

JOHN McCAIN  
ARIZONA

CHAIRMAN, COMMITTEE ON  
ARMED SERVICES  
COMMITTEE ON HOMELAND SECURITY  
AND GOVERNMENTAL AFFAIRS  
COMMITTEE ON INDIAN AFFAIRS

## United States Senate

February 5, 2016

The Honorable Robert McDonald  
Secretary of Veterans Affairs  
U.S. Department of Veterans Affairs  
810 Vermont Avenue  
Washington, DC 20420

Dear Secretary McDonald,

I write to you regarding recent allegations by patients and former staff that the Tucson Veterans Affairs Medical Center (VAMC) is unable to retain its medical providers and that this is having a severe impact on patient wait times for medical appointments. I am concerned that, by the VA's own metrics, the number of recent patient appointments taking thirty days or more to schedule has risen significantly.<sup>1</sup>

Allegations have also been raised that, due to reduced staffing, medical equipment may have become contaminated and inappropriately reused. Moreover, staff who have spoken out about these problems claim they have been retaliated against by VA leadership.

As you know, I have repeatedly raised issues regarding the VA's failed responses to allegations of whistleblower retaliation in Arizona. Additionally, the United States Office of Special Counsel wrote to President Obama and later testified to the Senate Homeland Security and Governmental Affairs Committee last year highlighting numerous cases of whistleblower retaliation at the VA and urged the VA to examine the need for systemic changes in disciplinary procedures to correct the many problems in this area.<sup>2</sup> I ask you to ensure that allegations of whistleblower retaliation at the Tucson VAMC are thoroughly investigated.

These serious allegations also raise questions about whether the VA is using all of the tools and resources it has been granted through the *Veterans Access, Choice, and Accountability Act* and subsequent legislation to improve the quality and timeliness of medical care at the VA. The Veteran Choice Card Program was created specifically to prevent excessive wait times at VA hospitals and clinics by allowing veterans to receive care in the community if they cannot access care at a VA facility. Please identify what specific steps the VA has taken to ensure that the it is using all available tools and resources to ensure that the Choice Card program is being effectively implemented in the veterans community in and around the Tucson VAMC.

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<sup>1</sup> U.S. Department of Veterans Affairs, Veterans Health Administration, "Patient Access Data," <http://www.va.gov/health/access-audit.asp>.

<sup>2</sup> United States Office of Special Counsel, "Testimony of Carolyn Lerner, Special Counsel," United States Senate Committee on Homeland Security and Governmental Affairs, September 22, 2015, <https://osc.gov/Resources/Testimony-Lerner-2015-09-22.pdf>.

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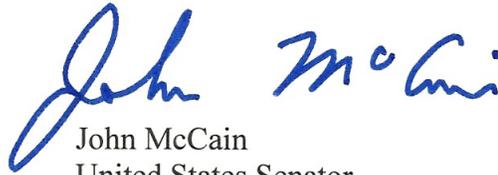
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Also, Congress has given the VA billions of dollars in emergency spending and direct-hire authority for hiring new doctors and nurses. The VA's Patient-Centered Community Care (PC3) provider network has progressed to the point where the inability of a veteran to see a primary care doctor within 30 days should be very rare. Perhaps the most troubling allegation is that VA has not yet changed its culture to eliminate retaliation against whistleblowers who identify problems and issues with veteran care.

I look forward to your timely response to these troubling allegations.

Sincerely,

A handwritten signature in blue ink that reads "John McCain". The signature is fluid and cursive, with the first name "John" written in a larger, more prominent script than the last name "McCain".

John McCain  
United States Senator

cc: Department of Veterans Affairs, Office of Inspector General  
cc: United States Office of Special Counsel