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United States Senate

May 21, 2014

Richard J. Griffin
Acting Inspector General
Department of Veterans Affairs
Office of Inspector General (50)
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Griffin:

Thank you for your prompt reply and decision to open an investigation into allegations of manipulated wait times at the Edward Hines, Jr. VA Hospital in Maywood, Illinois. I have spoken to Secretary Shinseki personally and asked that in addition to the Hines VA, all Illinois VA hospitals be investigated to ensure that no Illinois veteran is being denied proper and timely care. I appreciate the opportunity to work closely with you as this matter proceeds.

In addition to specific concerns about manipulated appointment waiting times and duplicate wait lists, I ask that your office investigate allegations that veterans at the Hines VA facility were provided informational briefings and general consultations in lieu of medical care in order to meet the VA's mandated fourteen-day window for appointments. My office recently received additional reports that veterans seen within the fourteen-day window were sometimes not able to see a doctor, and instead met in-group consultation/informational sessions without actually receiving medical care.

It is my fear that there is a pervasive and systemic culture of bureaucratic dysfunction within the VA. It is critical that the IG investigate any and all allegations that may have impacted our veterans and their ability to receive proper and timely care. As this process moves forward, I ask that you please provide me the opportunity to meet with you and members of your staff throughout the process of the investigation. I would like to be updated consistently as to the status of the investigation. Additionally, I would like to be immediately informed of the date that you expect this review to be initiated and completed, including a detailed timeframe of the investigation process that your team will be working to complete.

I would ask that your investigation include assessments and recommendations on the following:

- An internal Hines VA memo dated May 8, 2014 from Hines VA Director Joan Ricard states: "Over the years, with the complexity of the scheduling process and the pressure to improve reported results, there have been instances across the VA where staff has taken steps to make wait times look better. This memo is both a request and a plea that we all do our best to follow the recommended scheduling

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practices closely to ensure our reported wait times accurately reflect the actual experience of patients. Unless we know actual wait times, we are unable to truly understand our supply and demand." I am concerned that this statement admits to the practice of manipulating wait times. Are wait times and scheduling processes manipulated to provide a positive impression of veteran health care at VA hospitals in Illinois?

- Freedom of Information Act (FOIA) requests show that since 2011 over $16.6 million in bonuses have been awarded at Hines VA alone. Are these bonuses related to expedited scheduling and treatment incentive programs and have these bonus programs led to institutional and cultural problems such as manipulating wait times in order to fill bonus criteria?

- A Cox Media Group investigation, based on a separate FOIA request, reports that from 2002-2011 there were five instances where alleged delays in referrals, consultations, diagnoses or treatment may have resulted in veterans' deaths at the Hines VA. According to this database, the VA settled or was court-ordered to pay amounts in similar cases at other Illinois VA hospitals as well. Have any delays in scheduling or treatment resulted in exacerbation of illness, suicide or the death of veterans at any Illinois VA hospital?

I appreciate your continued attention to this matter and look forward to your reply.

Sincerely,

Mark Kirk
United States Senator