Congress of the United States
Washington, DC 20510

October 4, 2024

The Honorable Gene L. Dodaro
Comptroller General of the United States
U.S. Government Accountability Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Dodaro:

On Friday, September 27th, the Department of Veterans Affairs Office of Inspector General ("OIG") released its findings following its inspection of the VA Western New York Healthcare System in Buffalo, New York. The report – *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo* – found a shocking pattern of apathy and incompetence on the part of Department facility and community care leaders in addressing the needs of patients with complex and high-risk conditions.

As the report indicates, these delays caused or led to an increased risk of harm to the patients. One veteran passed away while waiting months to receive palliative care that would have helped manage cancer pain in their final months. Another patient waited nine weeks to schedule radiation therapy for a new cancer malignancy, despite efforts by the chief of oncology to get the community care team to schedule treatment. Another veteran in their twenties continued to suffer from seizures for another 10 months as they waited for a consult to be scheduled, the delay partially caused by a referral being canceled by the community care medical director. These are only some of the cases highlighted by an OIG report that identified incompetence, and bureaucratic red tape that failed the veterans in Buffalo again and again.

The failure by the leadership at the Buffalo VA Medical Center must never occur again, and veterans across the United States must be reassured that they can receive timely and high-quality health care across the VA health care system. Therefore, we request that the Government Accountability Office (GAO) conduct a review of Veterans Integrated Services Networks' (VISN) community care consult practices. The review should include, but not be limited to:

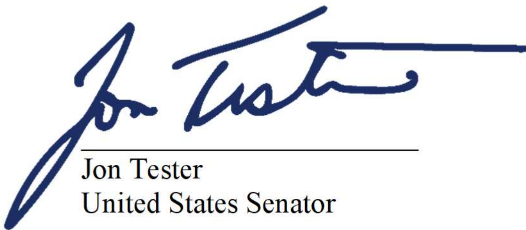
(1) Oversight of medical centers' adherence to Veterans Health Administration (VHA) requirements for processing consults for conditions considered high-risk or complex;
(2) Whether consults are appropriately prioritized and consistently processed within VHA's timeliness requirements;
(3) Reviewing how medical facility, VISN leaders, and the VHA Office of Integrated Veteran Care respond to concerns regarding delays in consult scheduling from providers, staff, patients, and their families and how this is built into VHA's quality and risk management programs;
(4) Best practices to prevent and address leadership deficiencies within the community care scheduling process, including the prioritization of patient safety;

We request a briefing on the preliminary findings with final results to be submitted on a date and in form mutually agreed upon. Please include recommendations, as appropriate, for agency or congressional action in your evaluation.

Sincerely,

Kirsten Gillibrand
United States Senator

Jerry Moran
United States Senator



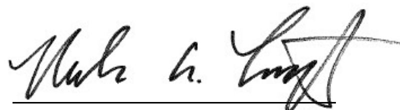
Jon Tester
United States Senator

Charles E. Schumer
United States Senator

Mike Bost
Member of Congress

Mark Takano
Member of Congress

Timothy Kennedy
Member of Congress



Nicholas A. Langworthy
Member of Congress