

Congress of the United States
Washington, DC 20515

July 10, 2014

Mr. Sloan D. Gibson
Acting Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Acting Secretary Gibson,

We write to express significant concerns regarding the Raymond G. Murphy Veterans Affairs Medical Center (VA Hospital) in Albuquerque, New Mexico. We have frequently asked the VA Hospital to provide us with its written policies and practices related to scheduling, patient wait time, bonus and performance award system, and general management issues including how schedulers are trained. However, VA Hospital staff has repeatedly denied this information to us and most recently told our offices that we must file Freedom of Information Act (FOIA) requests for all written VA Hospital documentation. Such responses tremendously impede our constitutional responsibility to oversee the faithful execution of the laws we pass.

We are particularly disturbed about a conference call held on July 7, 2014, between our congressional staff and VA Hospital staff, including interim Director Dr. James Robbins, to discuss the handling of a medical emergency that occurred on June 30, 2014. As you are aware, Jim Napoleon Garcia, a Vietnam War veteran, suffered a heart attack in the VA Hospital's cafeteria and died after reportedly waiting approximately 30 minutes for an ambulance to arrive. Subsequent to Mr. Garcia collapsing, a 911 call was placed. VA Staff did not mobilize an on-site VA Hospital EMS team to provide emergency medical services. According to the VA, staff acted in accordance with an April 4, 2014 Medical Center Memorandum, which defines VA Hospital policy during medical emergencies on campus.

However, when congressional staff asked for copies of the Medical Center Memo, VA Hospital staff withheld this material and asserted that the only way to obtain this information would be to file a FOIA request. Due to numerous exemptions in information provided via FOIA requests, it is not a means of obtaining information consistent with Congress' constitutional authority to properly conduct its oversight responsibilities. This shows either an alarming ignorance or an utter disregard for our constitutional responsibility to oversee the faithful execution of laws we pass. Providing this memo through a FOIA request would enable the VA to invoke material exemptions to prevent full disclosure to members of Congress.

At a time when the VA as a whole is under serious scrutiny, it is imperative that the VA Hospital is as transparent as possible about its policies and procedures. This information would serve an important Congressional purpose to provide oversight of a VA hospital whose mismanagement practices have been identified by the VA Office of Inspector General and the Senate Appropriations Committee. Accordingly, we strongly believe that the VA Hospital is inappropriately withholding not only this Memo but also other written VA Hospital documentation. Our inability to receive information after legitimate congressional inquiries diminishes our capacity to conduct our oversight and legislative duties as members of Congress.

Therefore, please provide the following information:

1. Please explain the VA's policy for training VA Hospital staff in responding to Congressional inquiries. Specifically, is there a uniform procedure in place that VA Hospital staff follow in determining whether a facility may release written policies, directives, and practices per Congressional inquiries? Is it a common practice to condition disclosure of such information on a Congressional office first filing a FOIA request?
2. Please provide clarity on why the 2014 Medical Center Memo can only be released through a FOIA request;
3. Release the April 4, 2014 Medical Center Memorandum to our offices and any other document which outlines VA Hospital policy during medical emergencies on campus to the public;
4. Please provide training materials provided for staff whose duties involve scheduling veterans for appointments at the VA Hospital;
5. Copies of the letters sent to veterans after three unanswered phone calls from VA staff attempting to schedule appointments; and
6. Documents or handbooks with policies pertaining to VA staff bonus and performance standards and structures.

If you are unable to comply with these requests, please explain how this is consistent with VA standards for sharing information with Congress and the millions of veterans served by the VA.

We all share the same goal of ensuring that our veterans receive the quality, timely care that they have earned. Our requests for pertinent written VA Hospital policies are part of that shared obligation and transparency—not secrecy—will help restore the public's confidence in the VA's ability to care for our nation's veterans.

Sincerely,



Tom Udall
United States Senator



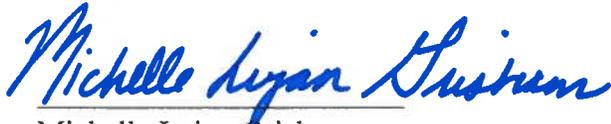
Martin Heinrich
United States Senator



Steve Pearce
Member of Congress



Ben Ray Lujan
Member of Congress



Michelle Lujan Grisham
Member of Congress