Congress of the United States
Washington, DC 20510

December 15, 2023

The Honorable Denis McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, D.C. 20420

Dear Secretary McDonough:

We write with regards to a urology nurse practitioner at the James A. Haley Veterans Hospital (Tampa VA) that was removed from seeing patients in June 2023 because the practitioner did not meet the U.S. Department of Veterans Affairs (VA)'s highest standards of care, including appropriate follow-up care and adequate evaluation and assessment. We are concerned that the VA did not notify our offices or initiate a three-month clinical review of the situation until November 2023. Florida's veterans deserve the highest level of service and transparency about their health care, and we expect the VA to act expeditiously to notify veterans about the situation and the steps the VA is taking to rectify the situation.

We are additionally concerned that the clinical review period to redress this issue does not span a long enough time frame to review possible impacts on deceased patients. The nurse practitioner was employed by the Tampa VA for 21 years, yet the clinical review period only spans through October 2021. We are concerned that there may be deceased patients outside the purview of the current clinical review impacted by the lack of proper care. We request that the VA provide a detailed accounting of whether the overall health and wellbeing of veteran patients seen by this provider was impacted due to a lack of follow-up care.

We understand that the VA is in the process of reviewing approximately 3,000 urology patients previously seen by the provider. We appreciate the efforts of the VA to prioritize veterans' health and safety, and understand the VA is currently working to notify veterans for follow-up medical appointments as necessary. However, we would like assurances from the VA that the detrimental oversight that led to this situation will never occur again. We request that the VA ensure appropriate follow-up care is provided in the absence of this practitioner.

Veterans put their trust in the VA to receive high quality health care from attentive and professional medical providers. When the providers fail to meet these standards, veterans deserve timely communication about steps the VA is taking to address their health care needs and concerns going forward. As such, we request answers to the following questions:

1. What was the exact time frame for when the Tampa VA was made aware of the issue to when the nurse practitioner in question was actually removed from the Tampa VA Hospital?

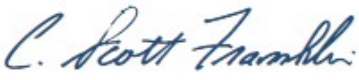
2. Why did the VA delay informing veterans about the removal of this medical professional and the initiation of a review, until nearly six months after physically removing the practitioner from seeing patients?
3. What is the criteria or reasons necessitating a three-month turnaround on the review?
4. The Tampa VA stated that their ability to review patients for follow-up care is based on local facility resources. What is the Department doing to support these efforts and what additional resources will be provided, if any?
    a. Does the VA need any additional authorities to expedite such reviews?
5. What steps is the Department taking to ensure the misconduct does not happen again?
6. How does the VA intend to assess the deceased patients to determine if poor urological care at the VA contributed to their deaths? What will be done if/when a death is discovered to be related to the lack of quality care by this provider?
    a. What is the VA doing to review the possible impact of this nurse practitioner on deceased patients over the years not included in the review?
7. How will expedited care be given to the provider's patients who are determined to need follow-up care? What is the time frame?
    a. Does the VA have bandwidth to provide this expedited care for up to 3,000 affected patients in a timely manner, considering the urgency of overlooked patients' urology needs?
8. Will patients that do not require follow-up care still be notified that they received care from a provider that was removed?
    a. What is being done to notify the general public of this issue?
9. Has the provider been terminated from the Tampa VA? Does the agency predict that the provider will be reinstated to their duties?
10. What changes has VA/Tampa VA made to the processes and procedures by which its urologists perform their day-to day duties to ensure any needed tests and assessments are done timely and thoroughly, including follow-up with patients?

Thank you for your attention to this important matter.

Sincerely,

Marco Rubio
U.S. Senator

Rick Scott
U.S. Senator



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