

JOHN McCAIN
ARIZONA

COMMITTEE ON ARMED SERVICES
COMMITTEE ON FOREIGN RELATIONS
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
COMMITTEE ON INDIAN AFFAIRS

United States Senate

April 23, 2014

VIA U.S. MAIL & EMAIL (janko.mitric@va.gov)

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

Dear Secretary Shinseki:

I am writing you today to express my deep concerns regarding allegations of gross mismanagement and neglect at the Phoenix VA Health System (PVAHCS) that were reported by the *Arizona Republic*. According to the article, thousands of veterans have been impacted by delays in care at PVAHCS; wait-times have been covered up by VA officials; and as many as forty veterans passed-away while awaiting care. I cannot express how troubling these allegations are to me as a veteran and to the community of veterans whom the VA was established to serve.

Indeed, I have been concerned about these, and related, issues for some time. Last year, when allegations of delayed care caused by a backlog in disability claims at the Phoenix Regional Office were first raised, I wrote to you several times to express my concerns and to seek more information regarding these problems. Despite the delayed feedback to my inquiries, I was able to work with the Regional Office to establish a series of informational forums on the Fully Developed Claims process and provide critical information and assistance to my constituents. But, from those forums and from the increased contact into my office from patients and doctors alike, it became clear that systemic problems with how PVAHCS serves veterans were not only widespread but also quickly escalating. As a result, I dedicated two of my staffers in Phoenix and a staffer in my DC office to handle the problems with the VA system in Maricopa County, sending inquiries for, and otherwise helping, veterans wherever possible to schedule appointments critical to their health, as well as conducting oversight of the VA generally. I am appalled by the number of veterans who stated to my office that the VA was just "waiting" or "hoping" that they would die and be one less burden on the system. These increasing individual delays clearly illustrate systemic problems with how effectively the VA is providing care to our veterans.

On April 10, 2014, the *Arizona Republic* published an article regarding the delays in medical care at PVAHCS. According to this article, PVAHCS officials have been fraudulently misusing the Electronic Waiting List (EWL) system employed by all VA Health Centers and are keeping a non-official list outside of standard VA procedures. The consequence of the two-list system is that veterans' actual wait times can be significantly longer than what is reported by Phoenix VA officials. Thousands of veterans may have been affected by these previously

241 RUSSELL SENATE OFFICE BUILDING
WASHINGTON, DC 20510-0303
(202) 224-2235

2201 EAST CAMELBACK ROAD
SUITE 115
PHOENIX, AZ 85016
(602) 952-2410

122 NORTH CORTEZ STREET
SUITE 108
PRESCOTT, AZ 86301
(928) 445-0833

407 WEST CONGRESS STREET
SUITE 103
TUCSON, AZ 85701
(520) 670-6334

TELEPHONE FOR HEARING IMPAIRED
(602) 952-0170

unreported delays and as many as 40 veterans have died as a result of the delays in obtaining care, according to allegations in the *Republic's* report. While whether these deaths were specifically caused by the mismanagement of PVAHCS officials is unclear, these allegations appear indicative of broader trends that I have observed regarding the VA's failure to provide quality health care to our veterans in an effective, efficient, and timely matter.

To get to the bottom of these whistleblower reports, Senator Flake and I are requesting that the Senate Committee on Veterans Affairs conduct an investigation and hold hearings as soon as possible. This matter requires the urgent attention of all those charged with overseeing the VA's operations. Also, the individuals responsible for unreasonable delays in veterans' health care must be held accountable. As you appreciate well, American veterans have sacrificed much for their country and our nation has a solemn obligation to deliver them quality care in a timely manner.

With this information in mind, please provide answers to the following questions:

1. Did, as was recently reported, at least 40 veterans die while waiting unreasonably for the delivery of medical care by PVAHCS? If so, to what extent were those delays a causal factor in their deaths? What does the nation-wide data in this regard show?
2. Does PVAHCS keep multiple lists of veterans awaiting care? If so, what is the purpose of keeping multiple lists? Is this practice intended to obscure how long veterans have been awaiting care?
3. What is the actual average wait time for PVAHCS patients? Have any previously reported average wait times been based on the alleged deceptive unofficial list system?
4. To what extent have these multiple waiting lists obscured actual waiting times?
5. What mechanism is in place to guarantee a veteran is placed on the EWL as soon as he/she requests an appointment?
6. PVAHCS reportedly paid-out bonuses to VA officials for reducing wait times, even though those reductions only occurred by manipulating wait lists. How many officials received bonuses by reducing wait times through waitlist manipulation? What did each official receive as a bonus? What was PVAHCS's aggregate spending on such bonuses?
7. According to a recent report by the Department of Veterans Affairs, no Phoenix patient deaths in recent years have resulted in "adverse disclosures" to family members. Those disclosures are required when medical negligence or mistakes contribute to a patient's death. Given that as many as 40 deaths have allegedly resulted from delays in treatment due to the multiple waiting list issue, why were no "adverse disclosures" made regarding those reported patient deaths? Will "adverse disclosures" be issued? If not, why not?
8. What is the ratio of doctors to patients in the Phoenix VA Health Care System? Has that ratio had an adverse impact on patient waiting times?

9. Has an OIG team or other VA oversight body already addressed a waiting list problem at PVAHCS and what changes, if any, were recommended? If recommendations were made, what if anything did PVAHCS do to implement these recommendations? If not, why not?

If you or your staff have any questions regarding this letter, please contact Elizabeth Lopez at 202-224-8652. Thank you for your attention to this important matter.

Sincerely,

A handwritten signature in blue ink that reads "John McCain". The signature is written in a cursive style with a large initial "J" and "M".

John McCain
United States Senator