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United States Senate

WASHINGTON, DC 20510

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Honorable Eric K. Shinseki
Secretary
Department of Veterans Affairs
810 Vermont Avenue NW
Washington DC 20420

Dear Secretary Shinseki,

The release of the interim report by the Department of Veterans Affairs (VA) Inspector General office on Wednesday regarding the ongoing investigation into patient scheduling misconduct greatly disturbed me. The scope and nature of the problems identified at the Phoenix VA Health Care System (HCS) require significant and immediate action, especially since the report confirms that similar problems are systemic throughout the entire VA health care system. I am requesting you provide me specific information on the VA response to this crisis so our nation can work toward making sure this never happens again.

In reviewing the interim report, I was especially concerned regarding the contents of the 2010 internal memo to Network Directors from the Deputy Under Secretary for Health for Operations and Management. The memo clearly indicates that key VA officials understood that scheduling irregularities were occurring and directed Network Directors to take action to prevent such misconduct. That the VA had such detailed knowledge of an ongoing and identified problem makes what is occurring today that much more tragic – both for the veterans who received delayed care as a result and also for their families.

To help my understanding, and that of my constituents, of the VA response to this tragedy, I request information on the following:

- In the wake of the publication of the 2010 internal memo, what actions were taken by your office and other senior VA leaders, to ensure that network and facility directors were taking sufficient steps to prevent the type of scheduling problems and misconduct identified in the interim IG report?
- If steps were taken to prevent this type of scheduling misconduct, why were such steps not successful?
- Since the initial media reports about the scheduling delays at the Phoenix VA HCS, what specific actions has your office, or other senior leaders, taken to ensure that this sort of misconduct can not occur in the future?
- What steps do you feel can be taken in the next few weeks and months to start rebuilding the trust of veterans in the VA system?

Words are not sufficient to respond to this crisis. Action is required. However, to ensure we are taking the correct action, we must develop a complete understanding of how a problem occurred. I appreciate your willingness to cooperate with the ongoing Inspector General investigation and undertake a wide-ranging review of what led us to this unfortunate situation.

Our nation has a sacred trust to take care of those who have taken care of us. Our nation must respond to this tragedy with firm action. I look forward to your prompt reply.

Sincerely,



Heidi Heitkamp
U.S. Senator

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