United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

March 9, 2018

The Honorable David J. Shulkin
Secretary of Veterans Affairs
810 Vermont Avenue, North West
Washington, DC 20420

Dear Secretary Shulkin,

I write with concerns about the recent Office of Inspector General (OIG) report on the Department of Veterans Affairs (VA) Medical Center in Washington, DC. It is incredibly disconcerting that VA leadership did not have more visibility into the years-long deteriorating situation at this facility. To ensure the same conditions do not exist in other locations, I urge you to identify a process through which an audit of all VA medical facilities can be conducted.

The findings of the OIG investigators related to poor communication within the Veterans Health Administration (VHA) validates a concern I have had for years about the flow of information between the VA central office and the field. After all, if the flow of information between two points in Washington, DC - less than four miles apart – is broken, you can imagine the concerns I have about communication between VA central office and the Montana VA Health System – a distance of approximately 2,200 miles.

Over the years, I have worked very diligently, and very closely with you and your predecessors, to enact numerous policies that improve the delivery of care for veterans and their families. But far too often, these new policies and procedures are implemented in varying and inconsistent ways from facility to facility, or the implementation is unduly delayed at the expense of veterans. Further, it is clear that not all leadership guidance from VA central office is being executed in the field in accordance with Congressional intent, or even the intent of Secretary.

Additionally, I continue to be concerned that the flow of information is just as hindered from local facilities to the central office. I don't have confidence that the right people at VA Central Office have visibility into the indicators of poor quality at a particular facility, or that requests for more resources or assistance from the local level are getting to those who have the ability to provide critical support in a timely manner.

Above all, I believe VA needs to go about doing business much differently. And I need you take a hard look at the red tape, procedural hurdles, and various layers of VA middle management to determine how and by whom communication is frequently being lost, misconstrued, or neglected. As we have previously discussed, your ability to fix problems

depends entirely on your awareness of the problems in the field and a facility's understanding of your guidance. For that to happen, significant steps need to be taken to improve communication channels throughout VA.

I expect that the findings of this OIG report will inform your next steps. And I hope you take seriously your responsibility to audit facilities nationwide and to improve the flow of information to and from the field to ensure these problems are not replicated. I look forward to your response.

Sincerely,

Jon Tester
Ranking Member