United States Senate
WASHINGTON, DC 20510

March 8, 2017

The Honorable David Shulkin
Secretary of Veterans Affairs
810 Vermont Avenue, Northwest
Washington, DC 20240

Dear Secretary Shulkin,

We read with significant concern the results of the recent Department of Veterans Affairs Office of Inspector General (OIG) audit on access to healthcare in Veterans Integrated Service Network (VISN) 6. These findings indicate that due to Veterans Health Administration (VHA) staff continuing to record inaccurate wait time data, veterans are waiting for care significantly longer than reported by the Department of Veterans Affairs (VA), and in many cases, being denied the opportunity to seek care in the community through the Veterans Choice Program.

Additionally, facility staff are not consistently entering data that is necessary for leadership at the facility, VISN, and central office level to make decisions about staffing in VA facilities. Ultimately, these failures hamper Congress' ability to provide VHA with appropriate resources. The OIG also found that policies to audit schedulers, ensuring they were complying with policy in the best interest of veterans, were simply ignored.

Veterans in this VISN, and across the country, deserve to be seen more quickly than VISN 6 has achieved, and Congress, veterans, and the American public must be able to trust that the wait time information being provided by VA is accurate. That we, once again, cannot trust VA data is more than disappointing.

Secretary Shulkin, as you signed off on the action plan to address the IG's recommendations, we know you are anxious to ensure that the challenges identified in this audit are met promptly. We appreciate that new scheduling and consult directives were released last year, and that many of the recommendations offered by OIG will be changes implemented nationwide, but we also urge you to take the following additional actions:

- Despite the various directives and handbook updates, this audit makes it clear that there is an inconsistent understanding among front line staff of the appropriate process to take when scheduling veterans. We ask you to commit to nationwide retraining of schedulers, virtual or in-person, by the end of this fiscal year, which would be over a year after the publication of VHA's most recent outpatient scheduling and consult directives. Additionally, please explain how scheduling staff and supervisors were

trained on the directives when they were released last year and whether any VHA employees have been held accountable for failing to follow these directives.

- As a result of the finding in a January 2017 OIG report, Review of the Implementation of the Veterans Choice Program, as well as this VISN 6 report, indicating that it takes medical facility staff an average of 42 days to provide authorization to the Third Party Administrator to begin the Choice process, we ask that you initiate an analysis of this front-end process. This timeline is unacceptable. Please indicate what provisions in your Response for Proposals for a new community care network are responsive to lessons VHA has learned during the course of the Choice Program with respect to scheduling processes.

- The OIG found that facilities did not consistently conduct scheduler audits, and so we ask you to require that an individual at each VISN is responsible for ensuring that the required scheduling audits are completed as prescribed. Further, we ask you to identify an individual or a team at the VISN level who will complete these audits quarterly, to ensure that audits are impartially completed by people outside the scheduler's and scheduling supervisor's direct chain of command.

- The audit showed that VISN 6 medical facilities did not consistently provide timely access to health care for new patients. How is VHA ensuring that adequate care capacity will be available to meet the increasing needs of Veterans in high growth areas? Are there adequate resources to meet the specific needs of subpopulations like women veterans?

- VA had a goal that by December of 2016, every VA medical center would be able to provide same day access. Given this concerning audit. Do you have confidence that facilities in VISN 6 are meeting this goal, and what data can you share to validate?

- Finally, VA stakeholders rely on the wait times information that is published regularly by VA. It appears, based on this audit, that incorrect information is being published without validation. We urge you to complete a thorough review of these channels of communication, and opportunities for accountability for incorrect information being passed between VISNs and facilities, and between VHA Central Office and VISNs.

We appreciate your prompt response and attention to these important matters.

Sincerely,

Jon Tester
U.S. Senate

Johnny Isakson
U.S. Senate

Tim Kaine
U.S. Senate

Richard Burr
U.S. Senate

Thom Tillis
U.S. Senate

Mark Warner
U.S. Senate