March 17, 2016

The Honorable Robert A. McDonald
Secretary
United States Department of Veterans Affairs
810 Vermont Avenue N.W.
Washington, DC 20420

Dear Secretary McDonald,

We write today regarding recently confirmed reports of improper scheduling practices and extended wait times throughout the Department of Veterans Affairs (VA) Health Care Systems in Texas. We remain troubled that the VA continues to fail to provide timely health care to our nation's veterans, despite receiving enhanced authorities and funding from Congress to hire new employees and address additional problems facing the VA.

On March 8, 2016, the VA Office of the Inspector General (IG) issued twelve reports on VA Health Care Systems in our home state, with seven reports pertaining directly to patient wait times and scheduling mismanagement. We have reviewed the findings and conclusions of the reports, which make clear that VA scheduling clerks manipulated data in order to manually adjust wait time statistics, while failing to follow appropriate protocols. Specifically, VA employees, when making appointments within the computer system, entered the first available date for an appointment as the patients' actual desired date to be seen, thereby hiding actual wait times. More concerning, the report revealed that improper scheduling practices were systemic throughout VA Health Care Systems in Texas. The IG reports indicate that improper training, lack of supervision, and non-centralized scheduling are the primary causes of the data manipulation; however, some employees reported feeling pressured to change wait times or risk getting fired.

The IG reports make clear that Texas veterans were misled by a mismanaged, bureaucratic system intent on providing the appearance of short appointment wait times in order to improve the image and performance statistics of individual VA health facilities. The VA's continued inability to properly and efficiently train and supervise employees is deeply distressing. We urge you to address the clear and fundamental need for standardized training on scheduling throughout VA Health Care Systems in Texas and protect from employer retaliation those employees who follow the correct scheduling practices. In addition, we encourage you to make

more robust use of the authority granted to you by Congress in Section 707 of the Veterans Access to Care Through Choice, Accountability, and Transparency Act (P.L. 113-146) to remove any individual from the VA Senior Executive Service whose poor performance or misconduct warrants such removal. These ongoing scheduling problems clearly evidence failures of leadership at senior levels of these Health Care Systems in Texas and, more broadly, within the Veterans Health Administration.

We thank you for your prompt attention to this critical matter. Our veterans have fulfilled their solemn duty to the nation, and the VA has an obligation to provide them with timely, high-quality health care.

Sincerely,

JOHN CORNYN
United States Senator

GREG ABBOTT
Governor of Texas

TED CRUZ
United States Senator