



**DEPARTMENT OF VETERANS AFFAIRS**  
**INSPECTOR GENERAL**  
**WASHINGTON DC 20420**

MAY 27 2014

The Honorable Lamar Smith  
United States House of Representatives  
Washington, DC 20515

Dear Congressman Smith:

This is in response to your letter co-signed with 23 other members of the Texas congressional delegation dated May 13, 2014, expressing concern about allegations that employees at the North Central Federal Clinic in San Antonio, Texas; the Austin, Texas, VA Outpatient Clinic; and the Waco, Texas, VA Medical Center manipulated patient scheduling data to conceal long waiting times for care.

These allegations were made following extensive reporting on the Office of Inspector General's (OIG) ongoing review into similar allegations at the Phoenix VA Health Care System in Phoenix, Arizona. When the OIG first became aware of these issues at the three VA facilities in Texas, we immediately expanded our Phoenix review to include the Texas sites. Subsequently, at the request of VA Secretary Eric Shinseki, the OIG agreed to review similar allegations on patient scheduling practices and manipulated wait times at the three Texas VA facilities that a VA whistleblower reported to the U.S. Office of Special Counsel.

The OIG has assembled a multidisciplinary team comprised of auditors, healthcare inspectors, board-certified physicians, and criminal investigators from across the country to address these allegations that were first reported in Phoenix. I have directed our team to answer two fundamental questions: (1) whether the facility's electronic wait list (EWL) purposely omitted the names of veterans waiting for care and if so at whose direction, and (2) whether the deaths of any of these veterans were related to delays in care.

To get to the bottom of these allegations in Phoenix, the OIG has an exhaustive review underway that includes:

- Interviewing staff with direct knowledge of patient scheduling practices and policies, including scheduling clerks, supervisors, patient care providers, management staff, and whistleblowers who have stepped forward to report allegations of wrongdoing.
- Collecting and analyzing voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.
- Reviewing medical records of patients whose deaths may be related to delays in care.

- Reviewing performance ratings and awards of senior facility staff.
- Reviewing past and newly reported complaints to the OIG Hotline on delays in care, as well as those complaints shared with us by members of Congress or reported by the media.
- Reviewing other prior reports relevant to these allegations, including administrative boards of investigations or reports from the Veterans Health Administration's Office of the Medical Inspector.
- Reviewing massive amounts of e-mail and other documentation of relevant VA employees.

To facilitate our work, on May 1, 2014, I asked the VA Secretary to place the Phoenix HCS Director, Associate Director, and another individual on administrative leave. This was done because of the gravity of the allegations and to ensure cooperation by Phoenix HCS staff, some of whom expressed concern about talking to the OIG team. Secretary Shinseki immediately agreed to my request.

I am confident that we have the resources and talent to complete a thorough quality review of these allegations at the Phoenix HCS. We are using our top audit experts on VHA patient scheduling from our Office of Audits and Evaluations to determine the accuracy of the facility's EWL and board-certified physicians from our Office of Healthcare Inspections to review patient medical records, treatment, and harm that may have resulted from delays in care. OIG criminal investigators, including IT forensics experts, are also assisting the team. We are working with Federal prosecutors from the United States Attorney's Office for the District of Arizona and the Public Integrity Section of the Department of Justice so they can determine if any conduct we discover merits prosecution.

Since the Phoenix HCS story broke in the national media, we have received additional reports of manipulated waiting times at other VHA facilities either thru the OIG Hotline or from members of Congress and the media. In response to these reports, we have opened simultaneous reviews at several other VHA facilities, including the three Texas VA facilities cited in your letter. These reviews are being conducted by other OIG staff to enable the team working on the Phoenix review to focus their efforts on that project. We expect that these reviews will give us insight into the extent to which these scheduling issues are present at other VHA facilities.

My staff is working diligently to determine the facts of what happened at the Phoenix HCS, the three Texas VA facilities, and other VHA facilities, and who is accountable. While much has been done, much more remains ahead. Be assured, however, that these reviews are the OIG's top priority and that maximum resources are dedicated to bring about their timely conclusion. We intend to brief you and other members of Congress once we have reached final findings of facts and are ready to publish our

report, which is projected to be in August 2014, and will also provide you with any interim reports on these matters.

A similar letter is being sent to other members who co-signed the May 13<sup>th</sup> letter. Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

A handwritten signature in black ink, appearing to read "Richard J. Griffin". The signature is fluid and cursive, with a large initial "R" and "G".

RICHARD J. GRIFFIN  
Acting Inspector General