

REPUBLICANS

JEFF MILLER, FLORIDA, CHAIRMAN

DOUG LAMBERT, COLORADO  
DUSTY M. BURMAN, FLORIDA  
DAVID P. BEE, TENNESSEE  
BILL FLORES, TEXAS  
JEFF GIBBY, CALIFORNIA  
JOHN BURNHAM, NEW JERSEY  
DAN BIELSKAMP, MICHIGAN  
TIM BUELSCHAMP, KANSAS  
MARY E. AMDEH, NEVADA  
MIKE COFFMAN, COLORADO  
DRAKE WENSTHER, OHIO  
PAUL COOK, CALIFORNIA  
JACKIE WALORSKI, INDIANA

HELEN W. TOLAN, STAFF DIRECTOR  
AND CHIEF COUNSEL

DEMOCRATS

MICHAEL H. MICHAUD, MAINE, RANKING

CORINNE BROWN, FLORIDA  
MARK TAKANO, CALIFORNIA  
JULIA BROWNLEY, CALIFORNIA  
DINA TITUS, NEVADA  
ANN KIRKPATRICK, ARIZONA  
PAUL RUFF, CALIFORNIA  
GLORIA NEGRETE MCLEOD, CALIFORNIA  
ANDY M. KUSTER, NEW HAMPSHIRE  
BETO O'RIEN, TEXAS  
TIMOTHY J. WALZ, MINNESOTA

NANCY DEAN  
DEMOCRATIC STAFF DIRECTOR

U.S. House of Representatives

COMMITTEE ON VETERANS' AFFAIRS

ONE HUNDRED THIRTEENTH CONGRESS

335 CANNON HOUSE OFFICE BUILDING

WASHINGTON, DC 20515

<http://veterans.house.gov>

August 23, 2013

The Honorable Eric Shinseki  
Secretary  
U. S. Department of Veterans Affairs  
810 Vermont Ave. NW  
Washington, DC 20420

Dear Secretary Shinseki,

Pursuant to the House Committee on Veterans' Affairs oversight jurisdiction of the Department of Veterans Affairs (VA), I write to ask your cooperation in response to my requests for information regarding VA's response to, and policy concerning, specific incidents which occurred around the country. The requests relate to serious management failures identified primarily by VA's Inspector General, and the appearance of rewarding those failures through bonus payments.

Accordingly, please provide answers to the following questions:

- 1) VA Pittsburgh Director Terry Wolf received a perfect score on her VA Senior Executive Performance Agreement covering 10/1/11-9/30/12, a period representing the bulk of the deadly VA Pittsburgh Legionnaires disease outbreak. Why does Ms. Wolf's 10/1/11-9/30/12 performance review make no mention of the outbreak?
- 2) VA Regional Director Michael Moreland formally accepted a \$63,000 bonus three days after VA's Inspector General reported VA Pittsburgh's response to the outbreak was plagued by persistent mismanagement. Why does Mr. Moreland's Presidential Rank Award justification make no mention of the deadly VA Pittsburgh Legionnaires disease outbreak? Were you notified of this threat to patient safety before you signed off on Mr. Moreland's award? Should you have been? Do you believe VISN Directors like Mr. Moreland have a responsibility to keep their superiors informed of serious patient safety issues at facilities they oversee?
- 3) From 2009-2011, while presiding over a near seven-fold increase in backlogged disability benefits claims, VA Deputy Undersecretary for Field Operations Diana Rubens collected almost \$60,000 in bonuses. Please explain the apparent disconnect between the rising backlog and the award of such a large sum of bonuses?
- 4) Carl Lowe, the former director of the VA regional office in Waco, Texas, collected more than \$53,000 in bonuses as the office's average disability claims processing time grew to

historic levels, making it the most backlogged regional office in the country. Was the poor performance of the Waco office considered in determining Mr. Lowe's bonuses?

- 5) During a July 11 press conference, Atlanta VA Medical Center Director Leslie Wiggins said she does not think any Atlanta VAMC employees should be fired in response to three patient deaths that VA's Inspector General linked to mismanagement at the facility. Do you share Ms. Wiggins' view? Do you feel the punishments we have seen in response to the events in Atlanta (two reprimands for three patient deaths) are sufficient to prevent future adverse incidents at the facility?

More generally, please provide answers to these broader policy questions:

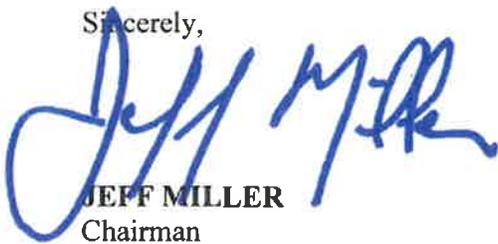
- 1) Do you think the Department of Veterans Affairs is doing enough to hold poorly performing executives and employees accountable?
- 2) When evaluating employee performance and determining bonuses, does VA generally consider preventable patient deaths and/or inspector general findings of malfeasance that may have occurred on a particular employee's watch? If not, why not?
- 3) Do you need or require any additional authorities to take swift action to hold poorly performing employees accountable?

Finally, please provide a detailed response as to what disciplinary action is being considered, or has been taken regarding the known patient-safety issues at VA facilities in Atlanta, Pittsburgh, Dallas, Buffalo, N.Y., and Jackson, Miss., along with a timeline with indicators or estimates for completing any adverse employment action.

Please provide the requested information by 4 p.m., Friday, August 30, 2013.

If you have any questions, please contact Mr. Eric Hannel, Majority Staff Director of the Subcommittee on Oversight & Investigations, at (202) 225-3569.

Sincerely,



**JEFF MILLER**  
Chairman

JM/rm