STATEMENT OF

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HOUSE COMMITTEE ON VETERANS' AFFAIRS

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Good morning, Mr. Chairman and Members of the Committee. I am grateful to have the opportunity this morning to provide an update on our efforts to reset accountability across the Department of Veterans Affairs. Accompanying me is Meghan Flanz, our Deputy General Counsel for Legal Operations and Accountability.

Accountability Defined

It seems the term "accountability" has taken on a new meaning. Instead of the dictionary definition – "providing a record or explanation of one's conduct" – the term has become shorthand for firing people.

Secretary McDonald and I want to reclaim the term "accountability" in its fuller meaning, in the sense of being transparent about what our goals are and how well we achieve them, what taxpayers can expect us to achieve with each dollar we receive, what Veterans can expect us to do for them, by when, and to what level of quality and satisfaction.

Abraham Lincoln said "Commitment is what transforms a promise into reality." Within that framework, we believe "accountability" is interchangeable with "commitment." We hold ourselves accountable for making good on our promises to Veterans – to President Lincoln's promise to care for those who have borne the battle and for their survivors – by providing timely, high-quality care and service to Veterans, while using taxpayer dollars wisely.

In that fuller sense, accountability means setting the right goals, both as an organization and for individual employees, so the work we do produces the outcomes Veterans deserve.

- It means ensuring our employees have the training and resources necessary to achieve those goals.
- It means providing a work environment that is free of fear, so our employees feel safe raising concerns about the work we do and about the quality and safety of our programs and processes.
- It means setting clear performance standards and expectations up front, and then assessing performance candidly, based on actual achievement
- It means rewarding people for exceptional performance that furthers desired outcomes.
- It means training our leaders to lead, and ensuring they understand our vision of a transformed VA that provides Veterans with a satisfying – even delightful – experience with VA care and services.
- Accountability also means taking appropriate actions when things go wrong. It means taking the time to understand the reasons for a failure – whether it's a systems failure, lack of clear policy or guidance, insufficient training, or an intentional act of misconduct.
- It means responding to failures quickly, with a sense of urgency, to make things right for Veterans and to learn from our mistakes.
- Accountability also means disciplining those who have done wrong, swiftly and meaningfully but in a way that is proportionate to the offense. Significant offenses and repeated misconduct may well warrant removal. Other offenses may warrant less severe, corrective penalties rather than terminating employment.

If we define "accountability" only in the narrower way – in terms of the number of employees we remove from their jobs serving Veterans – then success on the accountability front means failure in our core mission, service to Veterans. Overemphasis on punitive measures prevents us from recruiting and retaining the best and brightest employees to serve Veterans. Secretary McDonald and I are not

interested in a definition of success that requires us to decimate our workforce and, ultimately, to close our doors.

We define “accountability” broadly, to include achievement of Veteran-centric goals and continuous improvement of VA programs and systems, because the narrower definition isn’t good for Veterans.

With the Veteran-serving sense of “accountability” as our definition, here is what we have accomplished this year:

Where we started

In the context of patient access and scheduling data manipulation concerns that came to light at the Phoenix VA Medical Center, allegations of whistleblower retaliation, concerns about over-prescription of opioids at the Tomah VAMC, and cost overruns related to our construction of a replacement medical center in Denver, CO, VA has experienced a crisis of confidence.

As a result, throughout 2015, VA’s Office of the Inspector General (OIG) remained extremely busy, investigating a wide variety of allegations raised by whistleblowers and others across the broad spectrum of VA programs and services. The VA OIG website lists 400 reports published in Fiscal Year (FY) 2015, with a large number of investigations still ongoing.

What we have done

Expanding access to VA care

- Nationally, the Veterans Health Administration (VHA) completed 56.2 million appointments between June 1, 2014 and May 31, 2015, which is 2.5 million more than were completed in the comparable time period the year prior.
- In October 2015, VA completed 97 percent of appointments within 30 days of the clinically indicated or Veteran’s preferred date; 91 percent within 14 days; 87 percent within 7 days; and 24 percent are actually completed on the same day.

- VA's average wait time for completed primary care appointments is 4 days, specialty care 5 days, and mental health care 3 days.
- VA is a national leader in telehealth services. VA Telehealth services are critical to expanding access to VA care in more than 45 clinical areas. At the end of FY 2014, 12.7 percent of all Veterans enrolled for VA care received Telehealth based care. This includes over 2 million telehealth visits, touching 700,000 Veterans.

Providing More Care in the Community

- VHA created 2.4 million authorizations for Veterans to receive care in the private sector from November 19, 2014 through November 18, 2015. The average authorization generates 7 appointments.
- Over 1.4 million appointments are completed per month through doctors and clinics in the community, which represents nearly 23 percent of total appointments.

Recruiting and Hiring New Healthcare Professionals

- From August 2014 to September 30, 2015, VHA has increased net onboard clinical staff by over 15,000. This includes over 1,500 physicians, 3,900 nurses, and 566 psychologists for VHA's clinical care to Veterans.

Improving Healthcare Services for Women Veterans

- VA has enhanced provision of care to women Veterans by focusing on the goal of developing Designated Women's Health Providers (DWHP) at every site where women access VA. VA has trained over 2,200 providers in women's health and is in the process of training additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a DWHP.

- VA now operates a Women Veterans Call Center (WVCC), created to contact women Veterans and let them know about the services for which they may be eligible. As of June 2015, WVCC received over 24,000 incoming calls and made over 219,000 successful outbound calls.

Ending the Claims Backlog

- The Veterans Benefits Administration (VBA) completed 1.4 million claims in FY 2015, nearly 67,000 more than last year and the highest completion rate in VA history. FY 2015 marked the sixth year in a row of more than 1 million claims.
- VBA reduced its claims backlog 88 percent from a peak of 610,000 in March 2013 to a historic low of 75,122; reduced inventory 58 percent from a 884,000 peak in July 2012 to 369,328 (28 percent lower than FY 2014). At the same time, VBA has sustained claims-processing quality at 90.2 percent; issue quality at 96 percent; and above 98 percent in 7 of 8 categories in which we measure quality.
- The average days a Veteran is waiting for a claims decision (pending) is 91 days, a 191-day reduction from a peak of 282 days in March 2013 and the lowest average days pending in the 21st Century. VBA's average days to complete is now 129 days – a 60-day reduction from FY 2014.

Reducing the Number of Homeless Veterans

- VA has worked with federal, state, and local partners to reduce the estimated number of homeless Veterans by 36 percent as noted in the Department of Housing and Urban Development (HUD) 2015 Point-in-Time Estimate of Homelessness. With the assistance of VA and other Federal partners, numerous communities, including the entire Commonwealth of Virginia, have now declared that they have ended Veteran homelessness.
- In FY 2015 alone, nearly 65,000 Veterans obtained permanent housing through VHA Homeless Programs. In FY 2014, 50,730 homeless Veterans obtained permanent housing through these initiatives.
- Through the homeless Veterans initiative, VA committed more than $1 billion in 2015 to strengthen programs that prevent and end homelessness among Veterans.

Transforming the Customer Service Experience through MyVA

- VA is working to reorganize the department for success, guided by ideas and initiatives from Veterans, employees, and all of our shareholders. This reorganization, part of the MyVA initiative, is designed to provide Veterans with a seamless, integrated, and responsive customer service experience.
- MyVA is our transformation from VA's current way of doing business to one that puts the Veterans in control of how, when and where they wish to be served. Under MyVA, the Department has created a integrated regional framework to enhance services.

Employee Discipline – Our Approach and the Overall Numbers

We continue to approach employee discipline as we have done since Secretary McDonald and I took office – with a commitment to do what is right and necessary to rebuild Veterans' trust in VA programs and services.

Of course, punitive action against employees must be reserved for instances involving actual evidence of misconduct. This is not only the right way to impose discipline but it is the legal way. If VA does not have evidence of misconduct, any disciplinary action taken by VA will not be upheld on appeal. This remains true under the Senior Executive accountability provision of the Choice Act, and under the more traditional disciplinary procedures that apply to VA's non-Senior Executive Service (SES) employees.

It is important to note what constitutes evidence of misconduct -- and what does not.[1] Materials such as documentary evidence, data, and witness testimony constitute evidence. VA works with its OIG to provide and compile evidence. But VA cannot rely wholesale on an OIG report to impose discipline. Under the law, "summary, unsworn, hearsay conclusions" in an OIG report will not support discipline.[2] For that reason, VA must carefully consider the evidence underlying adverse OIG reports to make sure there is substantiated evidence of misconduct upon which VA can rely to impose discipline.

[1] Prouty & Weller v. General Services Administration, 2014 MSPB 90 (December 24, 2014), ¶ 6.
[2] Prouty & Weller v. General Services Administration, 2014 MSPB 90 (December 24, 2014), ¶ 6.

Similarly, the fact that VA OIG has referred a matter to DOJ for possible criminal investigation or prosecution does not constitute evidence of misconduct. Rather, referral simply means that VA OIG has asked DOJ to review the matter to determine whether any of the underlying allegations, if proven, might constitute a crime. Because, under the Constitution, individuals are presumed innocent unless and until proven guilty, we cannot support employee discipline on the basis of a pending criminal referral.

It is also important to note that VA does not rely solely on OIG or DOJ to investigate misconduct. Though VA respects and appreciates the work of its partners, sometimes OIG and DOJ move at their own pace or are restricted by their own resource constraints. Thus, Secretary McDonald and I are committed to collecting relevant evidence quickly and effectively through our own resources, where necessary and appropriate, rather than allowing issues to remain unresolved throughout a protracted external investigation. When the evidence collected demonstrates misconduct warranting discipline, it is also important to understand the due process we are required to afford all VA employees, including Senior Executives. There is a long line of case law that tells us that Federal employees – like those who work for state and local governments – have a constitutionally-protected property right in continued employment. That doesn't mean they can't be fired for misconduct, but it does mean that they are entitled to due process before they are fired. Pre-decisional due process includes the right to provide a meaningful response to the charges and evidence against them before a decision is made.

One thing that can undermine pre-decisional due process is inordinate pressure on the deciding authority to reach a particular decision. Where such pressure exists, it can be hard for the deciding authority to make an independent decision based solely on the evidence. In the military, this phenomenon is referred to as "unlawful command influence." In our world, the pressure to reach a particular decision doesn't come from our commander, but rather from Members of Congress and/or the press who react to an OIG report or a news story by demanding an employee's termination. Whether such demands are actually intended to influence the decision-maker or merely to express outrage, they challenge our ability to take fair, neutral, and sustainable actions. They

also wrongly undermine Veterans' faith in VA employees when – as sometimes happens – little or no discipline is taken because the underlying evidence does not support the story as reported.

In early November, this Committee held an oversight hearing focused on issues underlying what were then two pending employee discipline matters. Secretary McDonald and I implored the Committee then to defer the hearing until after we had made our decisions in those matters. I reiterate the plea today that the Committee please permit us to carry out the Executive Branch responsibility of proposing and deciding employee discipline independently, without undue influence, to ensure that our actions are sustainable and that Veterans are not misled about the conduct of VA employees upon whom they depend.

Senior Executive actions

The Choice Act authorizes the Secretary to remove a Senior Executive from employment, or from the Senior Executive Service through demotion to a non-SES position. The Secretary has delegated that authority to me. We have used the Choice Act removal authority ten times since it took effect in August 2014. We have proposed removal of eight Senior Executives from Federal employment; three individuals' removals were effected, and the others chose to resign or retire in lieu of removal. We had also removed two employees from Senior Executive Service to non-SES positions. Due to administrative error, these demotions had to be rescinded. We have corrected the error and proposed actions are now back in the employees' hands.

While the paperwork effecting a resignation or retirement in lieu of removal is coded to reflect the underlying circumstances, by law, any Federal employee who has the years of service and is of an age to retire is entitled to do so. By law, the only basis for terminating a Federal employee's retirement benefits is if the individual has been convicted of espionage, treason, or one of the other national security offenses listed in 5 U.S.C. § 8312.

Non-Senior Executive Actions

VA provides a weekly report to the Chairmen and Ranking Members of the House and Senate Committees on Veterans' Affairs in response to a June 3, 2014 request from this Committee for information related to employee discipline "taken on any basis related to patient scheduling, record manipulation, appointment delays, and/or patient deaths." The latest report, sent on Friday, November 27, shows 316 such actions proposed or decided between June 3, 2014 and November 25, 2015. This tally includes proposed penalties ranging from counseling through removal and is limited to the types of misconduct listed in the Committee's June 3, 2014 request.

The Department is frequently asked for information reflecting the total number of employees fired in a given Fiscal Year, or since Secretary McDonald's July 2014 confirmation. That number is currently over 2,400. However, as noted earlier, we believe such numbers to reflect only a small and less than useful fraction of the information needed to accurately assess the VA's accountability activities. Moreover, we have seen the conversation about such numbers quickly devolve from a meaningful assessment of our accountability efforts to skeptical questions about why one set of numbers we report differs from another, or why we "allow" employees to resign or retire before a removal action can be completed. Of course the numbers we report depend upon the question asked, and – as has been noted – all Federal employees have the legal right to retire or resign with or without a proposed removal pending.

Framed within that necessary context, the Fiscal Year 2015 count of employees who were for any reason removed, terminated during probation, or retired or resigned with a removal action pending is as follows:

FY 2015 Adverse Action Totals

Removals, Probationary Terminations, Resignations and Retirements effective within FY15

Action Taken	Number of Actions Taken
Probationary Termination	950
Removal	869
Employee Resigned in lieu of	423
Employee Retired in lieu of	106

Total	2348
Data current as of 11/18/2015 0700	

Discipline related to Scheduling/Access Data Manipulation

With respect to employee discipline for scheduling and access data manipulation, we have relied upon the VA OIG to provide us the evidence they have collected through the approximately 120 VA health-care-site-specific investigations they began in 2014. Where that evidence is inadequate to answer all questions relating to individual employee misconduct, the VA Office of Accountability Review (OAR) initiates follow-up investigations to complete the evidentiary record.

- OIG has provided the Department with reports and evidence relating to 77 VA sites.
- At 62 of those 77 sites, OIG found no data manipulation had occurred.
- At 6 sites – Phoenix AZ, Cheyenne WY, Ft. Collins CO, Dublin GA, Wilmington DE and Hines IL - OIG substantiated intentional misuse of scheduling or other access data. We have taken a total of 21 disciplinary actions, ranging from reprimand to removal, in connection with misconduct at these sites. There may be additional actions considered at Phoenix when OIG releases all of the relevant evidence to the Department.
- At 9 sites, OIG found scheduling practices that were not in accord with VHA policy but did not make conclusive findings with respect to individual misconduct. OAR has convened administrative investigations at those sites to determine whether, and for whom, discipline is warranted.
- We are still awaiting OIG's reports relating to 43 VA sites.

Discipline Related to Whistleblower Retaliation

- We continue to work collaboratively with the Office of Special Counsel (OSC) to improve our supervisors' understanding of the whistleblower protection laws and to speed relief to whistleblowers who believe they are experiencing retaliation.

- OSC is the independent Federal investigative and prosecutorial agency authorized by the Whistleblower Protection Act to protect federal employees and applicants from prohibited personnel practices, especially reprisal for whistleblowing.
- This past summer, OSC's Director of Training and Outreach provided in-depth training to representatives from VA's Office of General Counsel and Office of Accountability Review (OAR) to enhance VA's capacity to investigate whistleblower retaliation and to hold those who retaliate accountable.
- We are grateful to Special Counsel Carolyn Lerner and her staff for their continuing collaboration with OAR and VHA's Office of the Medical Inspector to address unsafe or unlawful health care practices and support corrective measures, including discipline, where such deficiencies are found.
- It is also worth noting that the large majority of allegations referred to OSC ultimately are not substantiated.
- We share Ms. Lerner's concern that discipline should not flow more swiftly and easily to whistleblowers than to retaliators. We are optimistic that our continued collaboration with OSC will ensure proper treatment for whistleblowers and for those who may retaliate against them.

Discipline Related to Over-prescription of Opioids and Other Issues at the Tomah VA Medical Center

- In January 2015, the Milwaukee Journal Sentinel and other publications ran an article about over-prescription of painkillers by the then-Chief of Staff of the Tomah VA Medical Center, who is a psychiatrist, and cited several former Tomah employees' complaints about retaliatory behavior after they questioned the Chief of Staff's prescribing practices. The article also cited an unpublished March 2014 VA OIG "administrative closure" report finding the Chief of Staff's prescriptions were "at considerable variance compared with most opioid prescribers" and "raised potentially serious concerns."
- We acted quickly to prohibit the Chief of Staff and an affiliated nurse practitioner from providing care to Veterans and initiated a comprehensive evaluation of the

quality of the care they provided. The then-interim Under Secretary for Health ordered a series of three clinical reviews to assess practice patterns, prescribing habits, and staff interactions at Tomah. In reports issued between March and August 2015, these review teams found that the Chief of Staff's prescriptive practices were potentially unsafe and that an apparent culture of fear existed at the Tomah facility which comprised patient care and damaged staff satisfaction and morale.

- Simultaneously, OAR began a series of administrative investigations into alleged mismanagement by Tomah VAMC leadership. Those reviews led to a number of leadership changes at the Tomah facility. The Chief of Staff lost his clinical privileges and was removed from Federal employment; his removal is currently pending appeal. The Former Medical Center Director and Associate Director both resigned. Madison VAMC Director John Rohrer, a native of La Crosse whose father receives his care from the Tomah VA, became acting Tomah Medical Center Director from mid-March through late September 2015. Mr. Rohrer worked closely with facility leaders, union leaders, employees and external stakeholders (including Veterans Service Organizations) to assure that ongoing investigations did not disrupt clinical care and that all voices were heard.

Accountability Related to the Denver Construction Project Cost Overrun

- In early 2015, VA engaged the U.S. Army Corps of Engineers (USACE) to evaluate four major construction projects to identify program weaknesses and opportunities for improvement in the management and execution of the program.
- USACE identified a fundamental need for VA to undergo a "transformative change in organizational process" to be effective at controlling cost and schedule growth in the major construction program. VA agreed with this assessment and has issued new policy that identifies roles and responsibilities for the development of needs, requirements and control of design and construction.
- One of the highest profile projects reviewed by USACE is the replacement Denver Medical Center. The considerable cost overruns and delays associated

with building the Denver center cast doubt on the prospect of completing the project and raised difficult questions about the future of VA's construction program.

- In response to USACE's findings, VA has instituted a process to assure that any change to the scope and/or budget of major construction projects are justified and approved as required to safely and effectively deliver health care before any resources are committed to executing the requirement change.
- In addition to these process improvements, we have made sweeping changes in the leadership of our construction and acquisition programs, through retirements and resignations at the senior-most levels and reassignment of some lower-level employees to roles more consistent with their skill sets.
- To look at individual accountability at all levels, we also convened an administrative investigation board, under the auspices of OAR but with assistance from an external expert from the Department of the Navy's Medical Facilities Design Office and a construction contracting law expert from VA's Office of General Counsel. That group has finished its work in July and it is being reviewed for any accountability actions that may be warranted against current VA personnel.

Discipline Related to VBA's Senior Executive Relocation Practices

In an investigative report issued on September 28, 2015, VA OIG took issue with VBA's policies and practices for reassigning Senior Executives between and among Regional Offices and other VBA leadership positions.

The OIG report addressed both people and processes. While we agree with the findings with respect to processes and have already implemented improvements to address those findings, we were very disturbed to find that the underlying evidence does not support the report's findings with respect to people.

On the process side –

- The report identified issues with VBA's use of the Appraised Value Option (AVO) program, which helps relocating employees sell their

primary residence, and with other aspects of the Permanent Change of Station (PCS) expense reimbursement process.

    - We have discontinued the AVO program and undertaken a review of PCS reimbursements across the Department to determine how best to administer those payments and to ensure we are making the best use of taxpayer money.

- The report also identified inconsistencies in the way VBA pays relocation incentives and adjusts executives' salaries upon reassignment.
    - While salary adjustments and other relocation incentives are a vital management tool for any geographically dispersed organization, we need to be sure VA is using those incentives wisely, when and where they are needed to attract top talent to challenging leadership assignments. We've undertaken a top-to-bottom review of our relocation incentive policies and practices to ensure we are using them properly.

On the people side, the report asserted that two VBA Regional Office Directors were "inappropriately coerced" to leave their stations so their supervisors could come in and take their jobs, with their relocations inappropriately paid for at taxpayer expense., We found that there were significant gaps between the rhetoric in the report and the relocated employees' testimony. Both of the subordinate Directors testified, repeatedly, that they had initiated the talks that led to their relocation. While one of them ultimately felt pressured to move to a different Regional Office than the one he preferred, neither provided any testimony consistent with the finding that they were "inappropriately coerced" to leave assignments they wanted to keep, nor did the evidence establish that the superior leaders' reassignments to their subordinates' former positions was improper or contrary to law. Moreover, VA OIG could not identify any violation of law, rule, or regulation in the reimbursements the two higher-level executives received related to the costs of their moves.

What the evidence did show – and what the higher-level executives have been disciplined for – was that these senior leaders' failure to fully extricate themselves from

the decisions surrounding their subordinates' reassignments and relocation benefits created the appearance that the transactions were approved for reasons other than the best interests of Veterans. This was not "inappropriate coercion" nor, in our attorneys' analysis, a criminal conflict of interest, but it did demonstrate less than sound judgment, warranting these leaders' demotion.

While the evidence did warrant the actions we have taken, Secretary McDonald and I remain disturbed by the gaps between the rhetoric in the OIG report and the underlying evidence because the published report, which expressly referenced pending criminal referrals, and OIG's press release identifying the subject executives by name, created a public expectation that these two career employees should be fired and forced to repay large sums of money expended to support their moves. That unfounded expectation does a distinct disservice to taxpayers and to the Veterans we all serve.

Last August, Congress gave VA expedited authority to remove Senior Executive leaders from Federal employment or from the Senior Executive Service to a lower-paid position when their performance or misconduct warrants removal. It is a humbling thing to end someone's career. It is one of the most difficult things I do in this role, but I have done it when it was warranted. I have removed a number of VA executives whose misconduct or poor performance put Veterans' health or taxpayer dollars at risk. I will do that when it is the right thing to do, when the evidence supports it.

But it does not help Veterans or taxpayers to fire a high-performing executive whose lapse of judgment warrants a less severe penalty. In light of all the facts and evidence – and notwithstanding the OIG report's unfounded rhetoric - the right thing to do was to demote these executives rather than fire them. That is what I decided to do.

As we told the Committee last week, an administrative error required us to withdraw the demotion actions to correct the incomplete evidence files that were initially provided to the employees. That was a very regrettable error occasioned by our haste to get the proposals issued quickly. We have corrected the error and the actions are now back in the employees' hands.

Looking Ahead

I'd like to end as I began, with President Lincoln's observation that "Commitment is what transforms a promise into reality."

Secretary McDonald and I are committed to sustainable accountability, to a VA in which employees know what is expected of them and do it, and then some.

Sustainable accountability means VA uses taxpayer dollars wisely and well to improve post-military life for our war fighters and their families.

Our commitment to sustainable accountability is reaping benefits today.

We know it is working because Veterans now have easier access to VA care and to care in the community than they did before.

We know it is working because claims take less time to process, and are more likely to be processed accurately than before.

We know it is working because Veteran homelessness is down and health care provider hiring is up.

Ultimately, you will know it is working when the number of disciplinary actions goes down, not up.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. We would be pleased to respond to questions you or other members may have.