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ONE HUNDRED FOURTEENTH CONGRESS

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December 11, 2015

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

Dear Secretary McDonald,



I am writing regarding the persistent problems at the Department of Veterans Affairs' Phoenix VA Health Care System. As you know, Phoenix VAHCS is ground zero of the department's secret wait-list scandal. Yet more than 18 months after Americans first learned of the problems in Phoenix, serious issues are still surfacing, raising questions regarding the effectiveness of VA's efforts to reform the facility into one truly worthy of the veterans it is charged with serving. With that in mind, please answer the following questions and respond to the following requests:

Recently VA appointed Deborah Amdur as director of the Phoenix VAHCS. As you may know, Amdur was accused earlier this year of misleading a U.S. senator regarding the prescription of recalled drugs to a veteran at the White River Junction VA Medical Center in Vermont. According to an April 2, 2015, report in the Washington Examiner, Amdur assured Sen. Kelly Ayotte that the facility had completed several reviews and could not verify that VA had prescribed veteran patient Ted Stachulski a recalled bupropion pill. An Internet search done by the Examiner on March 31, 2015, for the pill's lot number, however, turned up recall notices for pills from the same drug lot VA prescribed to Stachulski. Was VA aware of this report at the time of Amdur's appointment to Phoenix VAHCS? If so, please outline all of the steps the department took to investigate the allegations and determine whether Amdur was culpable for misleading Ayotte. If there was no such investigation, I ask that you conduct one to determine whether Amdur did, in fact, mislead Ayotte and provide the results to this committee.

On Nov. 24, 2014, VA announced that former Phoenix VAHCS Director Sharon Helman had been fired. A Merit Systems Protection Board judge later upheld the firing, not for the facility's wait-time issues, but on the basis that Helman had improperly accepted gifts from a health care industry consultant. The MSPB's decision said that VA did not even attempt to "connect the dots of fault" to Helman regarding wait-time issues. Further, according to a Dec. 24, 2014, news release by Helman's attorneys, VA never even attempted to interview Helman regarding wait-time manipulation and whistleblower retaliation in Phoenix, nor did VA's inspector general

interview – or ask to interview – Helman for its Phoenix investigation. What this shows is that – due to shoddy investigatory and legal work – had VA not lucked out and stumbled across Helman’s inappropriate gifts, she would likely still be firmly entrenched in the VA bureaucracy to this day. Please explain how such serious failures in basic investigatory due diligence happened. Please explain why VA did not even attempt to interview Helman regarding her misconduct before proposing discipline. Please identify by name, the VA employee or employees in charge of Helman’s disciplinary actions and the investigation into her conduct as well as their VA central office supervisor. Additionally, please provide a by-name list of every VA employee who has been disciplined for these lapses in conducting a thorough and professional investigation of the Helman case, to include what disciplinary actions were proposed and taken. If no such actions occurred, please explain why.

A Sept. 16, 2015, decision by an administrative judge ruled that Sharon Helman is allowed to keep her fiscal year 2013 performance bonus, which VA had sought to rescind. In his decision, Judge Alan Caramella admonished VA for acting “negligently” and exhibiting a “damning” failure to produce crucial records and testimony. Please explain why – even when compelled by a judge’s order – VA failed to produce the documents and testimony cited in Judge Caramella’s decision. Please identify by name the VA employee or employees in charge of the department’s attempt to rescind Helman’s FY 2013 bonus as well as their VA central office supervisor. Additionally, please provide a by-name list of every VA employee who has been disciplined for this failure, to include what disciplinary actions were proposed and taken. If no such actions occurred, please explain why.

According to a Feb. 16, 2015, Arizona Republic report, a VA investigation into alleged misconduct by VA employees Lance Robinson, Brad Curry and Darren Deering at the Phoenix VA Health Care System was reset because VA had appointed an investigator to the case who had a conflict of interest. Please provide an update into the status of this investigation and include a precise explanation of the conflict that interrupted it. If the investigation is not complete, please explain why and detail when it will be completed. Please identify by name the VA employee or employees in charge of the department’s investigation into these matters as well as their VA central office supervisor. Additionally, please provide a by-name list of every VA employee who has been disciplined for the problems and delays associated with this investigation, to include what disciplinary actions were proposed and taken. If no such actions occurred, please explain why.

According to a Nov. 2, 2015, Arizona Republic report, a human resources team sent by VA headquarters to the Phoenix VAHCS to help triage and fix major problems within the facility’s HR department was obstructed by a lack of cooperation from Phoenix VAHCS leaders and staff. The report also notes that the HR team was ordered to leave the premises by then-acting medical center Director Glen Grippen. Please explain why VA went to the trouble of assembling the HR team and sending it to Phoenix only for local staff to disregard its recommendations and send it away. Please detail what actions VA central office leaders took when they learned from the HR

team what had happened in Phoenix. Did the HR team contact VHA senior leadership and ask them to order the Phoenix staff to cooperate? Did the HR team have any authority to ensure that Phoenix VAHCS implemented its recommendations? If not, what was the point of this exercise?

An Aug. 26, 2014, VA Inspector General report (#14-02603-267) on patient wait times and scheduling practices at the Phoenix VAHCS noted problems with access to care within the facility's urology department and said those issues would be the subject of a subsequent report. A Jan. 28, 2015, interim report (#14-00875-112) on the matter noted staffing shortages in the department and stated that delays associated with processing referrals could be putting patients at risk and required VA's "immediate attention." A third report (#14-00875-03) referencing problems within the urology department was released Oct. 15, 2015. It noted seven patients died after delays or lapses in care and that Phoenix VAHCS leaders had no plan to deal with staffing shortages, "which contributed to many patients being 'lost to follow-up.'" Please identify by name the VA employee in charge of the Phoenix VAHCS urology department. Additionally, please provide a by-name list of every VA employee who has been disciplined for the problems highlighted in the aforementioned reports, to include what disciplinary actions were proposed and taken. If no such actions occurred, please explain why.

Please provide this information and documentation to the Committee by no later than close of business on Monday, January 4, 2016. In doing so, regardless of whether it is stated above, all documents should be provided free of redactions or water marks. Do not produce the documents in a way that disables printing. Note that the deliverables opened by this request will not be closed until the Committee is sufficiently satisfied with the responses provided, including whether VA has adhered to the formatting instructions. If you have any questions, please contact Mr. Jon Towers, Majority Staff Director of the House Committee on Veterans' Affairs, at (202) 225-3527.

Sincerely,



JEFF MILLER
Chairman

Cc: Corrine Brown, Ranking Member

JM/mb