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March 31, 2016

Ms. Linda A. Halliday, Deputy Inspector General
Office of Inspector General
Department of Veterans Affairs
801 I Street, NW Washington, DC 20001

Dear Deputy Inspector General Halliday,

In response to the OIG's recent announcement that it will launch a "formal healthcare inspection" of the Southern Arizona Veteran Affairs Health Care System (SAVAHCS), I write to urge that you ensure a thorough and in-depth investigation that includes efforts to address individual allegations raised in recent media reports.

Similar to the recent issues within the Phoenix VA Health Care System, local media reports have suggested that several hundred orthopedic cases were never put on the electronic wait list and were instead kept in paper form, potentially to diminish the ability to track wait times. I am also gravely concerned by emails from those media reports, which have subsequently been provided to my office, in which SAVAHCS employees discuss the discovery of 600 requests for urology appointments that were "stuffed into a drawer" by a staff member, an act that would have resulted in stopping the appointment clock.

Those reports also highlight another email that appears to show a screenshot of a consult logged into the SAVAHCS system that specifically notes that the consult findings should not be communicated to the patient and/or the patient's family because "the consult is for performance measures only."

Other serious allegations raised in media coverage of this issue include:

- The manipulation of wait times through the limitation of scheduling only appointments that could be slotted within 30 days.
- Improper use of consult management to ensure facility wait times and metrics did not fall below VA-wide standards, including examples of canceling consultation requests and rescheduling them to a later date to restart the appointment schedule timeframe.
- The closing out of consults or withholding the scheduling of consults and later marking them as complete to give the appearance that they occurred within the appropriate time requirements.
- The creation and cancellation of new patient visits to ensure that wait times met the VA-wide standard.

Along with these troubling allegations, some have suggested that a negative work environment at the SAVAHCS led many physicians and medical professionals to leave the facility, resulting in understaffing and impacting the quality of care for veterans.

Given the seriousness of the issues raised in these media reports, I ask that each of these specific allegations be addressed during your investigation. Additionally, I ask that my office be kept up-to-date with status reports on the investigation. I appreciate your attention to this request and would appreciate a prompt written response. I ask that you handle this matter in accordance with all agency rules, regulations, and ethical guidelines.

Sincerely,



JEFF FLAKE
United States Senator