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US DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
US HOUSE OF REPRESENTATIVES
HEARING ON
"ACCOUNTABLE OR ABSENT?: EXAMINING VA LEADERSHIP UNDER THE BIDEN–HARRIS ADMINISTRATION"
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Chairman Bost, Ranking Member Takano, and committee members, thank you for the opportunity to discuss the efforts of the Office of Inspector General (OIG) to address leadership and governance issues within VA as well as our findings and recommendations to increase accountability at every level. This statement discusses the foundational elements of accountability that I shared with this committee in a prior testimony, drawn from the recurring themes that OIG oversight personnel often see when identifying failings in VA. It also highlights reports we recently issued on the Hampton VA Medical Center in Virginia and the VA Eastern Colorado Health Care System in Aurora, Colorado, as two case studies on how veterans' care is affected when there is ineffective leadership and management officials are not held accountable for providing personnel with a safe and supportive culture. Several examples are also provided in which accountability breakdowns resulted in missteps that had significant financial consequences (the critical skills incentives for VA Central Office senior leaders and the pause of the Payment Integrity Tool).

I want to acknowledge from the start that the vast number of VA personnel and leaders OIG staff encounter in VA medical facilities work extremely hard to care for veterans, often in the face of significant challenges. I also recognize that VA senior leaders seek to have a culture of accountability where staff feel comfortable reporting problems without fear of retaliation or retribution. However, more work needs to be done to achieve this objective.

In a system as large as the Veterans Healthcare Administration (VHA), there will be occasions when processes break down, clinicians do not meet standards of care, and offices or services within a facility are mismanaged. Mistakes happen. The real test for VA is how leadership—at the facility, regional, and central office levels—works to promptly identify these deficiencies and hold themselves and their staff accountable for correcting them before they lead to poor or even tragic outcomes for veterans. The OIG has also recently testified and published repeatedly on quality assurance weaknesses within the Veterans

Benefits Administration (VBA) that affect both beneficiaries and VA's stewardship of taxpayer dollars, as well as the failings by multiple leaders and senior personnel across VA in awarding critical skills incentives to nearly every VHA and VBA senior executive working in VA's central office.[1]

When I testified before this committee last year on how enhancing accountability at VA is an OIG priority, I discussed the OIG's goal to provide the department with the information and recommendations to not only improve its services, programs, and operations, but also to increase accountability.[2] This is no small task. It requires sustained efforts by OIG auditors, healthcare inspectors, and investigators to conduct the most impactful oversight work possible. It also necessitates that VA leaders be engaged and responsive to our findings and recommendations. In interactions with VA personnel and leaders, this is routinely true. Secretary McDonough, other department and administration leaders, and the vast majority of VA personnel with whom OIG staff engage are dedicated to serving veterans and receptive to independent oversight to improve their efforts. The OIG recognizes that changing the culture of any organization takes time and sustained effort. Given the importance of VA's mission, every individual at VA should feel a responsibility to identify risks, report those risks and any resulting problems, and then take action to address the underlying causes and mitigate the chances for future occurrences. That is a culture that has not yet consistently taken hold across VA.

FOUNDATIONS OF ACCOUNTABILITY

The OIG's work often focuses on identifying gaps in the five components of accountability described below.

Strong governance and clarity of roles and responsibilities

Misconduct, failures to take appropriate action, and persistent problems are often the result of VA personnel or contractors not understanding their roles and responsibilities. In other cases, they understand their duties, but simply do not or cannot fulfill them. This may be due in part to outdated policies and procedures, conflicting guidance, or a lack of clear decision-making—often with those best positioned to act lacking the authority to do so.

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[1] Recent OIG testimony to Congress related to VBA issues can be accessed here. Recent reports regarding the National Cemetery Administration are also available on the OIG reports page. Given the focus of this hearing, however, this statement addresses recent OIG oversight of VHA. As mentioned later in this statement, Inspector General Missal's written testimony to this committee on VA's critical skill incentives to headquarters' senior leaders outlines a litany of missteps and failures in accountability.

[2] VA OIG, Statement of Inspector General Michael J. Missal before the House Committee on Veterans' Affairs, February 28, 2023.

Adequate and qualified staffing to carry out those duties

Historically, VA has faced high vacancy rates across its programs and operations, especially within VHA. Shortages of qualified personnel in key positions have made it difficult for VA to carry out its goals and functions. Having the right people in the right positions committed to doing the right thing is essential to building a culture of accountability, as is instilling that culture in new hires.

Updated information technology (IT) systems and effective business processes to support quality healthcare, accurate and timely benefits, and efficient operations

VA is in the process of modernizing a number of significant systems that are critical to its operations. The OIG has been proactively overseeing VA's implementation of these crucial systems. However, as detailed in multiple reports, VA has had significant troubles with upgrading or replacing key systems that support patient care, supply management, benefits to veterans and their families, and the stewardship of taxpayer dollars. VA's process for replacing crucial IT systems faces significant ongoing challenges. Major plans to modernize electronic health records, supply chain management, claims processing, and financial management systems have been marked by critical missteps. These have typically included weaknesses in planning, insufficient stakeholder engagement, failures to promptly fix known issues, and program management or coordination deficiencies. These issues must be resolved for VA to remain accountable for the care, services, and benefits it provides. The OIG understands the tremendous complexity and cost of these efforts and continues to provide recommendations that are as practical and actionable as possible to support VA personnel working to ensure patient safety and to deliver benefits and services to eligible veterans.

Effective quality assurance and monitoring to detect and resolve issues

VA often lacks controls that adequately and consistently ensure quality standards are met. Breakdowns in routine monitoring and the continual use of work-arounds undermine efforts to provide timely quality services and benefits to eligible veterans and their families. Failures in quality assurance and monitoring relate not just to systems and processes, but to personnel as well—particularly in areas such as personnel suitability programs, credentialing, privileging, and monitoring of healthcare professionals entrusted with veterans' care.

Stable leadership that fosters responsibility for actions and continuous improvement

VA leaders at every level often do not get the information they need to make effective decisions; some fail to take necessary and prompt action, while others struggle to create a culture in which every employee feels empowered to report problems. The frequent turnover in key positions or the long-term use of acting positions exacerbates these challenges.

Many of these foundational elements for accountability were lacking in the OIG's recent reporting on the Hampton and Aurora medical facilities (detailed in the sections that follow). It is important to stress that OIG recommendations that focus on just a single medical facility or benefits process are often a road map for other facilities and offices across VA to help prevent or correct similar problems that have

gone undetected or unaddressed. It is vital that OIG findings are routinely shared with VA leaders across the enterprise to promote positive change within their respective programs and operations.

THREE OIG REPORTS ON THE HAMPTON MEDICAL CENTER FOUND LEADERS FAILED TO APPROPRIATELY ADDRESS CLINICAL CARE CONCERNS

For each of the last three years (2022–2024), the OIG has published healthcare inspection reports of the Hampton facility that substantiated a range of concerning allegations related to clinical care. These reports collectively uncovered failures in care coordination, communication, quality of care, administrative and clinical oversight, quality assurance, and overall employee engagement. These failings contributed to increased risks to patient safety and adverse outcomes.

Unfortunately, within VHA and the private sector, substandard care and delays in diagnoses and treatment are not as rare as they should be. There are instances in which delays and deficiencies are reported to OIG staff but VHA leaders are already in the process of taking appropriate action to correct the issues. In those instances, the OIG may allow VHA to attempt corrective action before determining whether additional review is warranted. What OIG healthcare inspectors find most troubling is when facility managers and leaders are either unaware of personnel and patient concerns or do not ensure the required quality management processes are carried out that would detect and correct them. High reliability organization principles foster a culture of "collective mindfulness," in which all staff look for and report small problems or unsafe conditions before they pose a substantial risk. If leaders are not aware of concerning singular events or more systemic challenges, they cannot ensure the appropriate steps are taken to safeguard patients. Implementing quality improvements to address specific patient safety issues requires open and honest communication from, and among, staff at every level of a facility.

Staff Responsible for Quality Assurance Failed to Take Appropriate Actions

First, in the 2022 Hampton facility report, the complaint made to the OIG focused on the delay in a single patient's diagnosis of prostate cancer.[3] However, the OIG team's review identified multiple healthcare providers who did not appropriately manage abnormal test results for this patient. As to this complaint, the mismanagement included the patient's surgeon, primary care provider, and nurse practitioner failing to take action (when required) or missing opportunities to do so (when they could have).

This inspection revealed that those tasked with the responsibility to ensure quality care did not take appropriate measures. According to VHA, a facility's patient safety program aims to prevent harm to patients by reporting and reviewing adverse events, identifying underlying causes, and implementing changes to reduce the likelihood of recurrence.[4] Facility policy requires that all staff complete patient

[3] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, June 28, 2022.

[4] Facility Policy 590-11-28, Patient Safety Improvement Program, April 30, 2020.

safety reports as soon as adverse events are discovered. The OIG determined that facility staff and leaders were aware of deficiencies in the patient's care that was the focus of the initial complaint; however, they did not initiate or submit patient safety reports. Further, quality management staff did not screen for and initiate peer reviews in a timely manner consistent with VHA policy, delaying facility leaders' ability to (a) identify staff who may need additional training, (b) improve quality of care, and (c) ensure patient safety. The chief of Quality, Safety and Value reported becoming distracted by other work and forgetting to inform the risk manager of the need for peer reviews.

The OIG made seven recommendations for the facility to make the needed improvements in its patient safety program. All recommendations have been closed as implemented after the OIG determined that the facility had shown sustained compliance with their action plans.

Oncology Leaders Failed to Implement Critical Functions Needed to Deliver the Highest-Quality Care

Second, in 2023, the OIG substantiated that a patient at the Hampton facility experienced a delay in diagnosis and treatment for a new lung mass that was highly suspicious for cancer.[5] The assigned team found facility leaders were unaware of the patient's case until the notification of the OIG inspection. The team identified deficiencies in primary and specialty care services' prompt scheduling and access to care that might have resulted in an earlier diagnosis and treatment of the patient's lung cancer.

In addition to the concerns with the delays in patient care, the OIG found a troubling absence of many practices critical to ensuring high-quality oncology care. VHA's Oncology Program policy "seeks to ensure that the delivery of VA cancer care is provided following a national standard of practice," which includes the requirement that each facility have a facility-level cancer committee, tumor board, and cancer registry.[6] VHA policy requires the use of the VA Cancer Registry System to monitor all cancers diagnosed or treated in VHA.[7] As such, each VA medical facility must identify and report data on patients with a cancer diagnosis.[8] The OIG found that, at the time of the inspection, the facility did not have an operational cancer committee, tumor board, or a cancer registry as required.[9]

The facility's chief of staff told the OIG team that the lack of a cancer committee was due to an "oversight." However, the facility director stated that a cancer committee had not been chartered earlier

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[5] VA OIG, *Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia*, September 29, 2023

[6] VHA Directive 1415, VHA Oncology Program, April 9, 2020.

[7] VHA Directive 1412(1), Department of Veterans Affairs Cancer Registry System, May 29, 2019, amended April 7, 2020; VHA Directive 1415.

[8] Each facility director is responsible for appointing a facility cancer registrar responsible for ensuring the provision of complete, timely, and accurate data of at least 90 percent of cases within six months of first contact with the facility.

[9] Since the inspection, the facility has taken steps to establish the cancer committee and tumor board, as well as to fill the facility cancer registrar position.

due to a lack of continuity in relevant staff. The OIG concluded that without an active facility cancer committee and tumor board, the facility was unable to conduct the additional review that assists with identifying and assessing cancer patients' needs. As a result, facility staff may have missed opportunities to ensure patients received the highest quality of oncological care available.

The components of accountability were clearly lacking in the Hampton facility. Leaders did not create an environment that fostered individual responsibility and continuous improvement. Staffing concerns and unclear roles and responsibilities meant the facility lacked functions critical to a high-performing oncology program. Two of the seven recommendations remain open (not yet fully implemented), and the OIG continues to follow VHA's progress in satisfying the recommendations.[10]

Facility Leaders Did Not Understand or Properly Employ the Basic Processes That Support Delivery of Safe Health Care

The third report, released in July, demonstrates that Hampton facility leaders did not properly address clinical care concerns and subsequent privileging actions involving the assistant chief of surgery.[11] In the course of this inspection, the OIG determined the facility mishandled the processes for professional practice evaluations of surgeons, the surgical service's quality management, and institutional disclosures to patients or their representatives of an adverse event that resulted in harm.

Facility leaders made numerous process errors when determining whether changes were needed to the assistant chief of surgery's clinical privileges.[12] For example, facility leaders failed to document any of the three focused clinical care review (FCCR) results in the appropriate system, did not provide the results of two of the reviews to the Medical Executive Committee (MEC), and delayed reporting the results of the third. These errors limited the MEC's knowledge of all reviews, which could have more fully informed members' decisions and recommendations about whether to reduce or revoke any of the assistant chief of surgery's privileges. The three FCCRs also were not completed by multiple reviewers to ensure interrater reliability and an objective evaluation of the assistant chief of surgery's clinical care.[13]

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[10] At quarterly intervals commencing 90 calendar days from the date of the report's issuance, the OIG sends a follow-up status request to the VA office overseeing corrective action asking for an implementation status report. The OIG follow-up staff provides VA with 30 calendar days to respond. Nothing precludes VA from providing interim progress reports. The next OIG request for an update on this report will be on or about September 29, 2024.

[11] VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, July 23, 2024.

[12] Clinical privileging is defined as the process by which a VA facility authorizes a physician to independently (i.e., without supervision or restriction) provide healthcare services on a facility-specific basis. Clinical privileges are based on the individual's clinical competence as determined by peer references, professional experience, health status, education, training, and licensure.

[13] Interrater reliability is the extent to which two or more independent raters or observers consistently obtain the same result when using the same assessment tool.

A summary suspension of privileges was issued to the assistant chief of surgery, but the OIG identified several inconsistencies between the MEC meeting minutes and suspension letters, as well as improper procedural actions taken by the facility director.[14] These inconsistencies had the potential to impact patient care because the assistant chief of surgery was unaware of which privileges were suspended, affecting the level of services available for patients.

While attempting to reduce the assistant chief of surgery's privileges, facility leaders did not send letters to the assistant chief in the correct order and did not include all required elements in the proposal letter to provide the necessary due process. As a result of these errors, facility leaders rescinded the proposed actions and restored the associate chief of surgery's clinical privileges. When the assistant chief of surgery transferred to another VA facility, their privileges at Hampton ended and facility leaders could not take additional privileging actions.

Hampton facility leaders failed to report the assistant chief of surgery to the state licensing board as well. Failing to report physicians with identified incidents of substandard care to the state licensing board may result in medical facilities, within and outside of VHA, hiring providers who do not meet generally accepted standards of clinical practice, increasing risks to patients.

An institutional disclosure enables facility leaders to inform a patient or their personal representative that an adverse event has occurred. This refers to an event that "resulted in, or is reasonably expected to result in, death or serious injury" and the disclosures are meant "to maintain trust between patients and VA healthcare professionals."[15] The OIG team found that facility leaders generally did not communicate and document required elements of an institutional disclosure, such as advising the patient or family about potential compensation or the option to obtain outside medical or legal advice. In fact, of the 10 institutional disclosures completed at the facility from July 1, 2022, through May 31, 2023, the OIG found that nine did not include "advisement about potential compensation." Such mistakes could result in patients or their personal representatives being unaware of their rights and options for recourse. Simply put, these types of lapses undermine VA's commitment to build and restore patients' trust.

The findings identified through this inspection highlight failures of facility leaders to make certain that required responsibilities were appropriately implemented. They also revealed leaders' lack of a basic understanding of the quality assurance processes that support the delivery of safe health care. This inspection underscores that negative outcomes can occur when such fundamental accountability elements are not present—including strong governance and an understanding of roles and

[14] A summary suspension is a "summary action" taken by the VA medical facility director to suspend clinical privileges when the failure to take such action may result in an imminent danger to the health and safety of any individual. A summary suspension may be applied to one or more selected privileges or all privileges depending on the circumstances and clinical concern.

[15] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018.

responsibilities, effective quality assurance and monitoring, and leadership that constantly fosters continuous improvement.

The OIG made 12 recommendations, including 11 to the facility director on issues related to FCCRs, summary suspensions, proposed reduction or revocation of privileges, state licensing board reporting, patient safety reporting, and institutional disclosures. VA concurred with the OIG's findings and all recommendations and has provided acceptable action plans and completion timelines. VA's progress in implementing these recommendations will be monitored until sufficient evidence is provided to warrant closure.[16]

THE AURORA FACILITY'S SENIOR LEADERS CREATED A CULTURE OF FEAR AMONG PERSONNEL, LEADING TO POOR COMMUNICATION AND STAFF DEPARTURES

Last month, the OIG released two reports on the VA medical facility in Aurora that tell a similarly disturbing story of accountability failures. The OIG found in its first report that key senior leaders created an environment in which a significant number of clinical and administrative service and section leaders and frontline staff felt psychologically unsafe, deeply disrespected, and dismissed. They feared that speaking up or offering a difference of opinion would result in reprisal. In a second report, an OIG team substantiated that leaders' actions to change the facility's intensive care unit from an open to a closed model (affecting which providers had patient care responsibility) were made without adequate planning and input from relevant leaders and staff. These problems were allowed to persist because Veterans Integrated Service Network (VISN) leaders did not fulfill their own required oversight of the medical center.[17]

Aurora Facility Senior Leaders Created an Environment That Undermined the Culture of Safety for Staff

The OIG substantiated that key senior leaders (including the facility director, chief of staff, deputy chief of staff for inpatient operations, and the associate chief of staff for education) failed to use high reliability organization principles, undermined the stability and psychological safety of service leaders and staff, and created a culture of fear.[18] Accountability is dependent on leaders maintaining a culture in which every employee feels empowered to report problems. Having failed to do so, the climate that key senior leaders created led to frequent turnover in core positions, which only exacerbated the facility's challenges.

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[16] The OIG will make the first request for an update on this report on or about October 22, 2024.

[17] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks that oversee the medical facilities in their designated area.

[18] VA OIG, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment That Undermined the Culture of Safety*, June 24, 2024

In a "just culture," personnel feel safe reporting concerns and trust that actions are going to be "judged fairly."[19] Instead, personnel interviewed by OIG staff shared concerns and cited examples of key senior leaders not valuing their opinions and expertise, making decisions "in haste," and dismissing concerns. Facility staff shared their fear of retaliation from these key senior leaders. A staff member noted there were repercussions for sharing a different opinion, including being "berated in a meeting" or "pushed out" of their positions by being falsely accused of misconduct and enduring an investigation into the claims. Another clinical leader also described the weaponization of administrative investigations, with the intent of targeting individuals rather than finding the truth and making improvements. A clinical leader described more subtle forms of retaliation as well, such as having staffing resources removed from the department.

The OIG also substantiated there was a negative change in culture associated with the Peer Review Committee (PRC), which is responsible for clinical oversight. A majority of clinical PRC members, and some non-PRC clinical leaders and staff, perceived the committee to be psychologically unsafe and punitive. After the key senior leaders began attending and acting as voting committee members, clinical PRC members reported that these leaders took over or "dominated" committee discussions. In addition, PRC meetings and processes became focused on finding fault and assigning blame as opposed to identifying improvements to patient care, practices, and processes. It should be noted, there are other forums and mechanisms for doing so, such as the FCCR process discussed in the recent Hampton report, meant to complement efforts by the PRC and others to identify and redress problems before they escalate to adverse events or incidents that warrant investigation. The OIG team found that key senior leaders missed opportunities to understand and address PRC members' concerns. When leaders fail to foster a psychologically safe environment, staff avoid speaking up and sharing ideas for improvement.

The OIG substantiated that mid-level leaders' authority had been eroded and there was a lack of continuity of leadership at the service level due to many clinical service and section-level resignations and extended vacancies. These extended vacancies consolidated control among key senior leaders, leaving facility service and section chiefs with limited avenues for communication and with no one to advocate on behalf of their services. Twenty former leaders who had worked in the Aurora facility shared with the OIG the factors that contributed to their decisions to leave. They all reported that a work-related factor contributed to their decision, with the majority reporting poor or psychologically unsafe working conditions and all reporting a lack of trust and confidence in senior leaders. The majority also reported that unethical treatment of staff was important in their decision to leave.[20] An OIG analysis of the responses found common themes in their responses, such as fear of retaliation,

[19] VHA, "Why is Just Culture important to a High Reliability Organization (HRO)?" VHA Journey to High Reliability, https://dvagov.sharepoint.com/sites/vhahrojourney/. (This website is not publicly accessible.)

[20] For the purposes of the OIG report, unethical treatment factors included harassment or retaliation for voicing concerns, harassment, or retaliation for participating in a complaint process, and unethical behavior on the part of leadership or the organization.

feeling bullied, or a "toxic culture." Nearly half of these former leaders reported feeling undervalued or disrespected by senior leaders, and some reported experiencing medical conditions related to their facility employment.

Despite these losses, key senior leaders did not seek or use employee exit survey data to identify and address employee retention challenges. Turnover in VISN leadership positions and ineffective communication contributed to the then VISN director's lack of awareness regarding the extent of the staffing and culture challenges at the facility. The leadership failures found in this report reflect deficiencies in each of the foundational elements of accountability set out earlier in this statement.

The OIG made a total of seven recommendations for corrective actions that included conducting and utilizing a review of the VISN's awareness and oversight of the Aurora facility to help standardize roles and responsibilities across the system, with the goal of ensuring structured and robust oversight activities in support of high-quality healthcare delivery. All recommendations are currently open and subject to the OIG's routine monitoring and follow-up.

Inadequate Planning and Lack of Staff Input Led to a Troublesome Transition in the Operation of the Intensive Care Unit

In a second concurrent review at the Aurora facility, accountability issues were created by the lack of qualified staff to provide adequate coverage of the surgical Intensive Care Unit (ICU) and leaders' failure to involve key staff in the decision-making process to make changes.[21] Leaders also did not adequately communicate the operational changes up and down the chain of command.

The OIG found that facility leaders implemented surgical ICU changes that led to inadequate provider coverage for surgical patients, and adversely affected the provision of cardiothoracic surgical services. These surgeries were paused from September 2022 through August 2023 and the newly appointed chief of staff failed to notify the VISN of the pause so that VHA leaders would be informed.

The facility leaders and the acting chief of surgery proceeded with plans to resume cardiothoracic surgeries following an 11-month pause and the loss of all facility cardiothoracic surgical staff, without notifying or seeking required approval from VISN and VHA central office leaders. The OIG found the resumption of these surgeries met the VHA policy criteria for a "major augmentation of clinical services" that requires the approval of the under secretary for health or his designee.[22] The OIG escalated concerns about the facility's lack of readiness to safely conduct cardiothoracic surgical procedures to the VISN director in August 2023, after determining there was no detailed,

[21] VA OIG, *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, June 24, 2024.

[22] VHA Directive 1043, Restructuring of VHA Clinical Programs, November 2, 2016.

interdisciplinary evaluation and plan. Following additional internal reviews, cardiothoracic surgical procedures were restarted in late October 2023.

The OIG substantiated that facility leaders' changes to the medical ICU from an open to a closed model were made without adequate planning and input from service and section leaders and staff.[23] The sudden implementation of a closed ICU model resulted in a lack of ICU resident supervision and an ineffective teaching environment for residents. The chief of staff notified service leaders that due to a privileging concern there was a need to change medical ICU physician coverage, but the notification occurred only hours before implementing the change. In accordance with high reliability organization principles, the OIG would have expected facility leaders to plan and involve service and section leaders, and staff before implementing the change to a closed ICU model. The OIG substantiated that the sudden implementation of a closed ICU model resulted in a lack of ICU resident supervision and residents' reliance on on-call attending physicians or fellows. This created an ineffective work environment that did not meet the educational needs of ICU residents. After the change, ICU residents reported concerns to service leaders and cited in program evaluations the lack of on-site supervision, increased patient safety risks, diminished resident education quality, and decreased overall satisfaction.

The OIG recommended the under secretary for health to evaluate the VISN leaders' lack of awareness of the surgical pause and that the VISN director address issues related to cardiothoracic surgeries, facility high reliability organization principles implementation, and residents' education needs. Two recommendations to the facility director were related to on-call escalation and root cause analysis training. All of the recommendations are open, and the OIG will review VA's progress on implementing them during the routine follow-up process beginning September 24, 2024.

OTHER RECENT OIG OVERSIGHT THAT HIGHLIGHTS ACCOUNTABILITY CONCERNS

While this statement has focused on leadership failures within VHA, a number of recent OIG reports have found deficiencies within VBA programs and operations that can be traced back to the same accountability themes.[24] Every service within VA is susceptible to falling short of their mission if they do not fully embrace and constantly reinforce these foundations of accountability. The OIG's recent reporting on senior executives in VA's central office being improperly awarded critical skills incentives crossed two administrations and uncovered weaknesses in governance, leadership, and accountability,

[23] ICUs may be structured as open or closed models. An open model indicates that multiple physicians or teams, whether assigned to the ICU or not, are permitted to provide care to a patient in the physical space of the ICU. A closed model indicates that only the ICU team specifically assigned to the ICU manages the patient's care for all patients admitted to the ICU.

[24] VA OIG, *VBA Needs to Improve the Accuracy of Decisions for Total Disability Based on Individual Unemployability*, July 17, 2024; VA OIG, *VBA Did Not Identify All Vietnam Veterans Who Could Qualify for Retroactive Benefits*, June 27, 2024; VA OIG, *Better Oversight Needed of Accessibility, Safety, and Cleanliness at Contract Facilities Offering VA Disability Exams*, May 8, 2024; VA OIG, *Without Effective Controls, Public Disability Benefits Questionnaires Continue to Pose a Significant Risk of Fraud to VA*, January 4, 2024.

with excessive deference to VHA and VBA leaders by individuals responsible for providing necessary checks and balances.[25] As detailed in OIG testimony before this committee in June, officials at multiple levels across VA did not ensure their actions met the appropriate requirements and intent of the law and did not successfully escalate concerns to the Secretary. VA concurred with both OIG findings and all recommendations and has provided acceptable action plans and completion timelines. The OIG will monitor VA's progress in implementing these recommendations until sufficient evidence is provided to enable closure.

Finally, VA's ability to accurately forecast budget needs for its administrations and staff offices, and then properly execute appropriated funds, is dependent on adherence to these same foundational elements of accountability. The OIG is currently engaged in examining the conditions and contributing factors to the projected $12 billion shortfall for fiscal year 2025.[26] Staff have also continued to document how the absence of well-functioning IT and internal quality monitoring systems can exacerbate financial management problems. A recent example affecting revenues is the OIG's July 2024 management advisory memorandum to VHA regarding the pause in using its Payment Integrity Tool (PIT).[27] VHA uses PIT data to determine if healthcare claims should be billed to veterans or private insurance companies for the treatment of nonservice-connected care. VHA paused using the PIT in February 2023 after becoming aware of numerous issues, including inaccurate or duplicate claims and defective code. The pause had two major impacts: First, VHA could not bill veterans or private insurance companies for community care copayments or coinsurance because VHA relies on PIT data to do so. Second, the pause impeded internal oversight efforts that utilize the PIT to prevent, detect, and mitigate fraud, waste, and abuse related to community care claims. While VHA has reported that use of the PIT partially resumed in recent weeks, they must now review the backlog of claims to determine which are eligible to be billed to veterans or private insurers. The OIG estimated that VHA will be delayed in billing an estimated 2.8 million community care claims totaling about $2 billion that were paid between February 1, 2023, and February 1, 2024. According to VHA, the pause resulted in veteran copayment billings that were approximately $23 million lower for the first two quarters of fiscal year 2024 than the same period in 2023. The pause could also negatively affect veterans because VHA may send them copayment bills for

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[25] VA OIG, *VA Improperly Awarded $10.8 Million in Incentives to Central Office Senior Executives*, May 9, 2024.

[26] According to the budget submission dated March 2024, VHA initially estimated needing about $149.5 billion to care for patients in fiscal year (FY) 2025.[1] However, by July 2024, VHA estimated that it would need an additional $12 billion in FY 2025 for medical care. The OIG recently initiated a review to determine what factors and conditions resulted in VHA's request for nearly $12 billion in supplemental funding.

[27] VA OIG, *The Pause of the Program Integrity Tool Is Impeding Community Care*, July 16, 2024. While the OIG made no recommendations in this memorandum, the OIG remains concerned about whether VHA's Revenue Operations will have sufficient resources to timely bill the backlog of community care claims, and how the pause will affect fraud, waste, and abuse activities for community care claims. In addition, the OIG currently has three open recommendations from the 2022 report related to Revenue Operations' private health insurance billing for community care. VA OIG, *VHA Continues to Face Challenges with Billing Private Insurers for Community Care*, May 24, 2022.

care that are over a year old. To ensure the PIT fully recovers from these issues and will be reliable moving forward, VHA must fully embrace the accountability pillars of strong governance, updated IT systems, and effective quality assurance and monitoring.

CONCLUSION

The OIG has repeatedly found that an overwhelming number of VA leaders and personnel are committed to serving veterans, and that VA's skilled and dedicated frontline employees work to provide high-quality and timely care and benefits. However, OIG staff routinely find breakdowns in processes, infrastructure, governance, leadership, and other failings that erode the foundational elements of accountability. These breakdowns impede VA's efforts to make certain that patients receive timely, high-quality healthcare and that veterans and other eligible beneficiaries are afforded the compensation and services they are owed. Just as important as having accountability for those engaging in wrongdoing is creating a culture that addresses the conditions that allow mistakes or misconduct to fester and grow, a culture in which every employee feels a responsibility to identify and report risks and concerns. In turn, leaders must take prompt, effective actions based on the input of stakeholders and available data to address the underlying problems. The OIG strongly encourages VA personnel at every level to lead by example and escalate matters that put veterans' health and welfare at risk, undermine VA's services and operations, or waste taxpayer dollars. Significantly, those in positions of authority should ask themselves what they are doing to reinforce the pillars of accountability, including executing efficient governance and clarifying all roles and responsibilities; maintaining adequate numbers of qualified staff; updating IT systems and improving business processes; conducting effective quality assurance processes and vigilant monitoring; and promoting stable and strong leadership that fosters responsibility for actions and continuous improvement.

Finally, I want to thank those individuals who have come forward to report wrongdoing and exemplify the tenets of accountability and encourage others to do the same. Chairman Bost, Ranking Member Takano, and members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.