

Congress of the United States
Washington, DC 20515

June 4, 2014

The Honorable Richard J. Griffin
Acting Inspector General
Department of Veterans Affairs
801 I Street NW
Washington, D.C. 20536

Dear Mr. Griffin,

We are writing regarding the recent inquiry by the Office of the Inspector General (IG) into allegations of misconduct at various VA Hospitals; of particular interest is an investigation into the VA Pittsburgh Healthcare System (VAPHS).

It is our understanding that the IG's office is currently reviewing practices at VA facilities across the country. An interim report released on May 28, 2014 indicates that there are systemic problems at healthcare facilities across the nation. It is also our understanding that VAPHS was one of the 42 systems audited by the IG.

As you know, it has been discovered that approximately 700 veterans have been awaiting primary care appointments at the VAPHS for months and in some cases, years. In addition, senior leadership at VAPHS told us they did not know about the backlog or the existence of the New Enrollee Appointment Request (NEAR) list. These are deeply unsettling revelations, and we urge that all steps been taken to eliminate the backlog and prevent a reoccurrence so veterans receive immediate medical care.

In light of these recent allegations and discoveries, we urge you to move forward quickly with a review to restore the confidence and trust veterans have in VAPHS. To fix the problem, it is our hope that a full report on VAPHS will detail how the VAPHS intake system works, and make recommendations for operational improvements and supervisory responsibilities. A report will also include information such as:

- A calculation of the true average wait times for primary care and mental health appointments at VAPHS;
- A review of individual records to determine why individuals first requested appointments, and what became of their initial medical conditions so we can understand whether patients with severe acuity were properly referred for treatment;
- The use of performance incentives and bonuses that may have contributed to the large backlog;

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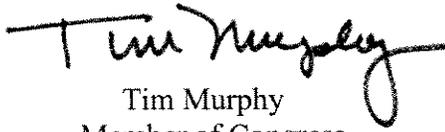
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- The roles and responsibilities of supervisors and hospital leadership in monitoring wait times, including whether senior officials knew of the growing backlog and problems with the New Enrollee Appointment Request (NEAR) list;
- Whether VAPHS officials or supervisors instructed employees to knowingly manipulate information or mislead investigators;
- Whether inaccurate or misleading statistics were knowingly presented to VA central office leadership, auditors, or VA IG personnel and;
- Whether any deaths occurred as a result of a veteran's inability to schedule a medical appointment at VAPHS within a timely manner.

Thank you for taking the time to consider our views on this very serious matter. We look forward to your response and stand ready to assist in any way possible.

Sincerely,


Tim Murphy
Member of Congress


Mike Doyle
Member of Congress