

ANN KIRKPATRICK  
1ST DISTRICT, ARIZONA

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June 10, 2014

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

Dear Mr. Griffin:

We are requesting an immediate investigation into the Prescott, Arizona VA medical facility. Based upon the June 9 VA Access Audit and System-wide Review of Access, the Prescott VA medical facility was listed as requiring further review. We ask that this review be started now.

The access audit was meant to address whether unauthorized scheduling practices were being used at VA medical facilities. We are concerned that patient access data were intentionally manipulated to cover up unreasonably long patient wait times or used to falsely meet performance goals in order to obtain bonuses.

We therefore request that your office specifically examine the following areas in order to address these questions:

1. Whether any patients at the Prescott VA medical facility were harmed due to an inability to obtain a timely appointment?
2. Whether the Prescott VA medical facility used any lists for appointment requests apart from the electronic waiting list and VISTA, and whether these unofficial lists were used to hide actual patient wait times?
3. Whether any schedulers were directed to engage, or engaged in, any of the "gaming strategies" outlined in the April 2010 memo in Appendix E of the OIG Interim Report: Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System?

4. Whether any schedulers entered different dates apart from the patient or provider's desired date for an appointment?
5. Whether the patient access data reported to VA Central Office accurately shows actual patient waiting times for appointments at the Prescott VA medical facility?
6. What the difference is between the actual patient wait times for appointments versus patient wait times reported to the VA Central Office?
7. Whether any administrators at the Prescott VA medical facility received bonuses in part due to the incorrect or false reporting of patient access data?
8. Whether any scheduling practices violated VA policies and/or regulations?

A thorough and efficient IG investigation into the Prescott VA facility is necessary to determine possible remedial actions and to determine whether a criminal investigation is required. At a minimum, such an investigation should allow us to proceed with holding anyone accountable who has violated the law or agency rules and regulations.

We are deeply concerned about veterans' access to care in Arizona and the manipulation of patient access data characterized in the IG Interim Report as "systemic" throughout the VA system. Our veterans deserve answers, and we look forward to getting the facts such an investigation will provide. Please adhere to all ethics rules and standard operating procedures when considering our request.

Sincerely,



The Honorable Ann Kirkpatrick  
U.S. Representative, Arizona District One



The Honorable Paul Gosar  
U.S. Representative, Arizona District Four