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February 12, 2014

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

Mr. Glen Grippen  
Interim Medical Center Director  
Phoenix VA Health Care System  
650 E. Indian School Road  
Phoenix, AZ 85012-1892

Dear Secretary McDonald and Mr. Grippen,

I write regarding the Department of Veterans Affairs' (VA) implementation of the Choice Program and new allegations of mismanagement at the Phoenix Veteran Affairs Health Care System (PVAHCS).

As you are aware, the Choice Program was intended to give veterans the ability to obtain non-VA health care if they face significant delays in the appointment process or if the veteran had to travel more than 40 miles to reach a VA facility. Unfortunately, the VA has decided to not factor in the form of care needed by the veteran and count Community-Based Outpatient Clinics as VA facilities regardless of the type of care they provide. With most specialty care only being provided at VA medical centers, which are fewer in number and may be further away than 40 miles, this is troubling. Also troubling is the VA's definition of how to calculate the location of the 40 mile limit, which is currently being based on distance measured "as the crow flies." This belies the fact that veterans are traveling by roads to the medical facility. It seems obvious that a more accurate way of determining a veteran's eligibility would be to use actual miles traveled.

With respect to the PVAHCS, I met Interim Medical Center Director Glen Grippen on January 14, 2015 and was offered assurances that the situation at the Phoenix VA was improving. However, a recent memo by the VA Office of Inspector General (OIG) documents otherwise. The OIG recently discovered conditions that "could potentially be putting patients at risk" and that require "immediate attention."<sup>1</sup> The PVAHCS is apparently six weeks behind in its processing of veterans' clinical tests due to mismanagement. According to the VA OIG, the PVAHCS Urology Department continues to provide below-standard care with severe understaffing, bureaucratic mistakes delaying patient referrals to private care, and reviews of clinical test results going unseen for months due to unacceptable backlogs.<sup>2</sup> The results of the OIG investigation, highlighted in a recent editorial in the *Arizona Republic*, revealed that more than 3,000 urology patients were not given prompt care from the Urology Department and were

<sup>1</sup> Department of Veterans Affairs Office of Inspector General, Interim Report: Review of Phoenix VA Health Care System's Urology Department Phoenix, AZ, January 28, 2015, Report No. 14-000875, p. 1.

<sup>2</sup> IBID, p. 1, 2, 4.

referred to private facilities. More troublesome is that the VA does not have records for the results of nearly a quarter of the veterans that received urology care in the private sector.

The undermining of the Choice Program appears an intentional effort by the VA to restrict access to health care for veterans in the private sector. This, coupled with the persistent revelations of mismanagement and lingering problems at the PVAHCS, paints a picture of an agency that is struggling to achieve its mission in a forthright manner. I respectfully request that the VA implement the Choice Program in a manner consistent with Congressional intent and that maximizes veterans being afforded choice rather than continue being roped into a bureaucratic morass. Additionally, the persistent revelation of issues at the PVAHCS is corrosive to the reestablishment of critical trust. I request that PVAHCS leadership make public all significant existing and ongoing issues associated with the availability of health care service and backlog problems.

Sincerely,

A handwritten signature in blue ink, appearing to read "Jeff Flake", is written over the typed name.

Jeff Flake  
United States Senator