THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

June 11, 2014

The Honorable Dan Coats
United States Senate
Washington, DC 20510

Dear Senator Coats:

This is a response to your cosigned letter regarding the Department of Veterans Affairs (VA) Phoenix VA Health Care System (PVAHCS). We take the allegations of misconduct seriously, and are moving quickly to address the situation. Upon learning of allegations of delayed care and employee misconduct at the PVAHCS, VA invited the independent VA Office of Inspector General (OIG) to complete a comprehensive review at PVAHCS and other facilities to determine all the facts. It is important to let OIG complete its review and VA is fully cooperating. Additionally, VA sent a team of experts to assess scheduling and administrative practices at the Phoenix VAHCS. This team began their work in April, and we are already taking action on multiple recommendations from their findings. We look forward to working with your office and providing you additional updates as information becomes available.

On May 28, OIG released an interim report on patient waiting times and scheduling practices in Phoenix. I have reviewed the interim report, and the findings are disgraceful to me, to this Department, and to Veterans. VA has already initiated the process for removing senior leaders at the Phoenix VAHCS, and directed that the Phoenix VAHCS immediately contact each of the 1,700 Veterans identified by OIG to offer them timely care. The Department has now attempted contacts with all identified Veterans with valid contact information to immediately begin scheduling appointments for those who wish to be seen. We will continue to aggressively and fully implement the remaining OIG recommendations.

I know that you care deeply about Veterans in Indiana and across the country and I want to reiterate VA's mission to provide the best quality, safe and effective health care to our Nation's Veterans. On May 23, the Veterans Health Administration (VHA) executed the Accelerating Care Initiative, a coordinated, nationwide initiative to accelerate care to Veterans throughout the VA system and in the communities where Veterans reside. This initiative is designed to increase timely access to care for Veterans; decrease the number of Veterans waiting for their care; and standardize the process and tools for ongoing monitoring and access management at VA facilities. We will continue to accelerate access to care for Veterans nationwide who need it, utilizing care both within the VA system and local communities.

VHA has now completed a nationwide access audit to ensure a full understanding of VA's policy and continued integrity in managing patient access to care.

The Honorable Dan Coats

The initial summary was released on May 30, and it acknowledged that we have systemic issues that need to be addressed. The final results of the nationwide access audit were released on June 9, and they confirm widespread problems with appointment scheduling across the country. We also released specific facility-level information, related to average wait times and numbers of appointment requests that have not yet been scheduled. National audit and patient access data are available to review at www.va.gov/health/access-audit.asp.

As we move forward to take action based on these findings, it is clear that an overly complicated scheduling process resulted in confusion among scheduling clerks and front line supervisors. We determined that 112 sites that we visited require a further review in order to determine the extent of issues related to scheduling and access management practices. This list is also available via the link above, and VA and OIG will be conducting those reviews in the weeks ahead.

While VHA has made efforts to address health care appointment scheduling and wait times for health care, further improvement is needed. On May 16, VA accepted the resignation of Robert Petzel, M.D., the Under Secretary for Health. Robert L. Jesse, M.D., Ph.D., is the Acting Under Secretary, and I have directed him to focus immediately on these important issues. Additionally, VA has suspended all VHA senior executive performance awards for fiscal year 2014.

I want to assure you that VA will use all authority at our disposal to enforce accountability among senior leaders who are found to have instigated or tolerated dishonorable or irresponsible scheduling practices at VA health care facilities, wherever they may have occurred.

This situation will be fixed. VA will work together with Veterans Service Organizations, Congress, and all VA stakeholders to restore the trust of Veterans and the American people by providing quality health care in a timely manner. VA will continue to keep you apprised as we make changes to ensure our Veterans get the timely medical care they have earned and deserve. Should you have further questions, please have a member of your staff contact [redacted]

A similar response has been sent to the cosigner of your letter. Thank you for your continued support of our Nation's Veterans.

Sincerely,

Sloan D. Gibson
Acting Secretary