

**Congress of the United States**  
**Washington, DC 20515**

May 3, 2013

The Honorable Eric K. Shinseki  
Secretary  
Department of Veterans Affairs  
810 Vermont Ave. N.W.  
Washington, D.C. 20420

Dear Secretary Shinseki:

With the release of the report from the Department of Veterans Affairs Office of Inspector General (OIG) on April 23, 2013, it is fully documented that the deaths of five veterans and 21 cases of Legionnaires' Disease at the VA Pittsburgh Healthcare System (VAPHS) were preventable. The OIG report, requested by Pennsylvania lawmakers in December 2012, describe a total breakdown in communication and a failure of leadership where internal guidelines were ignored, care was compromised, and patients were endangered.

Yet, as you are aware, the VISN 4 Director Michael Moreland recently was awarded a bonus payment after being nominated by the Department of Veterans Affairs for a Presidential Distinguished Rank Award. This honor, presented to just 54 senior executive employees across the entirety of the federal government, is ostensibly for those that "achieve[d] results and consistently demonstrate[d] strength, integrity, industry and a relentless commitment to excellence in public service."<sup>1</sup> Given the disturbing OIG findings, the ongoing investigation by the House Veterans Affairs Committee and the allegations of criminal actions at VAPHS, we urge you, on behalf of the victims and their families, to cancel the Presidential Distinguished Rank Award and rescind this \$62,895 bonus payment and made to Mr. Moreland immediately.

Mr. Moreland's nomination was subsequently reviewed by the Office of Personnel Management, a board comprised of private citizens, and the White House. This review process occurred during the same period of time when Mr. Moreland and other VAPHS Leadership were aware of an outbreak of Legionnaires' Disease at the hospital.

According to the Senior Executives Association, Mr. Moreland was nominated for the Presidential Distinguished Rank Award for two successful cost-saving initiatives at VAPHS. Specifically, Mr. Moreland implemented an independent liver and kidney transplant program and an infection control program that reduced incidences of Methicillin-Resistant Staphylococcus Aureus (MRSA).<sup>2</sup> Tragically, these cost-saving initiatives are some of the very programs where the OIG discovered systemic failures leading to the outbreak.

The OIG found that VAPHS failed to test all healthcare-associated pneumonia patients for Legionella as required by the Veterans Health Administration (VHA) for transplant centers with a history of healthcare-associated Legionnaires' disease [emphasis added]. The OIG also found

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<sup>1</sup> Office of Personnel Management. <http://www.opm.gov/policy-data-oversight/senior-executive-service/compensation/#url=Recognition>

<sup>2</sup> "Savings Achieved By 2012 Presidential Distinguished Rank Award Winners," Senior Executives Association.

that VAPHS failed to conduct routine flushing of hot water faucets and showers as recommended by the manufacturer of the water treatment systems; failed to properly respond to positive cultures with corrective actions consistent with VHA or the Centers for Disease Control and Prevention guidance; and failed to properly manage its water treatment systems during 2011-2012, which "allow[ed] ion levels inadequate for Legionella control to persist."

We respectfully request the nomination package for Mr. Moreland submitted by your agency to OPM; any additional information about all performance bonuses paid by the VA to Mr. Moreland and VAPHS Hospital CEO Terry Gerigk Wolf from February 2011 to present; and an explanation why the VA determined that it was appropriate to make those awards. In addition, we request similar details for any other bonuses the VA paid to other members of the VAPHS executive leadership team during that same time period.

Finally, many of the families of the veterans who tragically died as a result of the outbreak at VAPHS are frustrated that they have not yet had the opportunity to meet with you in person. As the senior-most official at the VA, you are ultimately responsible for the quality of care that veterans receive at VAPHS, and thus we request you travel to Pittsburgh and meet with these families as soon as possible. We are willing to help facilitate such a meeting.

The victims and their families have suffered an incredible amount of pain knowing the VA hospital where they sent loved ones to receive care and recover in fact caused them to become even more ill. Tragically, some even lost their lives. The anguish these families are experiencing is still very fresh and indeed will never disappear. Giving a taxpayer-funded bonus to the VISN Director would be tremendously insensitive and offensive to these victims. Indeed, as taxpayers, it is their money you are directing to Mr. Moreland. We urge you to do what is just and rescind this bonus now, Mr. Secretary.

We thank you for your prompt attention to these requests. Should you have any questions, please do not hesitate to contact us.

Sincerely,



Tim Murphy  
Member of Congress



Keith Rothfus  
Member of Congress



THE SECRETARY OF VETERANS AFFAIRS  
WASHINGTON  
July 12, 2013

The Honorable Timothy Murphy  
U.S. House of Representatives  
Washington, DC 20515

Dear Congressman Murphy:

Thank you for your cosigned letter expressing your concerns regarding performance awards given to Mr. Michael Moreland, Director of the Veterans Integrated Service Network 4. You questioned the appropriateness of the nomination of Mr. Moreland for the Presidential Distinguished Rank Award, and the granting of other performance awards to the executive leadership team in light of the outbreak of Legionnaires' disease at the Department of Veterans Affairs (VA) Pittsburgh Healthcare System (VAPHS). The enclosed fact sheet addresses the specific issues outlined in your letter.

I was saddened to learn of Veterans whose deaths were attributed to Legionella, and I remain committed to providing all our Veterans with a safe environment in which to receive care. VA employees at the VAPHS, along with all of our employees, have a solemn responsibility to provide safe, quality care for the well being of all our patients. VA has expressed heart-felt condolences on several occasions to the families of the deceased Veterans.

Mr. Moreland's award nomination had cleared my office and was approved by the Office of Personnel Management prior to any information or events related to Legionnaires' disease at VAPHS became known to VA leadership. Mr. Moreland received the Presidential Distinguished Rank Award based on his exceptional career in public service. As a career executive, Mr. Moreland has a sustained record of achievement that is recognized throughout the Department and is acknowledged on a national level. Mr. Moreland is an outstanding professional who continuously demonstrates strength, commitment, integrity, and a relentless commitment to public service.

The Veterans Health Administration is committed to managing the surveillance of both clinical infection of patients and the presence of the Legionella bacterium at VAPHS and all VA facilities. In response to the VA Office of Inspector General report, dated April 23, 2013, VA can and will do more to prevent future incidences. VA has partnered with both national and local organizations in an ongoing effort to understand and control Legionella. VAPHS is following the recommendations of external and internal review teams, such as superheating and hyper-chlorinating the water system among other remediation efforts. These efforts have successfully reduced Legionella in the water supply.

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The Honorable Timothy Murphy

Should you have any additional questions, please have a member of your staff contact Mr. Matthew Santos, Congressional Relations Officer, at (202) 461-6442 or by e-mail at [Matthew.Santos@va.gov](mailto:Matthew.Santos@va.gov). A similar letter has been sent to Congressman Rothfus.

I appreciate your continued support of our mission.

Sincerely,

A handwritten signature in black ink, appearing to read "Eric K. Shinseki". The signature is fluid and cursive, with a large, sweeping flourish at the end.

Eric K. Shinseki

Enclosure