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May 6, 2014

The Honorable Eric. K. Shinseki
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Shinseki,

As Ranking Member of the Subcommittee on Oversight and Investigations of the Committee on Veterans' Affairs, I am writing to request that you perform an immediate system-wide audit of appointment scheduling and consult scheduling practices at all VA medical facilities. If you have performed such an audit within the last 30 days, I ask that you immediately provide me, and the members of the Committee, the results and conclusions drawn from such an audit.

The allegations, if true, that 40 veterans may have died due to delayed care at the Carl T. Hayden VA Medical Facility in Phoenix, AZ, are horrific. Equally disturbing are the allegations that Phoenix VA employees were inaccurately reporting patient wait times. Widespread reports of patient wait times at other VA medical facilities across the country, and the VA Office of the Medical Inspector's finding that patient wait times were misreported at the Fort Collins, CO, Community Based Outpatient Clinic lead me to suspect that patient wait times are inaccurately reported at VA medical facilities across the country and that this may lead to an inability to properly manage the health care provided to our veterans. In addition, I am concerned that VA Central Office may not have the facility-specific data necessary to ensure that all VA policies and procedures regarding patient appointments are being followed.

As you are aware, the VA Office of the Medical Inspector suggested in its December 2013 report on the Fort Collins CBOC that the VA "consider conducting a VHA-wide audit of scheduling practices to determine the validity of the access data reported." In light of the Phoenix VA allegations and other reports, this audit should be performed without delay.

Having accurate, reliable data on patient waiting times by facility is essential to manage patient care and address access problems before these problems put veterans at risk. This audit is necessary in order to find and immediately address any inaccurate reporting practices and hold accountable those employees who did not follow VA Central Office policies and procedures. More importantly, this audit will begin to help us identify root causes of long patient wait times

and aid in the development of solutions to ensure our veterans are receiving the timely, world-class care they deserve.

Upon completion of this audit, I ask that the VA provide me, and the other members of the Committee with a copy of the conclusions drawn from the audit, and actions that the VA will take to improve scheduling processes, increase access to care, and ensure the validity of the data the VA Central Office receives so that accurate data on patient wait times is reported to Congress.

The VA must work to restore veterans' faith in the VA medical system, and this audit is one step that the VA can take to start rebuilding this faith. We owe this to our veterans that have honorably served and sacrificed for our Nation.

Sincerely,

The Honorable Ann Kirkpatrick

Ranking Member, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs