STATEMENT OF MR. JOSHUA JACOBS
UNDERSECRETARY FOR BENEFITS
VETERANS BENEFITS ADMINISTRATION (VBA)
AND
SHEREEF ELNAHAL, M.D., MBA
UNDERSECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)

BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 10, 2024

Good morning, Chairman Bost, Ranking Member Takano, and Members of the Committee. Thank you for inviting us here today to discuss VA's efforts to address accountability within the Department. Joining us today is Mr. Edward Murray, Acting Assistant Secretary and Chief Financial Officer for the Office of Management.

We at VA are committed to providing Veterans with the care and benefits they have earned through their service to our country. Our Veterans and their families, caregivers, and survivors deserve nothing less. We and the more than 400,000 employees at VA are devoted to this sacred duty and work diligently every day to fulfill this mission. Sometimes, though, even with the best intentions, we fall short in the delivery of this care and benefits. When we fall short, we—as a high reliability organization—are transparent about our errors, correct our mistakes, and learn from them. As part of that process, we hold ourselves accountable. In today's hearing, we welcome the opportunity to talk to you about the process that we follow to ensure that any errors are transparently investigated, corrected, and learned from, including by holding individuals accountable, and to discuss the status of the instances identified in your hearing invitation.

VA's High Performance

We would be remiss if we did not first underscore that these problem cases are exceptions. In fact, VA and its hardworking employees have been performing at an extraordinarily high level, especially over the past year. The numbers tell the story:

- Veterans trust VA at record rates, with 91.8% of VA's Veteran patients reporting that they trust VA health care, an all-time high level unmatched in the private sector and an increase of 6% over 2018 (when the survey began). Additionally, overall Veteran trust in VA has reached an all-time high of 80.4% -- up 25% since 2016according to the Veteran Trust in VA Survey.
- In 2023, VA delivered more disability compensation benefits to more Veterans than ever before. VA delivered $163 billion in earned benefits, including $150

billion in compensation and pension benefits to over 6 million Veterans and survivors. VA also processed almost 2 million Veteran and survivor claims, surpassing the previous all-time record set in 2022 by 15.9%. This fiscal year, we are outpacing last year's record-breaking rate by nearly 30% and are currently projected to complete 2.5 million compensation and pension rating claims in fiscal year (FY) 2024.

- For new patients, in FY 2024 Quarter 3, there was a 9% decrease in average wait times for VA primary care and an 8% decrease in average mental health wait times when compared to the same period last year. These improved wait times come at a time when VA is delivering more care to more Veterans than ever before. Compared to the same time period last year (which was a record-breaking year for appointments), VA completed 7% more new patient appointments – including nearly 19% more new patient primary care appointments and 15% more new patient mental health appointments this year in Quarter 3. These outcomes represent sustained results from VA's Access Sprints—a concerted effort in the winter and early spring of 2024 to offer more appointments to Veterans across the system, including night and weekend clinics, telehealth, and more.

- More Veterans are choosing VA health care than ever before. As of July 14, 2024, VA has enrolled more than 412,000 new patient Veterans in VA health care over the past year — 27% more than we enrolled the previous year. Since the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 was passed, more than 710,000 Veterans have enrolled in VA health care, a more than 34% increase in Veterans enrolling compared to an equivalent period before the legislation was signed. And more than 843,000 additional Veterans already enrolled in VA health care experienced a health care priority group increase since the PACT Act was signed.

- Nearly 70% of VA hospitals received 4 or 5 stars in the Centers for Medicare and Medicaid Services (CMS) annual Overall Hospital Quality Star Ratings, compared to only 41% of non-VA hospitals.

- VA provided an all-time record $1.5 trillion in life insurance coverage to 5.6 million Veterans, Service members, and their family members in 2023. This includes new coverage awarded through VALife, a program that extended life insurance access to millions of service-connected Veterans. The VALife program now provides more than $1.23 billion in coverage to more than 41,000 eligible Veterans.

- VA is supporting more Veterans in crisis. Upon the 2 year anniversary of 988, VCL has noted a 22.7% increase in calls/day, 76.7% increase in texts/day, and 27.5% increase in chats/day since the launch of 988. This means that more Veterans than ever are getting the support they need from caring, qualified responders during times of crisis. VA has also provided no-cost,

emergency health care to 67,975 Veterans in acute suicidal crises through a new program launched in January 2024.

- VA has screened 5.6 million Veterans for toxic exposures, a critical step to document Veteran exposure concerns, provide education, and connect Veterans to available medical care, registry, benefits, and other services, as indicated.

- VA is providing more resting places to the Nation's heroes, with a record 5.4 million people — including 4.1 million Veterans — now buried in VA national cemeteries.

These accomplishments are the result of a highly motivated and talented work force. The positive working environment and strong morale of the employees at VA are exemplified by our success in hiring new personnel during FY 2023, with a record number of external VHA hires (nearly 62,000 new employees) and net growth of full-time equivalents (FTE) by 7.4%. To keep up with the record number of claims received since the PACT Act, VBA also significantly increased its workforce, which has seen a nearly 33% increase since October 1, 2022.

Additionally, as perhaps the best indication of the increased satisfaction among our employees, retention rates have improved significantly. Attrition has decreased from an 11% total loss rate in FY 2022 to 8.4% in FY 2023, the lowest rate in more than 10 years. VBA has similarly seen historically low attrition rates, reporting an FY 2024 loss rate of 6.02% through the end of June 2024, compared to the 6-year average of 7.39%. Not surprisingly, in a recent All Employee Survey (AES) administered to VA employees, more than 88% reported that they feel a strong sense of pride and meaning in their work at VA. And trust among VA employees is at its highest level on record, and the score has steadily increased in recent years.

We are proud of these results and of our talented team at the VA, and we will not stop working to continue to provide quality care and benefits to our nation's Veterans and survivors.

Accountability Process

While our employees are dedicated and committed to public service and have a proven record of providing quality care and benefits to Veterans, VA also recognizes that the performance of a limited number of VA employees, including certain leaders, has at times fallen short of what we expect and what our Veterans deserve. When that happens, holding individuals accountable is an important part of effective management, and we take that responsibility seriously.

VA has various, complementary, means of holding its leaders and employees accountable:

Office of Accountability and Whistleblower Protection (OAWP)

Established by the VA Accountability and Whistleblower Protection Act (the Accountability Act) of 2017, OAWP actively promotes and improves accountability at VA. OAWP is responsible for receiving and investigating allegations that senior leaders engaged in misconduct and poor performance and allegations that any VA supervisor engaged in whistleblower retaliation. OAWP also receives whistleblower disclosures and refers them to the appropriate VA organization for investigation and resolution of potential problems and concerns, and then OAWP maintains oversight of those referrals. OAWP further tracks certain recommendations made to VA by other oversight entities such as the VA Office of Inspector General (OIG), VA Office of the Medical Inspector (OMI), and Office of Special Counsel (OSC), and the Government Accountability Office. In addition, OAWP also educates VA employees and VA leadership on whistleblower rights and protections and provides advice and support to the Secretary on accountability matters.

After conducting investigations into allegations of senior leader misconduct and/or poor performance or whistleblower retaliation by a supervisor, OAWP issues a report that includes the allegations, background information, factual findings, conclusions, and recommendations for disciplinary and non-disciplinary actions where appropriate. In FY 2023, OAWP made 72 recommendations including 20 disciplinary recommendations; *all* the disciplinary recommendations were either fully or partially implemented, or the employee retired or resigned before discipline could be implemented. For FY 2024, through July 17th, OAWP has made 103 recommendations, including 29 disciplinary recommendations. All but one of the disciplinary recommendations were fully or partially implemented, or the employee resigned or retired before discipline could be implemented. Seven recommendations remain open pending a disciplinary decision.

Office of the Medical Inspector (OMI)

OMI is responsible for assessing the quality of VA health care through investigations of VA facilities Nationwide. OMI investigations are initiated after receiving allegations and/or disclosures, including those referred by VA employees and leadership, OAWP, OIG, OSC, and Congress. OMI issues comprehensive reports of the health care investigations that generally include the allegations investigated, necessary background information, factual findings, conclusions, and actionable recommendations for corrective action and/or improvements to the quality of Veterans' health care. When OMI uncovers evidence of potential senior leader misconduct or poor performance during one of its investigations, it refers the allegations and/or evidence to OAWP for investigation of the alleged misconduct and/or poor performance. OMI focuses on issues related to oversight and improvement of Veterans' health care. For all OMI recommendations, an action plan to implement the recommendation is requested from the applicable medical center, Veterans Integrated Service Network (VISN), or program office. The action plan is approved by OMI leadership and then followed with quarterly updates until completion. OMI leadership approves closure of the action plan when

appropriate evidence is submitted to prove mitigation of the original findings and satisfy the intent of the recommendation.

Authorities

The Accountability Act, specifically section 201, provides VA with the authority to take disciplinary and adverse action against senior executives and other covered employees based on poor performance and misconduct. The Accountability Act created a new section 713 that sets forth a streamlined procedure for taking accountability actions against senior executives for misconduct and poor performance and the process by which senior executives can challenge such actions. The Accountability Act also provides the authority for VA to recoup relocation expenses, bonuses, and awards under certain circumstances. Personnel actions taken against senior executives demonstrate that section 713 is being utilized to hold senior executives accountable. Since 2020, there have been more than 40 actions taken under section 713 against Senior Executive Service members and title 38 equivalent employees. For other VA employees, VA takes accountability actions using the same Title 5 accountability authorities generally used by other Executive agencies. Title 5 provides all of the authority that VA needs to hold employees accountable for poor performance and misconduct, including removals. Each year, VA uses these authorities to take disciplinary action against thousands of employees, including taking more than 4,000 adverse actions in each of the last 2 years (i.e., FYs 2022 and 2023).

Challenges at VA Medical Centers

VA runs the Nation's largest integrated health care system serving over 9 million Veterans at more than 1,100 health care facilities. When there are problems identified at a medical facility, we, with the assistance of OAWP and OMI, act to investigate, remedy the problem, and ensure individuals are held accountable, if appropriate. This includes senior leaders. For example, in Detroit, as a result of multiple site review findings and OMI/OAWP investigations, three executive leadership team members were detailed out of their positions. Two were proposed to be removed resulting in one retirement and one termination. The third individual was permanently reassigned out of the facility and retired shortly thereafter. The facility subsequently has experienced better performance, including improved 2024 Joint Commission findings from the last triennial review.

Similarly, in Montana, the VISN 19 Network Director detailed the Montana VA Healthcare System Director out of the position in July 2023 who subsequently retired in December 2023, immediately upon identifying operational oversight concerns, including systems and process issues, and subsequently appointed an Acting Director. The Network Director took additional steps, to include: (1) appointing a Special Advisor on Montana Oversight and (2) chartering a system-wide review to identify any additional issues and ensure implementation of comprehensive corrective measures throughout the System. Montana VA Healthcare System's trust scores from Veterans have increased to 89.6%, enrollment increased last year by more than 2,000 Veterans, and

the Montana VA Healthcare System received a 5-star Patient Rating from CMS and a 4-star rating in Quality.

In your hearing invitation, the Committee noted several medical centers where there have been allegations of misconduct and other problems. We appreciate the oversight of the committee and address our efforts at those facilities specifically:

1. VA Eastern Colorado Health Care System. When concerns were raised about facility leadership and organizational culture at this facility in October 2023, VISN leadership moved with haste to remove the Director and Chief of Staff out of the facility. Two other facility leaders resigned in the wake of the internal investigation. The VISN 19 Network Director appointed a senior executive to serve as Acting Medical Center Director to promote continuity of operations, psychological safety, and to ensure high quality health care for Veterans. On March 4, 2024, Dr. Elnahal visited and hosted a townhall for VA Eastern Colorado health care staff to discuss issues there. The new leadership at VA Eastern Colorado also has held multiple listening sessions and conducted a series of trainings and stand-downs. VHA leadership intends to remain actively engaged to ensure that the culture and management in VA Eastern Colorado continues to reflect the values of a high-reliability organization for employees and the Veterans we serve. We have concurred in all of the OIG's recommendations relating to VA Eastern Colorado, and we are committed to promptly reviewing and taking appropriate action based on OAWP's recommendations when finalized. It should be noted that VA Eastern Colorado has a 90.5 trust scores from Veteran patients and Rocky Mountain Regional VA Medical Center is the only hospital in the Denver metro area with 5-star ratings from CMS for both patient experience and overall quality.

2. Hampton VA Medical Center (VAMC). The VISN's Chief Medical Officer has been actively addressing issues at the Hampton VAMC Surgical Service department since August 2023, conducting multiple trips and evaluations at the facility. As a result of the facility and VISN leadership's actions, the head of surgery has stepped down. The facility's Medical Center Director has been removed pending an ongoing internal investigation, and the Chief of Staff has resigned. VISN 6 officials have engaged in regular meetings with the Hampton VAMC medical and surgery leadership to establish an action plan focused on all aspects of performance and process to improve health care delivery for Veterans seeking surgical care. VHA also has concurred on all 12 of the recommendations in the OIG's recent report. Prior to the release of the OIG's report, Dr. Elnahal visited the Hampton VAMC on May 20, 2024, where the recommendations with mitigation strategies were presented, and VHA expects that all recommendations will be implemented by the end of 2024.

3. VA Loma Linda Healthcare System. Similarly, VA is committed to the continued improvement of the organizational culture at VA Loma Linda to ensure the well-being of all employees. Facility and VISN leaders have embarked on a plan of action based on insight from the VA all employee survey and feedback from organizational reviews, including a climate study conducted by OAWP. Toward that end, VA Loma Linda is now leading the VISN in the number of staff who have completed

Clinical Teams Training, which is a program that provides clinical and administrative staff tools to improve patient safety and overall job satisfaction. The Medical Center Director has increased his office hours to meet directly with staff and address concerns, and all of VA Loma Linda leadership conducts monthly safety forums and bi-weekly meetings that are focused on strengthening organizational excellence by gathering staff to celebrate successes and share best practices. OAWP conducted 11 other investigations into allegations of whistleblower retaliation, and none of the allegations were substantiated. One OAWP investigation is still ongoing. Additionally, Dr. Elnahal visited the site with Ranking Member Mark Takano on August 7-8, 2023, where they met with leaders, staff, and union officials to hear concerns and the progress made in improving the culture and climate of the organization.

Critical Skill Incentives

The new critical skills incentive (CSI) authority established under the PACT Act is an important tool that helps VA close mission-critical skills gaps that are in short supply or high demand and directly relate to the duties and responsibilities of an employee's position. As we voluntarily informed the Committee last fall, VA erred in the way this CSI authority for career senior executives working at VA Central Office (VACO) was implemented and executed. Upon identifying the problem, VA immediately cancelled and began recoupment for all CSI payments made to VACO career senior executives. VA also referred the matter to the OIG and notified this Committee, VSOs, and the media of the issue. In May, the OIG issued a lengthy report that detailed the failures in the approval of these CSI payments to VACO senior executives. VA has concurred with the OIG's findings and its eight recommendations and is in the process of implementing these recommendations, which include reviewing all CSIs awarded to date and strengthening the policies and governing practices associated with CSIs. To date, VA has collected through the recoupment process more than 92% of the CSI debts from career senior executives at VACO. Several other executives are on restructured bi-weekly repayment plans. While several executives have requested hearings or waivers, all hearings to date have confirmed that the debt and amount are valid. In addition, consistent with the OIG's recommendation, OAWP is conducting a review to determine whether disciplinary action against any VA official(s) is warranted.

Conclusion

VA takes seriously all allegations of misconduct and poor performance to ensure it is providing the highest quality health care and benefits to Veterans, their families, caregivers, and survivors. VA is committed to holding leaders accountable for misconduct and poor performance, including taking disciplinary actions when appropriate. VA's record-high trust scores with Veterans, the high morale among VA employees, and the Department's recent accomplishments in providing more care and more benefits to more Veterans than ever before, all are, in part, a product of our effectiveness in holding ourselves accountable. Nevertheless, there is always ample opportunity for improvement in our execution of our sacred mission, and we appreciate the Committee's oversight in helping make us better.

Thank you, and we look forward to your questions.