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United States Senate
WASHINGTON, DC 20510-1012

May 18, 2022

The Honorable Denis McDonough
Secretary of Veterans Affairs
810 Vermont Ave., NW
Washington, D.C. 20420

Dear Secretary McDonough,

I write today to draw your attention to a recently published U.S. Department of Veterans Affairs (VA) Office of Inspector General (IG) Report regarding the Atlanta VA Health Care System ("Atlanta VA").

On April 27, 2022, VA IG published a report titled, "Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims."[1] The VA initiated the investigation following a series of September 2021 articles in *The Atlanta Journal-Constitution* exposing a 10-month backlog in unprocessed mail at the Atlanta VA.[2] The IG conducted the investigation to determine how 17,660 pieces of mail containing important documents for thousands of veterans remained unopened and unprocessed until the issue was made public. While I am glad that the VA initiated an IG investigation into this situation, I am deeply troubled by the findings in the report and am disappointed to be writing to you again so soon to address new concerns at this facility.

The April 2022 VA IG report found that the impetus for the Atlanta VA mail backlog was a verbal, informal agreement between Atlanta VA and VA Office of Community Care Payment Operations and Management (POM) personnel in November 2020, which resulted in significant and unclear changes in Atlanta VA mail staff responsibilities. Despite outreach from mail staff to Atlanta VA management and POM to communicate their concerns and challenges over the course of a year, management did not provide additional resources, guidance, or training, or reach out beyond the Atlanta VA to find a solution to an evident and known problem.

This incident and the report detail a clear case of two different organizations avoiding responsibility for a key function and supervisors failing to elevate valid concerns of their staff to the necessary administrative levels. The actions of both the VA and POM staff also seem to demonstrate a failure at both the hospital and POM to recognize the disastrous effects of mishandled or ignored mail. The VA IG reports that due to the failure of the Atlanta VA to address the backlog, the Atlanta VA was unable to promptly file veterans' medical records, reimburse community care providers, accurately bill veterans, and over deposit over $200,000 in checks to the VA, which then expired. Clearly, each of the outcomes may have tangible and potentially very detrimental effects on veterans' medical care. Additionally, at a time when the

[1] Veterans Health Administration Inspector General, "Atlanta VA Health Care System's Unopened Mail Backlog with Patient Health Information and Community Care Provider Claims," 27 April 2022.
[2] Christopher Quinn, "Months-old mail piles up in Atlanta Veterans Affairs hospital basement," *Atlanta Journal-Constitution*, September 17, 2021.

VA is working to build out the community care network to address vast needs exacerbated by Covid-19, delayed payments and communication undermines this effort.

Finally, one of the most important takeaways from the IG report is that "the circumstances that led to the backlog in Atlanta could occur at other medical facilities across the nation—requiring proactive measures and better controls." [3]

While the VA does not yet fully know all the individual effects of this incident, it is evident that this incident further undermines veteran and public trust in VA facilities to address the needs of veterans with care and diligence. This is unacceptable, and I request that you respond to the following questions by June 18, 2022:

1. What are you doing to ensure Georgia veterans are made whole due to *any* issues caused by the backlog?
2. Why was the Atlanta VA hospital deputy director able to make significant changes to mail processes without external approval, an understanding of the then-needed training and resources, or input from the affected staff?
3. What regulations are you implementing to ensure this cannot happen again at the Atlanta VA or any other VA facility?
4. What steps are you taking to ensure all VA employees understand that failure to address incoming mail promptly is a very serious issue that they cannot ignore?
5. What steps are you taking to ensure that supervisors and staff know to continue to raise the issue of needed resources to the appropriate level if they are not able to fulfill their mail responsibilities?
6. What steps are you taking to change organizational culture and assumed responsibilities at staff and supervisor levels to encourage individuals to take responsibility for problems and believe they can raise concerns and be heard?
7. What steps are you taking to ensure clear mail protocol at VA facilities nationally, including restrictions on senior supervisors' ability to change significantly mail protocol without relevant staff input and external approval?
8. What steps are you taking to determine if other similar mail backlogs exist at other VA facilities?

On behalf of Georgia's veterans, I ask for your help in improving the reputation of the VA facilities in Atlanta by bringing to bear the necessary Department resources to ensure the leadership, training, resources, and personnel are on hand to ensure an incident like this never happens again and does not take excellent press reporting to expose and address.

Sincerely,

Raphael Warnock
U.S. Senator

[3] Veterans Health Administration Inspector General. Page ii.