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5TH DISTRICT, COLORADO

COMMITTEE ON ARMED SERVICES

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February 5, 2016

The Honorable Robert A. McDonald
Secretary, U.S. Department of Veteran's Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary McDonald,

I am writing you regarding the recent revelation that the PFC Floyd K. Lindstrom Outpatient Clinic in Colorado Springs, Colorado (CBOC) ignored its mandate and systematically delayed providing timely care to my district's veterans, and then deliberately falsified appointment records to prevent these veterans from receiving care under the Veterans Access, Choice, and Accountability Act of 2014.

I am infuriated that your department continues to intentionally delay the medical care our nation's veterans have earned, and that this transpired at a clinic within the district I represent. Did your department not learn from the Arizona scandal? Despite your repeated personal assurances to the House Veterans' Affairs Committee that this culture is changing, your own Office of Inspector General (IG) has shown these assurances to be false. This report is particularly troubling in light of the CBOC's failure to provide timely medical services to a constituent, Noah Harter, which resulted in his death.

Noah served in the Marines and was diagnosed with PTS. In April 2015, he went to the Lindstrom Outpatient Clinic—where medical notes state he was a suicide risk—but was not referred for care. A month and half later, Noah was found dead from an apparent suicide.

The IG's report raises numerous questions regarding the nature and extent of falsified records that demand answers:

1. Why did personnel at the Floyd K. Lindstrom Outpatient Clinic deliberately falsify the appointment wait time records?
2. Are there any other instances of falsified records/wait times?
    a. How many of the 7,438 specialty consults referenced in the IG report exceeded 30 days?
    b. How many of the 2,246 primary care appointments referenced in the report exceeded 30 days?
    c. Since January 2015, how many of the CBOC's total appointment requests exceeded 30 days?
3. How many personnel at the clinic were involved in the falsification of records?
4. From where or whom did the direction come to falsify these records?
5. How, and when, will the individuals who took these actions be held accountable?

6. Did any of the individuals who took these actions receive annual appraisal bonuses in 2015? If so, how many received them, and how much (both monetary and time off awards)?
7. If your department's reform activities are as successful as you claim, why does a pervasive, systemic culture of delaying care for our veterans persist?

In your response, I encourage you to refrain from blaming these problems on low staffing levels at the clinic. If the clinic did not have appropriate personnel or specialists to serve these veterans, your staff should have made immediate and full use of Veterans Choice Program funds to allow veterans access to timely care.

I am shocked that your department has not learned from past experiences. Congress has passed the Choice Act as well as met each of the department's budget requests. Despite this, nothing has changed. Rest assured, the Congress will investigate this latest incident, and we will uncover how deep and widespread this wrongdoing goes. I expect a response to this letter no later than February 19, 2016.

Sincerely,

Doug Lamborn

Doug Lamborn
Member of Congress