As a West Point graduate with a family history rich in serving our country, you have every intention of righting this Department to make certain veterans are treated with respect instead of being made to feel like a burden. Veterans must have their hope restored in the agency that was created to serve them. We look forward to working with you as you seek answers, hold individuals accountable and strive to break down the bureaucracy that has taken a hold of this agency for far too long.

On May 29, 2014, Senator Moran and other members of the Kansas delegation received a letter from Dr. William Patterson, Director of Veterans Integrated System Network (VISN) 15. The letter disclosed that as of May 28, 2014, a review conducted of the VISN's facilities revealed that 108 veterans were waiting over 90 days for health services. Furthermore, the letter describes that VISN 15's medical center directors were asked to determine whether any unauthorized wait lists were being utilized at these facilities. The medical centers directors reported there were 10 unauthorized lists, of which eight were "complements" to the authorized lists and "[t]he other two lists placed Veterans at risk." Lastly, the VISN Director states that the VA Office of Inspector General (IG) was notified of the two lists which were deemed to place veterans at risk. According to the VISN, medical centers have terminated the use of these lists upon discovery and are working to contact all veterans that were identified on these lists.

On May 30, 2014, Senator Moran received a second letter regarding the same unauthorized list disclosure from the Director at the Robert J. Dole VA Medical Center in Wichita, KS, Francisco Vazquez. Although similar, the second letter stated "the data on May 28, 2014, revealed 96 Veterans waiting over 90 days." We are troubled that the medical center and the VISN disclosed disparate information. Following receipt of these letters, Senator Moran's staff contacted the IG, and was told that the IG had not received any disclosure from VISN 15 related to the 10 unauthorized lists, and more specifically the two lists that put veterans at risk.

Secretary Gibson, we are writing to you today to fully understand the circumstances regarding the unauthorized wait lists disclosed by the Directors of both VISN 15 and the Wichita VA Medical Center. In order to do so, we ask you provide answers to the following questions:

1) Please explain why it is necessary for VISNs to conduct their own internal audit while a national audit is also being conducted. Additionally, please explain why results of this an internal local audit are released without coordination from objective VA entities. If VISN 15 acted within its own authority to conduct and complete internal reviews without seeking VA central office approval, how does VA maintain accountability for such reviews and findings?

2) Please provide the time period, scope, and methodology pertaining to the VISN's internal review that determined the number of veterans waiting more than 90 days, 10 unauthorized wait lists within VISN 15 and that only two of these lists put veterans at risk.

3) If the information provided to Senator Moran from the VISN and Wichita VA Medical Center are indeed the result of an internal review and not the results from the national audit announced by former Secretary Shinseki, please provide the results of the national audit for all of the facilities within VISN 15.

4) When and how did VISN 15 contact the IG to disclose the existence of unauthorized waiting lists? Please furnish the materials VISN 15 provided to the IG.

5) Did VISN 15 notify VA central office regarding the number of veterans who had waited more the 90 days and the existence of 10 unauthorized lists? If so, what actions did VA take when made aware of the internal reviews findings?

6) Did VA ask or encourage VISNs to conduct similar reviews? If so, please provide the findings of the internal reviews for all 21 VISNs nationwide.

7) Beyond the face-to-face national audit underway, has VA provided any guidance to the VISNs and/or facilities about how to identify wait lists and veterans who are waiting for care? How are VISNs and facilities instructed to identify veterans who haven't been placed on a wait list whatsoever, such as those told to call back at a later time to schedule an appointment?

8) At the VA medical center in Durham, NC, three employees have been placed on administrative leave for actions related to scheduling irregularities. Please provide the number of veterans in VISN 6, by facility, that have been waiting more than 90 days and the number of unauthorized waiting lists identified by each facility.

9) Does VA have a policy or other procedures, for all Veterans Health Administration (VHA) facilities, that require a facility or VISN to report up the chain of command to the VISN, VA central office, the Office of Inspector General, or Office of Medical Inspector any unauthorized activity identified within their facility?

10) What is the current process the VA utilizes to organize and account for all identified unauthorized activities throughout the VHA system? What organization is responsible for the accounting, monitoring, and follow-on administrative actions of every incident and investigation that results from identified unauthorized activities?

11) Please provide the procedures for facilities or VISN to provide information to Congress on disclosures directly related to issues identified since the allegations at the Phoenix Healthcare System surfaced.

Given the scope and severity of the current wait time allegations, it is imperative that VA provide guidance to facilities to make certain all unauthorized waiting lists, scheduling irregularities or procedures that limit access to care are identified and full investigations are undertaken by VA and the IG. Under your leadership and as these situations unfold, veterans must not continue to wait for

care and suffer because their access has been denied. Those who have undermined VA policies and committed this sacred breach of trust impacting veterans around the country must be held accountable for their actions and fully cooperate with the IG. We are seeking your personal attention to these matters and look forward to a timely response to our questions. For your reference, we have attached the two letters received by Senator Moran.

Sincerely,

Richard Burr
Ranking Member

Jerry Moran
United States Senator