

United States Senate

WASHINGTON, DC 20510-1605

June 4, 2014

COMMITTEES:
AGRICULTURE

FINANCE

HEALTH, EDUCATION,
LABOR, AND PENSIONS

ETHICS

RULES

Acting Inspector General Richard J. Griffin
Department of Veterans Affairs
Office of Inspector General
801 I St., NW
Washington, DC 20001

Dear Acting Inspector General Griffin:

I am writing in regards to a matter at the Robert J. Dole VA Medical Center, which I believe calls for your immediate attention. As the VA Inspector General, you are responsible for conducting independent oversight of the VA and have the resources to investigate this situation.

First, let me outline a meeting I had with the Robert J. Dole VA Medical Center and a follow-up letter I received last Friday, May 30, 2014. I want to make you aware of the disparities between information presented to me during my meeting with the medical center staff and the follow-up letter sent to my Wichita office just a few hours later.

On May 30, 2014, at 9 a.m. I met with representatives from the Robert J. Dole VA Medical Center. During the visit, members of the staff discussed their frustration with the antiquated Veterans Health Administration scheduling system and human resource policies that negatively impact the level of veteran care. Also, the staff mentioned that the medical center used a spreadsheet to keep track of some scheduling requests. At that time, I left the meeting with the understanding that the delivery of care provided by the Robert J. Dole VA Medical Center was not under further scrutiny.

Unfortunately, later in the afternoon on May 30, a fax written by Director Francisco Vasquez and signed by Associate Director Vickie Bondie was sent to my Wichita office. I have enclosed the letter for your reference. The letter stated that an unauthorized scheduling list, more commonly known as a "secret waiting list," was discovered at the Robert J. Dole VA Medical Center and investigations for accountability were ongoing. During my meeting earlier in the day with staff, this information was not disclosed to me. Nor was there any mention that the medical center terminated the use of the spreadsheet referenced in the meeting. Just today, the media has reported that 385 veterans have been waiting on the unauthorized scheduling list at the medical center. I am troubled that this information was withheld from me during my meeting with the Robert J. Dole VA Medical Center.

Additionally, on May 28, I received a letter from VISN 15 stating that there were 21 veterans waiting over 90 days for primary care appointments at the Robert J. Dole VA Medical Center. This letter is also enclosed for your reference. The letter sent to me on May 30, by the Robert J. Dole VA Medical Center listed only nine veterans waiting over 90 days. The inconsistencies between the two letters, sent two days apart are alarming.

On Friday, June 6, I have a meeting with the Kansas City VA Medical Center. I look forward to a candid discussion about the delivery of veteran care and if any other unauthorized scheduling lists in VISN 15 were being used at this facility.

Given the circumstances that have developed nationwide with the VA, I think it is necessary that we know the exact numbers of veterans on the unauthorized list at the Robert J. Dole VA Medical Center, if veterans were placed at risk, and if there was other information about veteran care, or the delay of such care, that has not been disclosed by the medical center.

I appreciate your attention on this matter, and I hope that we can work together moving forward to address the challenges facing the Kansas VA medical centers.

Sincerely,

A handwritten signature in blue ink, appearing to read "Pat Roberts", with a long, sweeping flourish extending to the right.

Pat Roberts

Enclosures



Department of Veterans Affairs

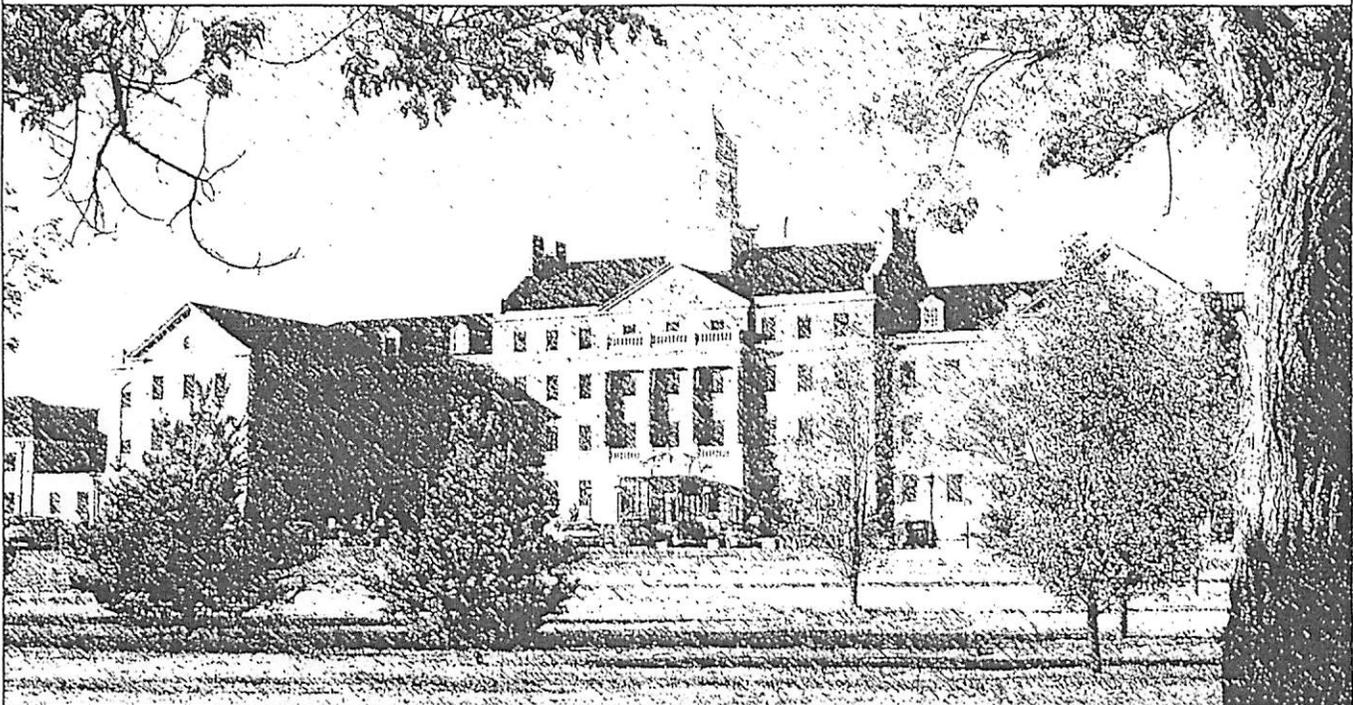
VA FACSIMILE

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If you have received this communication in error, please notify us immediately at the telephone number shown below. Thank you.



Robert J. Dole VA Medical Center

To: Honorable Pat Roberts	Fax Number: 316-263-0273	Date: 5-30-2014	# of Pages: 2
Subject: VAOIG Investigation Update			
From: Francisco Vazquez, MBA Robert J. Dole VAMC Medical Center Director	Department: MCD	Telephone Number: 316-651-3601	

**DEPARTMENT OF VETERANS AFFAIRS**

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

5-30-2014

The Honorable Pat Roberts
United States Senate
155 N Market, Suite 120
Wichita, KS 67202

Dear Senator Roberts:

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

The Honorable Pat Roberts
United States Senate
Hart Senate Office Building, Ste. 109
Washington, D.C. 20510

Dear Senator Roberts:

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.

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Senator Roberts

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,

A handwritten signature in black ink, appearing to read "W. Patterson". The signature is fluid and cursive, with a large initial "W" and "P".

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