FACT CHECK: AN END OF YEAR REVIEW OF ACCOUNTABILITY AT THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

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

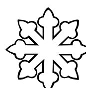
ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

WEDNESDAY, DECEMBER 9, 2015

Serial No. 114–48

Printed for the use of the Committee on Veterans' Affairs



Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE

24–362 WASHINGTON : 2017

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON VETERANS' AFFAIRS

JEFF MILLER, Florida, *Chairman*

DOUG LAMBORN, Colorado
GUS M. BILIRAKIS, Florida, *Vice-Chairman*
DAVID P. ROE, Tennessee
DAN BENISHEK, Michigan
TIM HUELSKAMP, Kansas
MIKE COFFMAN, Colorado
BRAD R. WENSTRUP, Ohio
JACKIE WALORSKI, Indiana
RALPH ABRAHAM, Louisiana
LEE ZELDIN, New York
RYAN COSTELLO, Pennsylvania
AMATA COLEMAN RADEWAGEN, American Samoa
MIKE BOST, Illinois

CORRINE BROWN, Florida, *Ranking Minority Member*
MARK TAKANO, California
JULIA BROWNLEY, California
DINA TITUS, Nevada
RAUL RUIZ, California
ANN M. KUSTER, New Hampshire
BETO O'ROURKE, Texas
KATHLEEN RICE, New York
TIMOTHY J. WALZ, Minnesota
JERRY MCNERNEY, California

JON TOWERS, *Staff Director*
DON PHILLIPS, *Democratic Staff Director*

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Veterans' Affairs are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

Wednesday, December 9, 2015

Page

Fact Check: An End Of Year Review Of Accountability At The Department Of Veterans Affairs 1

OPENING STATEMENTS

Honorable Jeff Miller, Chairman 1
Honorable Corrine Brown, Ranking Member 8
Prepared Statement 39

WITNESS

Honorable Sloan Gibson, Deputy Secretary, U.S. Department of Veterans Affairs 1
Prepared Statement 39

Accompanied by:

Meghan Flanz, Deputy General Counsel, Legal Operations and Accountability, U.S. Department of Veterans Affairs

STATEMENT FOR THE RECORD

Office of Inspector General 46

FACT CHECK: AN END OF YEAR REVIEW OF ACCOUNTABILITY AT THE DEPARTMENT OF VETERANS AFFAIRS

Wednesday, December 9, 2015

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Committee met, pursuant to notice, at 10:31 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Walorski, Abraham, Zeldin, Costello, Bost, Brown, Takano, Brownley, Titus, Ruiz, Kuster, O'Rourke, Rice, Walz, and McNerney.

OPENING STATEMENT OF JEFF MILLER, CHAIRMAN

The CHAIRMAN. Good morning, everybody. Thank you for being with us at today's hearing entitled Fact Check: An End of Year Review of Accountability at the Department of Veterans Affairs. I want to welcome our first and only panel to the table this morning. With us is Deputy Secretary Sloan Gibson for the Department of Veterans Affairs, and he is accompanied by Meghan Flanz, who is the Deputy General Counsel for Legal Operations and Accountability at the VA. We thank both of you for being here this morning. And I want to get straight to the witness' testimony and Ms. Brown is running a little bit behind. So I am going to allow Sloan to give his testimony before we give our opening statements. So Mr. Gibson, you are recognized now for five minutes.

STATEMENT OF SLOAN GIBSON

Mr. GIBSON. Thank you, Mr. Chairman. Let me get right to the point. In my many years in the private sector, I have never encountered an organization where leadership was measured by how many people you fired. And there is a simple reason for that, you cannot fire your way to excellence. I can promise you that a large and complex customer service organization will never deliver a great customer service experience, will never consistently deliver great outcomes if employees are living in constant fear of being punished for making a mistake. When enforcing discipline is the central element of accountability, an organization will not deliver sustained excellence.

Having said all of that, consequences for behavior that is inconsistent with our values is part of effective leadership. In those

cases we pursue disciplinary action appropriate to the offense and supported by evidence. I am committed and VA's senior leadership is committed to taking those actions.

We have asked this Committee to be one of our most important partners in the forward looking transformation of the department. We are all after the same ultimate objective, improving care and benefit outcomes for veterans. The only way we can achieve that shared objective is through strong forward looking leadership based upon what Bob and I call sustainable accountability. That is accountability that results in positive veteran outcomes, not just in the near term, but also in the long term. It is supervisors that are providing routine feedback to subordinates, recognizing what is going well and coaching where improvements are necessary. It is ensuring all employees understand how daily work supports our mission, values, and strategy. It is training leaders to lead and employees to exceed veterans' expectations everyday. It means making things right for veterans quickly and responsively, and learning from mistakes, understanding what went wrong and then fixing it. It is candidly assessing performance based upon merit and achievements and rewarding exceptional results. And it is taking corrective action when warranted and supported by evidence. If we have all of that, we have sustainable accountability. The same comprehensive notion of accountability that you find in virtually every high performing organization in the private sector.

I have often said that if VA was in the private sector it would be a Fortune 10 company, making enduring cultural and fundamental process changes in an enterprise of that size and complexity takes time. It takes persistence and some amount of patience. But investments in sustainable accountability are already paying off in improved veteran outcomes. Let me give you a very important example.

SAIL, S–A-I–L, Strategic Analytics for Improvement and Learning. SAIL is a tool that we use to measure veteran health care outcomes at every VA medical center, measures around quality, safety and efficiency, among others. Shortly after I arrived at VA, I learned about SAIL and looked into the correlation between hospital directors' performance ratings and the health care outcomes being delivered by their facilities as measured in SAIL. Here is what I found, stellar performance ratings at some of the lowest performing facilities. So beginning in October of 2014, we integrated veteran health care outcomes as measured in SAIL into every single medical center director's performance objectives. What happened?

Well for starters, SAIL became one of the most widely used management tools in the department, that tells you something to begin with. And roughly 60 percent of VA medical centers improved the health care outcome for veterans over the course of the year. How good is SAIL? The chief medical officer at one of the largest health care organizations in America told me that if he had SAIL in his organization he would implement it tomorrow. That is sustainable accountability. Delivering better outcomes for veterans, not just right now, but for the long term.

I suspect Bob and I have visited more VA facilities, spoken to more veterans and VA employees in the last 18 months than any

pair of top VA leaders in the department's history. We find employees as we are out there who care about the mission, who want to do the right thing, and who work hard everyday to serve veterans. Yet, if we take rhetoric as fact then, particularly as it relates to scheduling and access, VA is rife with corruption. To review the record, of the more than 100 investigations the IG launched based on the access field audit that we conducted last year, to date, we have received reports and evidence relating to 77 of those. The IG substantiated intentional misuse of scheduling or other access data at six sites. In our follow-up, we substantiated misuse at four other sites, and we are reviewing evidence at two more. So far, some 20 employees have been implicated and 20 disciplinary actions have been taken, from reprimand to removal. While our work is not done, and those numbers will change, it is not the widespread corruption and fraud pitched to veterans and the American people. But as we see it, if one veteran is not well served, we own it and we will work to fix it.

The IG still owes us the remaining reports. We appreciate their work, but we cannot let issues languish unresolved while waiting for protracted IG or Department of Justice investigations for months and sometimes even years. Our past practice has been to wait for these investigations to be complete. We are done waiting. Where we can collect relevant evidence more quickly and effectively with VA resources, we will do so. Then where evidence warrants disciplinary action, we will take action. If new evidence warranting additional action is presented later, we will take additional action. Where necessary, employees under investigation will be detailed to other duties, not routinely placed on administrative leave. Administrative leave will be reserved on a by exception basis set for only those extreme circumstances.

Let me shift to the recent IG report on relocation, which has garnered widespread attention. We agree with many of the process related findings and we have already made changes to address those issues. What is disturbing and indicative of the atmosphere in which we now operate is the gulf between the rhetoric in the IG report and the actual evidence. In the most important finding, the report concludes that two executives were coerced to relocate. The fact is that both executives testified under oath repeatedly, 16 times in one instance, that they initiated talks leading to relocation. Neither provided any testimony consistent with the finding of coercion. The report in the Associated Press release emphasized criminal referrals to the Department of Justice. Yet as I have reviewed the evidence as collected by the IG, it does not support one violation of law, not one violation of rule, not even one violation of regulation related to relocation expenses.

The easy option for me would have been to propose removal. That is what everybody wanted. I did not come to VA to do the easy thing, I came here to do the right thing. I did not find that the evidence supported an ethical violation. If I had, I would have removed the two executives. I did find that evidence supported a failure in judgment and therefore my decision was to propose demotion from the senior executive service, including a substantial reduction in pay. Rumor mills may have reported that we are negotiating some sort of settlement, not true. The fact is that we with-

drew the demotion action because of our administrative error and we have already reinstated the action. We want to make sure that all actions, including these, survive appeal.

I will close with a very short story. Last Thursday at our Denver Medical Center's mental health clinic, a veteran took Nurse Practitioner Kathy Rittenhouse hostage. Armed with a loaded pistol and two boxes of ammunition, the veteran's stated purpose was to be killed by police, suicide by cop. Evidenced and highly trained, Kathy calmed the veteran, persuaded him to let her make a phone call. When VA Police Officer Greg Crenshaw arrived, Greg persuaded the veteran to take him as the hostage to protect Kathy. In taking Kathy's place, Greg disarmed the veteran and resolved the crisis without any physical harm to anyone. The whole process took 13 minutes.

I should mention that the vast majority of our police officers are veterans themselves, and they all are specifically trained to de-escalate volatile situations. It would have been very easy for Kathy and Greg to wait for the SWAT team and the hostage negotiators that were already on their way. But they did not. They acted based on their commitment to care for veterans, their desire to do the right thing, and their considerable training. And in doing so I believe they saved lives.

A quick postscript, after the crisis, the team got together and insisted that this veteran not be sent somewhere else for his inpatient mental health care. They want to take care of him there.

These are the kind of people that are being vilified day in and day out in broad brush strokes about VA employees. So for employees like Kathy and Greg, as well as for our veterans, we will continue to approach discipline squarely with a single objective in mind, to do what is right and in the process restore veterans' confidence in VA. We will not hesitate to take corrective action when warranted and available evidence supports it. But we will not administer punishment based on IG opinions, referrals to the Department of Justice, recycled and embellished media accounts, or external pressure. It is simply not right and it is not in the best interest of the veterans we serve.

We look forward to your questions.

[THE PREPARED STATEMENT OF SLOAN GIBSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Gibson. I think your statement is pretty dang inconsistent. Not a single Member of this Committee would ever say something about disciplining people like Kathy or Greg. I appreciate you bringing that to our attention, but to imply that we have is disingenuous and you know that.

My statement this morning is based on the written statement that was sent ahead of time to us from VA, which is vastly different than what Mr. Gibson just laid out. So I hope you will all avail yourself to the written statement that was submitted for the record and is out for everybody to read on the table outside.

I want to start by saying that I believe many of the elements in your written statement reflect a passive criticism of our efforts and the calls for change which have been made by this Committee, this

Congress, and in fact many of the veterans service organizations that you so highly praise, and whose work we appreciate everyday.

We are all educated enough to know what the definition of accountability is. You and the Secretary have now decided to change that definition. You say that we have changed it, but in fact, I do not think we need to be educated on what that word means as you did in your written statement. Holding somebody accountable is for their actions, actions that they are liable for and should have to transparently answer for. And it is not simply about being transparent about your goals and how to achieve them, as you stated in your testimony. According to Merriam-Webster's Dictionary, accountability means an obligation or a willingness to accept responsibility or to account for one's actions. Quite honestly, I think the tone of your written statement proves why we are so disappointed with the lack of accountability at the Department of Veterans Affairs because it illustrates that the department and its senior officials still refuse to take responsibility for the corrosive culture that is throughout the agency.

In fact if you look at the Google definition of accountability as it is used in a sentence, it says, quote, "their lack of accountability has corroded public respect," end quote. If you substituted the words "the Department of Veterans Affairs" for the word "their," it would be 100 percent correct today. The Department of Veterans Affairs' lack of accountability has corroded public respect.

As evidenced by VA's senior leaders' unwillingness to aggressively root out that corrosion you continue to blame this Congress and the media, for undue pressure for VA's problems in applying appropriate disciplinary measures. You even blame your own IG. For, and I quote from your statement, quote, "unfounded rhetoric that creates an unfounded expectation which does a distinct disservice to taxpayers and to veterans," end quote. Obviously to this day there appears to be no real acceptance of responsibility for VA's continued and pervasive failure to seriously discipline its employees and it seems as if there is no effort to change it. Words and actions matter.

Neither I nor anybody on this Committee has ever said that accountability is only achieved through firing people. You have alluded to that in both your written statement and your verbal statement. We have instead always believed that the disciplinary actions taken against employees should be commensurate with the actions that warranted them, and that is something that is consistently lacking at the department. You stated in your written testimony that we need to, quote, "permit you to carry out the executive branch's responsibility of proposing and deciding employee discipline independently," end quote. So let us take a look at your track record of independently proposing and deciding employee discipline.

In Alexandria, Louisiana a VA nursing assistant is charged with manslaughter in the death of a 70-year-old VA patient. VA officials originally deemed the death accidental. But a local coroner's efforts helped bring about legal charges. According to VA, the employee in question has been on paid leave since December of 2013 and continues to be on paid leave to this day.

At the heart of VA's delays in care scandal in Phoenix no employees have been successfully disciplined for wait time manipulation. Even in the case of Sharon Helman, the former director of the Phoenix VA Medical Center, the VA found a way to botch her removal after the Merit Systems Protection Board determined that VA did not even attempt to, and I quote, "connect the dots of fault," end quote, to Ms. Helman regarding the wait time issues. If VA had not lucked out and stumbled across Ms. Helman's unethical behavior of accepting inappropriate gifts, she would still be more than likely working at the department firmly entrenched in the bureaucracy and on the payroll of the American taxpayer. Further, two senior managers who were also central figures there have been on paid leave since May of 2014.

In Denver, the construction of a VA hospital was more than $1 billion over budget, and to this Committee's knowledge, VA has not disciplined a single employee in conjunction with this monumental failure. Instead, you rewarded those that were charged with overseeing the project with tens of thousands of dollars in performance bonuses. VA has completed an investigation into this matter but it is withholding the results from this Committee despite our repeated attempts to get the information.

And at the Martinsburg, West Virginia VA Medical Center the department refused to discipline appropriately an employee who was convicted of dealing heroin off campus. These examples of VA's lack of accountability demonstrate the importance of hearings just like this one. As Ms. Brown says, let me be clear; the constitutional role of Congress and this Committee is to conduct oversight of the executive branch and your department. And we will ask the questions and hold the necessary hearings to try to keep the department in check. That is basic government 101 and I am starting to believe that some of the senior leaders at VA missed that day in school. If we as Members of this Committee just sit idly by and do not hold hearings until it is convenient for the department, or do not request information that we need when we need it, or do not investigate your facilities, then we would not be fulfilling our constitutional role. And surely that is not what you are asking us to do.

I believe that the Secretary and yourself both came into the roles that you currently occupy with the will to make real change and that you want to provide high quality care and services to our veterans and I have always said, always said, that I believe the majority of people that work at the Department of Veterans Affairs share the same commitment. But the pervasive lack of real accountability hinders these efforts and is quite frankly a slap in the face to each of these employees' face. This has got to change. It gets tiresome to constantly be told by you and other VA leaders that things are changing for the better and that you are committed to sustainable accountability, but then to witness otherwise.

The department publicly continues to tout inflated numbers of those it has held accountable, but then those numbers do not square with the truth. It is even more disappointing to receive push back from the administration when this Committee and Congress as a whole tries to move legislation to cut through the bu-

reaucratic red tape and instill true accountability. In short, the defense of the status quo is unacceptable.

Just last week, VA once again showed its inability to hold bureaucrats accountable when it announced a decision to rescind the demotions of Kimberly Graves and Diana Rubens, two individuals who have been at the center of this Committee's attention for several months. It spurred the outrage of several veterans organizations and the general public following the IG report that found that they used their positions of authority to move into positions of lower responsibilities while maintaining their high pay, which allegedly enabled them to financially benefit for more than $400,000 in taxpayer moving expenses.

According to VA, one of the five binders containing evidence to support their demotions was not given to either individual when they received their proposed notice of demotion, thereby not giving them a fair opportunity to respond to the information that was documented in this particular binder. I find it ironic, Mr. Secretary, that you personally sent me two letters admonishing me for potentially damaging the cases against Ms. Graves and Ms. Rubens if I proceeded with hearings in October, yet in the end, their cases were damaged due to the inability of the VA's lawyers to simply keep track of critical evidence. I was already sorely disappointed with your decision, but I am dumbfounded that with such a high profile case which included a criminal referral to the Department of Justice that VA still found a way to botch its decision to merely demote them.

Frankly this ineptness clearly demonstrates that VA cannot even slap a wrist without missing the wrist. And it underscores the department's overall lack of focus on properly disciplining employees. What is even more infuriating about the whole situation is that under the Choice Act authority, VA was not required to provide the notice to an employee and the department set this process up on its own, yet sadly lawyers, the 700 lawyers' inability to properly execute their own self-created policies has left the American public disappointed. Now we must wait as you attempt to move through the disciplinary process for a second time. And I wish I could say that it does not worry me how this whole spectacle will affect Rubens' and Graves' impending appeals to the MSPB, but that is not the case. I just hope that VA's lawyers find a way not to lose another binder in the process.

VA's decision to not even attempt to recoup the money inappropriately spent on moving Ms. Rubens and Ms. Graves is astonishing to me. This money that your IG had recommended that you attempt to recoup, and money I believe they took from the American taxpayers inappropriately. It is simple. The relocation benefits were the fruit of Ms. Rubens' and Ms. Graves' inappropriate behavior as determined by you, Mr. Secretary. VA's decisions not to recoup these funds is akin to letting a bank robber off the hook with a mere slap on the wrist while allowing him to keep the money.

It is concerning as well that your testimony today seems to completely disregard the conclusions made by the IG and instead states that Ms. Rubens and Ms. Graves merely exercised, and I quote, "less than sound judgment," end quote. I would argue that two high level senior managers forcing their subordinates to move

to other locations so they could then obtain these positions for themselves, and causing the American taxpayers to foot the bill for their exorbitantly priced moves, illustrates a little more than, quote, "less than sound judgment," end quote. I know many of the veterans we represent would agree.

In addition to discussing last Thursday's announcement regarding Ms. Graves and Ms. Rubens, this hearing is an opportunity for the Committee to end this year with a review of VA's legal ability and self-willingness to hold its employees accountable. It will also allow for us to discuss a variety of outstanding requests made by Members of this Committee. I sent a letter to the Secretary in October seeking information regarding a variety of instances reflecting VA's inability or unwillingness to instill real accountability. I provided a copy of the letter in each of the Members' packets for you to review. The letter looks at several circumstances including instances of whistleblower retaliations at an assortment of locations, unconscionable settlement agreements with several VA employees resulting in huge payouts by the department, investigations into the behavior of several senior VA central office executives, the Denver hospital construction project, and the remaining concerns with Phoenix. To date, the Secretary has not responded to my letter.

As I said earlier, it is disheartening that Secretary McDonald continues to tout numbers of accountability that quite simply are not true. In February during an interview with Meet the Press, he claimed that 60 employees were fired for manipulating wait times, yet according to the Washington Post that was completely false. Earlier this year at a National Press Club event he announced 300 people had been proposed for some type of disciplinary action for scheduling manipulation, but at the time it was only 27. Additionally, VA's own staff has told Committee staff that several individuals identified as involved in patient wait time manipulation on the adverse action lists that VA provides to this Committee each week actually had nothing to do with wait time manipulation whatsoever. As the old saying goes, you cannot fix what you do not measure. And if the VA cannot even get its own data right about patient wait time manipulation, how will true accountability ever be achieved?

Congress can provide VA tool after tool and hold hearing after hearing, but without the will of the VA senior leadership to make real changes across the department, the corrupt culture will continue. Veterans and their families, and the majority of VA's employees who work hard every single day, deserve to be able to trust our VA. But that trust obviously needs to be earned.

With that, I yield to Ms. Brown for her opening comments.

OPENING STATEMENT OF CORRINE BROWN, RANKING MEMBER

Ms. BROWN. Thank you, Mr. Chairman, and to the Committee, and to you, Mr. Secretary, and to the veterans that are watching this proceedings.

Let me just say before I begin that I am a little uncomfortable with the quorum of this Committee and of the House at some times. In fact, I mentioned it to the Clerk. And I wanted to note

when I came here, I have been on this Committee for 23 years. And for the use of profanity was just not something that was done in the Congress. This Congress, and this Committee in particular that I have been on for 23 years, have been very bipartisan. And I do not know what has happened to this Congress and what has happened to the Members.

But let me just say that we are all here to serve the veterans and the VA serves over 50 million outpatients every year and we need to keep that in perspective as we do our due diligence. And we have attorneys on this Committee, and doctors, and I am sure you all will have all of the right questions that you want to ask.

But I am concerned, and you mentioned something, because I am concerned when you mentioned that story in the end about security. I want to know how that veteran got on that facility with a gun and with bullets that could have caused a disaster there. And I am concerned why that veteran is in outpatient and not inpatient facility. So I hope at the end of your testimony that you can answer that question for me, because I am concerned about the security at the facilities.

As we drill down on these issues I am most concerned about the veterans getting the care that they need. And also you mentioned in your report, and I asked the question about the year's end, we are supposed to be drilling down on homeless veterans. You mention it in your report. I want to know where we are. I want the Members to know there are so many cities that have signed up. I want us to know whether our cities have signed up to participate, our mayors and our communities, to help with the homelessness as far as the veterans are concerned.

We have also talked about having a health care day at the different facilities where we as Members can go in and have, bring in all of the people that have not had an appointment so they can get those appointments. I want to know about the health care for veterans.

Yes, I do know that we need to talk about accountability and that we need to make sure that you all, the perception, and this Congress and we contribute to the perception that there is widespread problems in the VA. I need, we need to assure the veteran that that is not the case. I do know when I visit my facilities, whether it is in Orlando or Jacksonville or Gainesville, once they get into the VA they are happy with the services. And I want everybody in this country to have that kind of experience. And so I am going to just yield my time to you to answer those questions about the security at the VA facility. I am interested in knowing how somebody got in there with a gun and bullets. Do we not have the security there to protect our employees? Can you answer that question for me?

[THE PREPARED STATEMENT OF CORRINE BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. Ms. Brown, we will allow the Secretary to answer it in the normal questions. We cannot allow him to answer that question during your opening statement time.

Ms. BROWN. Oh, I yield back the—

The CHAIRMAN. Okay, the time has been yielded back. I will begin the questioning at this point with the Secretary.

Who discovered the fifth binder of evidence that was not provided to Ms. Rubens and Ms. Graves?

Ms. FLANZ. Certainly, I would be happy to explain what happened. The—

The CHAIRMAN. No, I just want to know who discovered the binder was missing.

Ms. FLANZ. The legal team, it is a group of four people.

The CHAIRMAN. So you are saying VA discovered it?

Ms. FLANZ. We discovered it upon receiving the electronic copy of the two employees' appeals, yes.

The CHAIRMAN. So in other words the employees that were appealing, their attorneys found it?

Ms. FLANZ. No. They filed their appeals as they are required to and they included in their appeals all of the evidence they had received. Upon reviewing those, we realized that there, some of the materials were not included.

The CHAIRMAN. Sloan, do you agree with that?

Mr. GIBSON. It is, I am relying on Meghan for the details of what happened there.

The CHAIRMAN. Okay. Because that is not what this Committee has been told. But I will take your testimony. And can you tell me what you think the legal ramifications will be with having to rescind their demotions, and begin the process again?

Ms. FLANZ. Certainly, sir. The point of rescinding and reissuing is to cure what would otherwise be a due process violation. So the rescission and provision of the additional evidence should cure the problem entirely.

The CHAIRMAN. Sloan, in your written statement you said, in regards to Ms. Rubens' and Ms. Graves' cases that and I quote, "there were gaps between the rhetoric in the OIG report and the underlying evidence," end quote.

Mr. GIBSON. Yes, sir.

The CHAIRMAN. Explain to us about that gap, how do you see it so differently from the way the Inspector General sees it?

Mr. GIBSON. I cannot explain the Inspector General's position. I would simply say that, and Meghan will recall the occasion, as I sat down over a weekend and reviewed all the evidence in the matter, I came back in the next morning on Monday morning and my question was, I do not understand how they have reached the conclusion that they have reached based upon this particular evidence. What am I missing here?

The CHAIRMAN. Then how could they have made a referral to the Department of Justice? I mean, did the Inspector General's Office just mess it up that bad?

Mr. GIBSON. It is incomprehensible to me that they made that referral. I find no basis and our attorneys have found no basis for that referral.

The CHAIRMAN. And I do not want to dwell on that, but you have also said that you do not have the ability to recoup, whether it is Ms. Graves or Ms. Rubens or anybody else, you have no way to go in and recoup any of their relocation expenses, can you cite the statutory reason that you cannot go back and get that money?

Mr. GIBSON. I am going to lean on Meghan here again.

Ms. FLANZ. Absolutely. The process for recouping any improper payment in, that is made by the government, is through the Improper Payments Elimination and Recovery Act of 2010. It is Public Law 111–204, Section 2F. When it comes to employees, a debt may be owed and collected if the employee receives an improper payment. An improper payment is any payment that should not have been made or was made in an incorrect amount. The legal determination of our team is that with respect to certain payments that were made to Ms. Rubens in the context of her move, her temporary quarters subsistence expenses, there were some improper payments for alcoholic beverages and for—

The CHAIRMAN. I apologize. I appreciate that. The Committee is well aware. So it is your testimony that the other payments that were made to Ms. Graves and Ms. Rubens were appropriate payments?

Ms. FLANZ. They were duly authorized under the law, yes.

The CHAIRMAN. They were appropriate payments?

Ms. FLANZ. They were approved by the senior leadership based on their belief that these individuals should make those moves, yes.

The CHAIRMAN. Can you give us an update about Ms. Filipov and Mr. Hodge, who have been on paid leave since June? I am hearing a rumor, and you can dispel that rumor if you choose to do so today, that there has been a delay in a final decision because there were procedural mistakes there as well. Is that true or not?

Ms. FLANZ. Those actions are being taken by the Veterans Benefits Administration, not by my office. I do not have specific information with respect to their status.

The CHAIRMAN. Sloan?

Mr. GIBSON. I am not aware of the status on those two either, but we will provide you an update.

The CHAIRMAN. Okay. When? This afternoon?

Mr. GIBSON. Today is Wednesday, before the end of the week?

The CHAIRMAN. Yes? Okay. According to media reports, AFGE officials at VA central office completed and delivered a report to the Secretary alleging the misconduct of a number of VA executives. Has any action been taken with regards to the report? And can the department provide us an unredacted copy of the report?

Mr. GIBSON. Every one of the allegations raised in the AFGE correspondence have been investigated. There is a report that has been delivered, I think it is dated the third of December. And based on the earlier request we are prepared to provide unredacted versions of both the AFGE letter as well as the report.

The CHAIRMAN. Thank you. Ms. Brown?

Ms. BROWN. Thank you. Mr. Secretary, would you please answer the question, how many veterans do you all serve per year? We had major discussions about the wait time. What is the status about the wait times? And also, what is the approval rating of the veterans once they get into the system? And then we will go on to the incident that you mentioned.

Mr. GIBSON. Yes, ma'am. There are, we are seeing 6.5 million to 7 million unique patients, individual patients, over the course of a year. Inside VA in 2015, I am going from memory here, they completed somewhere in the neighborhood of 56 million inpatient ap-

pointments. There were roughly another 20 million—excuse me, I said inpatient, outpatient appointments.

Ms. BROWN. Fifty-six million?

Mr. GIBSON. Fifty-six million, yes, ma'am.

Ms. BROWN. Outpatient appointments?

Mr. GIBSON. Yes, ma'am, inside VA. And another roughly 20 million that are completed in the community over the course of the year.

Ms. BROWN. Okay, with our stakeholders, our partners?

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. Mm-hmm.

Mr. GIBSON. And so the second question was wait times.

Ms. BROWN. Yes?

Mr. GIBSON. You may recall in earlier testimony we talked about the effort that we undertook over the course of more than a year, and still are undertaking, to improve access to care. In that roughly 12-month period of time following the outbreak on the issue, we completed both inside and outside VA about 7 million more appointments, roughly a ten percent increase in appointments, a very material increase in access to care. Unfortunately, or fortunately depending on the perspective, over that same period of time more veterans came to us for more of their care. So what we saw is veterans waiting more than 30 days back in May or June last year. That number has actually increased over the intervening period of time because more veterans are turning to us for care as we improve access to care.

Ms. BROWN. Do you have the resources you need to serve those additional veterans?

Mr. GIBSON. My expectation, what we have been doing, and you asked about the health day—

Ms. BROWN. Yes.

Mr. GIBSON [continued]. —and I know you are aware of the stand down that we had a couple of weeks ago all across VA, the focus there was on ensuring that we are providing care that is needed urgently to veterans, and that they are getting that urgent care timely. I would tell you that is more and more of a focus on Dr. David Shulkin's leadership as Under Secretary for Health. I would tell you, I do not expect the wait times to come down. I think as we improve the quality of health care, as we improve access to care, as we improve the veteran experience, we are going to find more veterans coming to us for more care. And as long as there are economic incentives for veterans where they can come to VA for care at a lower out of pocket cost, we are going to find veterans coming to us for care.

Ms. BROWN. Now would you go and talk about that security? Because that gun really disturbed me.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. And I want to know how someone could get in the facility. Do we not have at the entrance point of the kind of security that we have here in Congress?

Mr. GIBSON. Absolutely not, ma'am. Not in any way, shape or form. We have enhanced security at two or three locations. They are in large metropolitan areas principally. If you look at the majority of VA facilities, they were built decades, in fact, the VA Med-

ical Center in Denver is 50 years old, 60 years old, something like that. There are multiple points of ingress and egress. The ability to secure every one of those, the ability to search and run every single veteran that comes in for care through those facilities is, would be an insurmountable obstacle to us being able to deliver the care that we need and the experience that veterans expect. So no, we do not have that.

And you will recall several months ago we actually had a physician assassinated in our El Paso Medical Center. We continue to work to refine and strengthen our security posture to ensure that we are protecting not only employees but other veterans. But our ability to put in place a moat, if you will, a security moat around the VA is really limited by our need to provide the care for veterans that we need to provide.

Ms. BROWN. Well I am just wanting to know, I mean, we have hardened as far as courthouses and this facility. I would like to know what it is that we need to do to protect the veterans at the facilities. I think this is major, given where we are.

Mr. GIBSON. Yes, ma'am. Well, and we, as we build new facilities, we build hardened facilities as well, which unfortunately adds to the cost of those facilities. We also build in more limited means of access, ingress and egress, so that it is easier to secure premises. But when we are operating with facilities that are on average 50 years old, it is very difficult for us to provide that kind of absolute security.

Ms. BROWN. Thank you.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. I think this is a major issue that we need to, as a Congress, need to address. I yield back the balance of my time.

The CHAIRMAN. Thank you. You mentioned the 50-year-old Denver facility not being constructed for safety reasons with multiple ingress and egress. Is the new hospital constructed to where you do not have an ingress and egress problem?

Mr. GIBSON. I think it is less severe than the issue in the old Denver hospital. But it will still be an issue.

The CHAIRMAN. Okay. Mr. Bilirakis?

Mr. BILIRAKIS. Thank you very much. Welcome, Secretary Gibson.

Mr. GIBSON. Yes, sir.

Mr. BILIRAKIS. Back home I am still hearing employees that they fear retaliation. How do you ensure moving forward that these employees are not getting retaliated for wanting to do the right thing?

Mr. GIBSON. That is a great question.

Mr. BILIRAKIS. With regard to whistleblowing?

Mr. GIBSON. Understand. Understand. We have come, I believe, a long way over the previous year in terms of dealing with the issue around whistleblowers and whistleblower retaliation. I mentioned earlier that the extent of the travels that Bob and I have made to VA facilities, we speak to employees at every single one of those facilities. We meet with whistleblowers at those facilities. In fact, I will be in Atlanta on Friday meeting with one of the principal whistleblowers down there as well as our staff. We make it clear consistently that retaliation against a whistleblower will not be tolerated and in fact we model behavior that says in fact what

we are looking for are employees that will raise their hands and help us find ways to deliver better care for veterans. The administration of discipline as part of leadership is something that happens all over the organization. And so as we change the culture of the organization, we will reset that kind of benchmark for what represents appropriate disciplinary action as it relates to any misconduct whatsoever, including whistleblower retaliation.

Mr. BILIRAKIS. Let me follow-up on this subject.

Mr. GIBSON. Sure.

Mr. BILIRAKIS. In September of this year, the Office of Special Counsel sent President Obama a letter which highlighted several high profile whistleblower cases. You are familiar with that letter, is that correct?

Mr. GIBSON. I am familiar with it, yes sir.

Mr. BILIRAKIS. Okay. What action has VA taken in response to this particular letter? And what additional legislative authority do you need to better protect whistleblowers and discipline those who retaliate against them?

Mr. GIBSON. In fact, I met with Carolyn Lerner, the Special Counsel. We discussed the letter at length and the specific issues in detail. There are a couple of instances where their findings and our findings have not matched up and we have asked that our respective teams reconcile those. There are other instances where we have, as you may know, implemented expedited processes where a whistleblower who has been retaliated against is made whole for that retaliation. We do that in concert working very closely with the Office of Special Counsel. As we undertake to pursue the manager, the responsible manager for the retaliation, we are back to the evidentiary standards that we are required to adhere to in order to be able to enforce that accountability. And I would tell you that the evidentiary standards for the action that we take to restore a whistleblower and the evidentiary standard that we take to impose discipline are two different standards. And that is part of the conversation that we have had with the Office of Special Counsel as it relates to those specific cases.

Mr. BILIRAKIS. Okay, I would like for you to follow-up, Sloan, on this issue—

Mr. GIBSON. Yes, sir.

Mr. BILIRAKIS [continued]. —with regard to the letter.

Mr. GIBSON. Okay, sir.

Mr. BILIRAKIS. And any recommendations you have and any possible legislation that we can actually present to—

Mr. GIBSON. Yes, sir.

Mr. BILIRAKIS [continued]. —and get passed.

Mr. GIBSON. Yes, sir.

Mr. BILIRAKIS. Okay. What type of message do you believe you are sending. I know we have been over this, but it is so very important, what type of message do you believe you are sending to the VBA employees when they read that the VA OIG's recommendations, then see, they read the recommendations, then see the relatively light proposed punishment for Mrs. Rubens and Mrs. Graves? Again, how will their subordinates ever take them seriously? Please answer that question directly.

Mr. GIBSON. Well I, you know, as I mentioned in my oral testimony, which obviously rubbed folks the wrong way, I believe what oftentimes happens today is there is an allegation made, whether substantiated or not. And what happens is investigations get launched and media gets contacted and there are stories. And at that point the individual becomes guilty until proven innocent. And I hope what the employees of VBA, the message that they will get, is that their leadership is committed to doing the right thing. That we are committed to holding senior leaders accountable for their behavior, but that we are also committed to doing what is supported by the evidence.

Mr. BILIRAKIS. Well in your opinion, have Mrs. Rubens and Ms. Graves, do you think they have lost credibility within the VA?

Mr. GIBSON. That is unavoidable. How do you go through all of—

Mr. BILIRAKIS. Well how—

Mr. GIBSON [continued]. —the public airing of the IG report and the reactions to the IG report and not lose face, not lose standing? It is impossible. It would be foolish to represent that. But I am not going to recommend, I am not going to propose a disciplinary action that is based upon a media coverage or an opinion that is expressed in an IG report if it is not supported by the evidence. That is just doing the right thing. It is that simple. And honestly, I meant what I said. When I went through this particular case, I knew that that proposed decision was not going to sit well with virtually everybody. And I own that. That is on me. But at least I can look at the mirror and be convinced that I made the right decision.

I look forward, once this case is concluded and the appeal process has run its course, I look forward to meeting with any Member of this Committee to discuss in detail the substantiation of my decision and providing to any Member of this Committee the full body of evidence, unredacted, so that they can form their own opinion as to whether or not I made a decision that was appropriate.

Mr. BILIRAKIS. I, I—

Mr. GIBSON. I own that. That is part of the accountability of me coming here.

Mr. BILIRAKIS. The bottom line is I am concerned about our veterans.

Mr. GIBSON. Yes, sir. Yes, sir.

Mr. BILIRAKIS. What type of service they receive.

Mr. GIBSON. And I am concerned about that, too. Yes, sir.

Mr. BILIRAKIS. Well thank you very much. I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Secretary, do you have any evidence that we do not have?

Mr. GIBSON. Sir, I do not know what evidence you have.

The CHAIRMAN. We got it from your office so I would think—

Mr. GIBSON. I believe, I am told that what evidence you got, you got from the IG. I do not, I have no idea what the IG gave you.

The CHAIRMAN. We have all the transcripts. And so will you give us the evidence at the end of the process?

Mr. GIBSON. Absolutely, positively yes. Every single piece of evidence.

The CHAIRMAN. How would you have evidence the IG would not have?

Mr. GIBSON. I am sorry?

The CHAIRMAN. How would you have evidence that the IG would not have?

Mr. GIBSON. I do not think that we have evidence that the IG does not have.

The CHAIRMAN. Okay, that is all.

Mr. GIBSON. I just do not know what they gave you.

The CHAIRMAN. That is fine. I—

Mr. GIBSON. We are sort of back to the question of making sure that we got all the evidence. We will give you everything.

The CHAIRMAN. I am sure the IG is much more transparent with us than you have been. Ms. Titus?

Ms. TITUS. Thank you, Mr. Chairman. Thank you for being here, Mr. Gibson.

Mr. GIBSON. Yes, ma'am.

Ms. TITUS. You said in your very opening statement that, you know, accountability and just about firing anyone. Several months ago, I made a similar comment in a hearing, saying that all we talk about is firing people. Some of our problem at the VA is hiring the right people in the first place. And I think we ought to put some more emphasis on that.

Mr. GIBSON. Yes, ma'am.

Ms. TITUS. And indeed I have been pleased to work with Dr. Wenstrup and Dr. Benishek to look at the hiring process and thank you for your good work on that.

Do you have, just shifting gears a little, do you have any suggestions of what we can do to help at that end of the process as well as the problems that you are having at the firing end of the process?

Mr. GIBSON. On the hiring end, among the legislative priorities that we have set forth is a provision requesting that we deem medical center directors and VISN directors Title 38 employees as opposed to Title 5 employees, which will provide us substantial additional flexibility to be able to attract the kind of talent that we want to attract and need to attract to fill those critical positions, yes ma'am.

Ms. TITUS. We had a round table the other day with some VA folks—

Mr. GIBSON. Yes, ma'am.

Ms. TITUS [continued]. —and then some representatives and the nurses association, and they were making just some bureaucratic suggestions of cleaning up the process, making it work, making the application simpler, quicker, more available. Are you all looking internally at some of those issues that you can do that we do not have to do, or might not be appropriate to do through legislation?

Mr. GIBSON. Absolutely, positively yes. We have identified underneath the MyVA structure 12 absolutely critical priorities that will be a focus over the coming 13 months. And one of those has to do with hiring practices, filling these key positions and streamlining the hiring practices. Particularly in VHA, we have an organization that does not operate like an integrated enterprise. We have talked about this before in here. And so you will find variances in hiring practices all over the organization—

Ms. TITUS. We heard that.

Mr. GIBSON [continued]. —people that are not taking advantage of the authorities that are available to them—

Ms. TITUS. Mm-hmm.

Mr. GIBSON [continued]. —people that are going through extra steps that are not necessary to go through. We have got to identify the streamlined best practice that gives us all the authority that we possibly can exercise and then standardize that approach to hiring all across the department.

Ms. TITUS. Well would you keep us apprised of that—

Mr. GIBSON. Yes, ma'am.

Ms. TITUS [continued]. —as it goes? And the staff for the three of us as we—

Mr. GIBSON. Yes, ma'am.

Ms. TITUS [continued]. —work on kind of a bipartisan bill? Because we do not want to wait a year and then get a report and then have to start all over.

Mr. GIBSON. No—

Ms. TITUS. It would be nice if we could kind of work this together as we go.

Mr. GIBSON. We would love to do that.

Ms. TITUS. All right. Thank you very much.

Ms. BROWN. Would the gentle lady yield to me for a question?

Ms. TITUS. Yes. Yes, I will yield.

Ms. BROWN. In our round table discussion, one of the things that is a major problem is how long it takes for the VA to hire someone. And as we develop expediting the process, I hope we include in there, because basically, by the time VA hires someone, some other agency has taken that person.

Mr. GIBSON. You are absolutely right, ma'am. And that is a critical component of what we have to do. You are absolutely right.

Ms. TITUS. Taking my time back, yes, that was one of the things that we mentioned about speeding up the process.

Mr. GIBSON. Yes, ma'am.

Ms. TITUS. And making it simpler.

Mr. GIBSON. Yes, ma'am.

Ms. TITUS. So that, I would appreciate working with you on that.

Mr. GIBSON. Yes, ma'am.

Ms. TITUS. Thank you.

The CHAIRMAN. Dr. Roe?

Mr. ROE. I thank the Chairman, and thank you, Mr. Secretary, for being here. And you are correct, I did take a little offense to some of what you said.

Mr. GIBSON. Yes, sir.

Mr. ROE. And I can assure you that if some of these people had been working in your shop when you were in the private sector, or in my shop when I was in the private sector, they would have been fired. And you cannot have 320,000 employees and everybody is doing a great job. That is just too big of an organization. And I understand that and you understand that.

Mr. GIBSON. Yes, sir.

Mr. ROE. I think probably you will find most of us physicians on the panel up here are more interested in the access and the quality of care that veterans are getting. Let me just read you a text I got here nine minutes before this hearing started. Phil, sorry to bother

you but we are doing—this is a general surgeon in Johnson City, Tennessee—we are doing VA critically ill patients that spill over when they are full. Unfortunately we are having trouble getting paid. Is there anything your staff can do to help us? This goes on, I get one of these once a week. And so everything is not good right now with the VA. There are a lot of issues and problems. And I think that is the problem.

And the other thing that I think the VA could do tomorrow to help access and quality, I spent four hours at the VA two weeks ago, before Thanksgiving. I went down and walked through the electronic health record, looked at that, and talked to one of my former, one of my friends who is an orthopaedic surgeon, formerly in private practice, now at the VA. I looked at how long it took him to see one patient, what he had to go through. So it is impossible to pick up with the current system that you have their productivity. So as long as that system stays in place, my friend cannot see any more patients. He just cannot do it. It took him 30 minutes to inject a rotator cuff. It would have taken him ten in his office. But it took 30. And with the electronic health record, and all the documentation, and all the stuff he had to do to put in the record, he just cannot do it. So you are going to have these waits. And then when you do that, we are going to be on you, and you are going to have people so that the data does not look bad manipulate those times. That is exactly what has happened. And that is why we are sitting here and been having this conversation.

So one of the things I would recommend you do is take people like myself and just make me a certified VA provider that sees patients on the outside and then pay them so I do not get these texts where in a timely fashion like most, like Medicare does, they are very good at it. They do not pay you very much, but at least they get the money to you and you can count on that. And I think when a physician, and I happen to know this physician very well. He operated on my wife. He is a very fine physician. And VA will not pay him. So why would you expect him to continue to bail the VA out and you are going to just back downstream, do exactly what you are talking about. Veterans cannot get in.

So anyway, I have said enough about that. You could certify me as a private practitioner, as a certified VA provider, and we will provide that care if you would just pay us. That is not a difficult thing to do. And knock off your long waits right now, if you would just let the private sector help you out. And you would not have these hiring things.

And Ms. Brown is absolutely right, it takes forever. And most of the, many of the good people get hired away by somebody else by the time the VA has made a decision to actually have them work. So the way you can fix that, if you cannot fix the hiring process, just take providers like myself, put a little thing at the bottom of my shingle that says Dr. Roe, certified VA provider. I will see the patients, get the information right back over there in a timely fashion, take care of them. If the veteran wants to do that. And many veterans do. Many veterans would like to have their care in the communities. So those are some suggestions I would make. I do not think everything is fine in Lake Woebegone, personally.

Mr. GIBSON. It is not.

Mr. ROE. You have got lots of problems.

Mr. GIBSON. We do.

Mr. ROE. And they are, I mean, and so to come up and accuse the Congress of, we did not create the problem. We are trying to find out what they are and resolve the problems because it is affecting veterans. I think that is our motivation. So I will finish with that. If you have any comments, I will be glad to hear them.

Mr. GIBSON. Well as I said, I think we are all after the same thing, better health care and benefit outcomes for veterans. Payment promptness has been a problem at VA for years. We have made great strides over the last probably nine to 12 months. But we still have a long way to go. And many of the changes that we are making there is moving us toward much more what the private sector practice looks like. We, I thought we talked about this three weeks ago at the last hearing as we were talking about payment processing.

Sixty percent of our payments are still processed on paper and we are encouraging our providers to do that electronically so that we can accelerate that timeline.

Mr. ROE. What do I tell my friend after I have had this hearing today? When is he going to get paid?

Mr. GIBSON. Please ask him, if you will email me his information, I will see that we are working on it today.

Mr. ROE. Okay. Good. I will do that. Thank you.

Mr. GIBSON. Please.

Mr. ROE. I yield back.

Ms. BROWN. Would the gentleman yield for me for a second? Was this physician prior approved before he saw the patient?

Mr. ROE. Oh he is, I think so. This particular physician I know has worked with VA for years like Dr. Benishek did.

Mr. GIBSON. Yes, I am sure he would have been. To be doing surgery, yes. Absolutely, positively yes.

Mr. ROE. And taking care of critically ill people.

Ms. BROWN. Well there should be no reason for slow pay.

Mr. GIBSON. That is exactly right. You are right.

The CHAIRMAN. Miss Rice, you are recognized.

Miss RICE. Thank you, Mr. Chairman.

Mr. Gibson, your testimony included reference to training that the VA's Office of General Counsel and Office of Accountability Review received from the Office of Special Counsel regarding their ability to investigate whistleblower retaliation and also to hold those who retaliate against whistleblowers accountable.

So just two questions regarding that. I know that you went into this a little bit with Mr. Bilirakis' questions. Some anecdotal evidence as to how this training has improved those two offices' operation, number one, and, number two, how do you implement these trainings at the level where it really matters, which is at the local level at an individual VA Medical Center or regional office.

Mr. GIBSON. If I may, I would like to ask Meghan to respond, because she was directly involved in that.

Ms. FLANZ. Thank you very much for the question.

The goal was train the trainer training. We do have lawyers and human resource specialists all over the country who can be our arms and legs and mouths. So some folks from the Office of Ac-

countability Review and some attorneys from the Office of General Counsel here in D.C. sat down with the Office of Special Counsel's head trainer, got ourselves trained, produced the curriculum that is then being cascaded out to all supervisors, is the goal, by the people who are on the ground with the supervisors in terms of HR specialists and lawyers in the field.

Miss RICE. And that is how it gets down to the local level?

Ms. FLANZ. That is right.

Miss RICE. So do you have a year-end compilation of the instances of the number of whistleblowers and any potential retaliation and, if there was retaliation, what was done vis-a-vis both the whistleblower and the person who retaliated against them, could you compile that information?

Ms. FLANZ. We don't collect it on a rolled-up basis, but certainly can put out a data call to provide that information to you, yes.

Miss RICE. I think that that would go a long way in terms of changing the culture of whistleblowers wanting to come forward, because they know that they are not going to be retaliated against and, if they are, there will be immediate accountability and punishment. And I think you can only do that by being able—I mean, you can't assume that someone in a VA in Texas knows about what happened to a retaliator in New York.

Ms. FLANZ. Absolutely. Yes, I agree.

Miss RICE. So I would make that suggestion.

Mr. Gibson, I don't recall if I have spoken directly to you about this, but I have asked for the Administrative Investigation Board report on the Denver construction project multiple times and that request has been repeatedly denied. Now, I understand that there is a review that is taking place, an evaluation as to whether or not there needs to be any administrative action taken against, you know, current personnel, but I don't understand—and maybe it is a legal impediment, but I don't understand why we, this Committee, can't see that, because when more money is needed for that project you come here and we, with a gun to our head, have to say yes. And this has been a big issue for me, no one has been held accountable for the cost overruns on that project.

And so I want to know if there is any way that this Committee can see that report. And I don't see how that could possibly hinder what if any administrative action would be necessary to take against current personnel, if any.

Mr. GIBSON. The position that I had taken previously as it relates to disciplinary actions in Denver was that we would look at any employees that continue to be at VA and any appropriate discipline following the completion of the IG's report. The IG is still doing their investigation. Based upon the different approach that I have outlined in my testimony, I have instructed that we not wait any longer, that we go ahead and conclude any appropriate disciplinary actions as it relates to individuals that are still employed at VA. I directed that proposing and deciding officials be appointed, that we complete that timely. And as soon as we have done that process, I look forward to providing the unredacted AIB report to the Committee. So that we have gotten through just the decision process on non-SES employees, because the appeal process can take

a very long, extended period of time. We feel like doing it immediately following the disciplinary decision is the appropriate time.

And I would tell you, my expectation in the future is that we are able to provide that and information much more timely, because we are not going to wait months and months and months for an IG investigation to conclude.

Miss RICE. Well, I guess we can look into why the IG's report is taking as long as it is. But when you come to this Committee and ask for people to—

Mr. GIBSON. Yes, ma'am.

Miss RICE [continued]. —release, you know, a billion dollars for a project that we have absolutely no empirical data about why these costs overruns, why we are facing that, I think it might behoove the agency to make as much relevant information available to us as possible.

Mr. GIBSON. Yes. As we mentioned on a hearing some time back on this particular subject, having read all the evidence, I continue to believe that the most authoritative, comprehensive account of what went wrong is the decision that was rendered by the court of the Civilian Board of Contract Appeal, CBCA, in which the decision was rendered last December and which is readily available, I would be glad to get a copy. That is the most comprehensive accounting of what happened and what went wrong that I have seen yet.

Miss RICE. Does it conflict at all with the Administrative Investigation Board's report?

Mr. GIBSON. I would tell you, the Administration Investigation Board is more granular and gets down to the individual, by-name parties, than the CBCA finding does not.

Miss RICE. Thank you.

Mr. GIBSON. Yes, ma'am.

Miss RICE. I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman.

Mr. Undersecretary, first, did I hear you correctly earlier that you stated wait times would not improve?

Mr. GIBSON. I don't expect wait times to go down, no. I think as we improve access to care, as we improve care quality, as we improve the veteran's experience at VA, I think we are going to find that demand will outstrip our ability to supply that care, that is my expectation.

Mr. HUELSKAMP. Do they need to improve?

Mr. GIBSON. Do what need to improve?

Mr. HUELSKAMP. Wait times.

Mr. GIBSON. I would love to see wait times improve, but it is a false promise for me to sit here—I am looking at what happened over the previous year. We increased in-patient and out-patient appointments inside and outside VA by—not in-patient, out-patient appointments inside and outside VA by roughly ten percent in a year, that is huge.

Mr. HUELSKAMP. Yet we had massive budget increases too, Mr. Undersecretary.

Mr. GIBSON. And yet what we saw were more veterans coming to us for care, longer wait times. We have got to ensure that we

are providing urgent care to those veterans that need care urgently and—

Mr. HUELSKAMP. By your own definition, you have over 512,000 veterans waiting more than 30 days for an appointment.

Mr. GIBSON. Yes, yes.

Mr. HUELSKAMP. And you are not going to improve that at all? You have got 142,000 waiting more than 60 days, by your own definition, and you can't improve that at all?

Mr. GIBSON. I would tell you that the dual focus, Dr. Shulkin has focused his organization very intensively on providing urgent care. The other area that I have pushed hard on and continue to push hard on are what I refer to as veterans waiting the longest for care. And so it starts at the longest wait times and works down. So that we are using the resources that we have to provide urgent care and to accelerate the access to care for those veterans waiting the longest. But for me to sit here and say that the 30-day wait list is going to go away, I don't think that is going to happen.

Mr. HUELSKAMP. And, Mr. Chairman, I am sure the Committee has received some information on this. But the definition and I want you to clarify, the preferred date, it is not the date they come in and ask for the appointment, you start the clock based on the date for the appointment deemed clinically appropriate; is that correct?

Mr. GIBSON. Either the date, if it is provided, that the date is deemed clinically appropriate or the date that the veteran wants to be seen. The large majority of our appointments are return-to-clinic appointments.

Mr. HUELSKAMP. I understand that and it shouldn't be a 60-day wait for those. But who determines what is clinically appropriate, who is the—

Mr. GIBSON. That is a discussion between the clinician and the patient.

Mr. HUELSKAMP. And the scheduler doesn't play a role in that at all? So a request comes in, the scheduler talks to the physician, for example, and says, what do you think when we should schedule that? That doesn't go to the clinician.

Mr. GIBSON. The clinician provides that clinically appropriate date in the—

Mr. HUELSKAMP. The scheduler or the provider?

Mr. GIBSON [continued]. The provider, the clinician, the doctor or the nurse provides that date to the scheduler. So it is in the system.

Mr. HUELSKAMP. So every call that comes in, the provider or the physician or a nurse actually makes the decision on scheduling?

Mr. GIBSON. If a veteran is calling in for an appointment, then they are asking to be seen. And in that particular—

Mr. HUELSKAMP. But that is not when the clock starts, correct?

Mr. GIBSON. If the veteran says, I want to be seen today, that is exactly when the clock starts. And if the veteran is conveying a need, for example, I have severe chest pains, come in right now.

Mr. HUELSKAMP. Or wait 60 days.

Mr. GIBSON. So it is that kind of fundamental triaging that is happening.

Mr. HUELSKAMP. Okay. I am trying to understand that and I don't think it really gets to the point, because you are claiming a waiting date of only four days for mental health services. Is that actually the claim that you have today, you only have four days' wait for mental health care?

Mr. GIBSON. If you look at the average wait time for a completed mental health appointment, yes, that is correct.

Mr. HUELSKAMP. No, not completed, waiting. What's the perspective, how long will they expect to wait?

Mr. GIBSON. I think the pending date is, you know, it is a few days longer than that on average. But I would tell you, what that doesn't capture is the 23 percent of appointments that are completed on a same-day basis, 20 percent if you exclude the emergency department.

Mr. HUELSKAMP. I understand that. So anyway, one last question about the VA wait time schedule problems. In Phoenix, you placed two, Mr. Curry and Mr. Robinson on administrative leave and been there since May of 2014. What is the status of any disciplinary actions against these two individuals?

Mr. GIBSON. We are wrapping up those two cases right now. Both of those two individuals were placed on administrative leave at the request of IG, along with Sharon Helman.

Mr. HUELSKAMP. IG doesn't make that decision, you make the decision. You placed them on administrative leave. Can you explain how somebody can be on administrative leave—

Mr. GIBSON. We made—

Mr. HUELSKAMP [continued].—for a year and a half and they are still getting paid?

Mr. GIBSON [continued]. We made the decision, we put them on administrative leave at the IG's request. We have—

Mr. HUELSKAMP. You told us here, Mr. Secretary—

Mr. GIBSON [continued]. —within the last several weeks—

Mr. HUELSKAMP. —the IG—

Mr. GIBSON [continued]. —received the—

Mr. HUELSKAMP. —makes recommendations—

Mr. GIBSON [continued]. —evidence—

Mr. HUELSKAMP. —and you don't—

Mr. GIBSON [continued]. —from the IG—

Mr. HUELSKAMP. Mr. Chairman—

Mr. GIBSON [continued]. —and have received the evidence from the IG, we are going to pursue disciplinary action.

Mr. HUELSKAMP. Mr. Secretary—

Mr. GIBSON. Yes, sir.

Mr. HUELSKAMP [continued].—those are recommendations from the IG; is that correct?

Mr. GIBSON. The recommendation from the IG—

Mr. HUELSKAMP. You spent your testimony attacking the IG. You placed them on leave for a year and a half, paid by taxpayers the whole time, when will we get disciplinary actions against those two people that went after three brave whistleblowers that you have settled with in Phoenix, when will we get an answer, when will they be disciplined?

Mr. GIBSON. Those disciplinary actions are in process now. We have received all the evidence.

Mr. HUELSKAMP. When will they be done?

Mr. GIBSON. Tens of thousands of pages of evidence that have been turned over to VA by the IG within the last 30 days and we are going through that evidence right now in order to be able to—

Mr. HUELSKAMP. You have to be kidding me.

Mr. GIBSON [continued]. —take action that can be sustained.

Mr. HUELSKAMP. After a year and a half they are still getting paid by the taxpayers and you can't figure out a way to discipline them. When will we know? You don't know?

Mr. GIBSON. As I said earlier, the practice changes now, because I am not going to wait any longer.

Mr. HUELSKAMP. A year and a half, I would say you have waited long enough.

Mr. GIBSON. We waited too long.

Mr. HUELSKAMP. They should lose their job or be disciplined, but not—

Mr. GIBSON. We waited—

Mr. HUELSKAMP [continued]. —be sitting on their—

Mr. GIBSON [continued]. —too long.

Mr. HUELSKAMP [continued]. —you-know-whats, getting paid.

Mr. GIBSON. We waited too long and we are not going to do it again, because I am not going to defer to the IG's investigation or, frankly, to a Department of Justice investigation—

Mr. HUELSKAMP. So you don't know when it will be done?

Mr. GIBSON [continued]. —because I can't be assured when it is going to be completed. That is the change that we are talking about. It is unacceptable. It is not acceptable to me, it is not acceptable to veterans, and it is not acceptable to the American taxpayer.

Mr. HUELSKAMP. Well, I agree. After a year and a half, it is time to do the job, take care of the Phoenix situation.

Thank you. Mr. Chairman, I yield back.

Mr. GIBSON. And the other change that I mentioned that we have imposed is, we will not routinely place employees that are subject to discipline action on administrative leave. They will be detailed to other duties, unless there is an egregious example where they need to be removed from all responsibility.

The CHAIRMAN. Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chairman.

And thank you, Mr. Secretary. I, like all of my colleagues here, are most concerned and as you are, about our veterans and making sure that they are well served on a timely basis.

Mr. GIBSON. Yes, ma'am.

Ms. BROWNLEY. And I know this hearing is supposed to be about a review of accountability and the broader accountabilities within the VA, and I think really for me and my perspective, it is much less about the disciplinary process. I know that that sometimes can be frustrating to people, but we must have the due process of the people, employees that we hire and retain. So I get that frustration, I understand it.

I think my personal frustration is more about sort of the broader accountabilities within the VA that we are changing procedures, doing what we can to close loopholes and other kinds of things, so that when we are hiring new employees, we are absolutely clear to them what their responsibilities are, what they are held account-

able for. So in the event that we have to get to this place of disciplinary action, we have our facts really, really clear. And for me that is where the frustration lies.

And I think my frustration also lies when I read your testimony, the testimony builds up about all of the progress that the VA has made. And I am not doubting that we have not made progress, and I believe in your leadership and the Secretary's leadership, and I believe that you are in a mode of continuous improvement, I am not doubting that. But I think my frustration also lies in that you end up citing the very best data possible as it relates to wait times in your testimony. So if you look at pending wait times and so forth, the data, it paints a different picture.

Now, you have just said in your testimony the demand outweighs the supply and I am not sure that we are ever going to be able to get there, but for me that is the kind of information that I want to be, you know, completely up-front with and not lead people down the path of look at this exceptional data, you know. The wait times, what did we say? I think you said the wait times right now, now I can't remember, the national wait time is four days. And that sounds great. It is like, oh, my goodness, where we were before and where we are now on a national basis, only four days. That sounds like we have done extraordinary work, but yet we still know that the problem still exists.

In my district, for example, the pending wait time is roughly 28 days. You know, that doesn't sound as good. And I know that we are down people in the district and that is causing those pending wait times to be longer.

So I think that is my frustration. And I am really looking to you and the VA to come back to us with ways in which we can improve upon our systems and regulations, so that we can be abundantly clear of what our expectations are, so that we don't run into—that we can minimize anyway, it will never be perfect, but that we can minimize some of these issues that we are talking about now, you know, with a Denver hospital, the Diana Rubens, Kim Graves issues. I think if we did it a little differently, maybe some of that would have been alleviated.

So that is what I am posing to you as, if you can come back to us and show us how we can—and if we need legislative fixes to it, let us know that, so that we can move forward collectively and continue to make improvement.

Mr. GIBSON. Yes, ma'am. There are differences in the numbers between pending appointments and completed appointments, as referred to earlier. One of the most powerful ways we can provide timely access to care is by allowing a veteran to be seen on the same day and 20-plus percent of our appointments are in fact accomplished and completed in that kind of a metric. So that represents a large portion of the difference between pending appointment wait times and completed appointment wait times. I am confident, even in the three-or-four-day metric, there are still veterans that are waiting too long for the care, waiting longer than they should be waiting.

And so that is part of the emphasis of looking at those that are waiting the longest, those that have the most urgent need, to ensure that they are being prioritized and seen as urgently as—

Ms. BROWNLEY. But you understand the point that I am making.

Mr. GIBSON. I do understand. Yes, ma'am.

Ms. BROWNLEY. I think there still are other improvements that can be made so that our expectations are clear and then, if we do get to a disciplinary situation, it should be clearer, because I think it takes that work up front. I mean, I was a school board member, you know, I have been through these processes before, and it is a matter of management doing their due diligence to make things abundantly clear, to make these processes clearer.

Mr. GIBSON. And I would point to the changes that we made in every performance evaluation for every single medical center director as a good example of that. Where instead of just tracking some random activities, we are focused on the veteran health care outcomes that they are most directly responsible for and, where there is poor performance, they are held accountable for poor performance.

Ms. BROWNLEY. Thank you.

And, Mr. Chairman, I apologize and I yield back.

The CHAIRMAN. That is okay.

Mrs. Walorski?

Mrs. WALORSKI. Thank you, Mr. Chairman.

So, you know, I want to just describe what it is like in my office in Indiana. Veterans and a lot of other advocacy groups watch these hearings, they tune in, they track what the VA says, they track the questions we ask, and they will, oftentimes come in and be very excited about what the VA says. One of the issues that in my district has been really important is the Choice program, which has never really rolled out correctly. And, you know, the VA just held a town hall meeting a couple of nights ago in our district. And, again, you know, every time the town halls roll out, it is people talking about, you know, the need for service, you know, they are outside the area, they are in a rural area. And the answer from our VISN comes back that the Choice program, you know, isn't really rolling out yet and it has got these issues. And the number of people that actually can apply for the program and actually receive any kind of help other than through the VA is very very small. We have continual turnover in our VISN with people that actually run the facilities have been expanded now all over the country. And one of the issues that happens in my district, though, and probably other districts as well, is we will get a veteran that walks in the front door of our district office and they will be carrying either a box or a bag and it is full of prescription drugs, high-powered opiates, psychotropic drugs. And they will come in and they will set this box down and they will say, I have all these drugs, I am in so much pain and the VA isn't helping me, they are just giving me more drugs and I don't know what to do. And they come in to us.

And so we obviously pick up the phone, we call and make a congressional inquiry out of it and start asking questions. Who is taking care of this veteran? And, you know, we look at that when we look at the suicide rate and those kind of things, but I am curious, what is the policy, the oversight and the standard operating procedure that the VA uses when it comes to this issue of veterans that are either in-house or coming and going from someplace in the veteran community for mental health services, what kind of due dili-

gence is the VA doing to make sure that there is a tight control on policy and individual plans then for these veterans?

Mr. GIBSON. I will take my best shot at that answer, being a non-clinician. I would tell you that one of the most powerful tools we have inside VA is the fact that we have integrated mental health care into the primary care practice. And so oftentimes, what we find, our veterans that have modest mental health care conditions are being treated inside the primary care team, and that is one of the ways that we improve access to care.

I would say where we have veterans that are more significantly dealing with behavioral health challenges, one of the new tools, one of the new structures that has been rolled out across the department is, and I am not going to remember the exact name, it is a structure where, for the most seriously affected veterans that there is a whole team of mental health care professionals that look at that veteran from a holistic standpoint. So it could be a psychiatrist, it could be a social worker, it could be some group therapy provider that are all looking from a holistic standpoint at that particular veteran.

Mrs. WALORSKI. Yeah, and I get you, that is probably the best-case scenario. So for the folks that come in my office, though, and for the issues we have, we have a very very lack of mental health services, we have a lot of drugs being prescribed.

Mr. GIBSON. Yes, ma'am.

Mrs. WALORSKI. And so what happens then? So our answer to that veteran is what? They call the 800 number for help, they call the help line as a veteran with all these drugs?

Mr. GIBSON. I would hope that—

Mrs. WALORSKI. What does the VA do, though, when you find out that there's either excess drugs being written, lack of supervision, lack of doctor-patient involvement? Because this is realtime, really happening.

And then my second question is this, Secretary. When it comes to the prescription registries in individual states, like in the State of Indiana, there is a prescription registry that every single doctor, anybody prescribing any kind of heavy narcotic turns into that state and it is monitored. Do the VAs have a procedure that is nationwide that says that they work with those state units and they do the reporting as well? Or I think we had a piece of legislation last year that said that the VA may provide that to a state. Is that customarily provided to a state or is the VA pretty much self-contained?

Mr. GIBSON. My understanding is that it is standard practice for us to participate in those state registries. And that is one of the ways that we are able to help improve the continuity of care for those veterans that are taking habit-forming drugs.

Mrs. WALORSKI. And if there is a doctor violating that in a state, what is the role of the veteran? Does the veteran call the congressional office and we call the VA when we know or have some kind of suspicion that there is going on inside of the facility, over writing of prescriptions or lack of supervision?

Mr. GIBSON. The focal point is the VA physician. I would tell you that as we have rolled out the opioid safety initiative all across the department, what we have built are dashboards for every single fa-

cility and every single physician that allow us to see at all levels of the organization, the activity and intensity of opioid prescriptions.

Mrs. WALORSKI. And has that led to greater compliance, the dashboard, has that led to greater compliance?

Mr. GIBSON. It has, yes, and reduced incidents of opioid prescriptions.

Mrs. WALORSKI. I appreciate that.

I yield back my time, Mr. Chairman.

The CHAIRMAN. Mr. O'Rourke, you are recognized.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Secretary, thank you for being here and for answering all of our questions, and I think perhaps just as importantly listening to some of the concerns and suggestions on how we make improvements. I do want to make sure that this continues to be a collaborative relationship to the degree that it can with our oversight responsibility.

Mr. GIBSON. Yes, sir.

Mr. O'ROURKE. And I have got to tell you, I sympathize with the fact that you are managing, you know, an all-funds, all-accounts budget organization that controls $156 billion that has one of the most sacred responsibilities that this country has to fulfill, and you and Secretary McDonald, and actually you before Secretary McDonald, took this over at a time of unparalleled crisis. And so I am trying to figure out what the balance is between the Committee and the VA and the administration, I want to focus on outcomes. I want you to hit those things that are your commitment that I know you deeply believe in. I don't want to get into personnel issues in a $156 billion organization. And yet because of the trust that was broken with this Committee, with this country, with the veterans, with the VSOs who represent them, I think it is very understandable that there is a heightened sensitivity on the part of the Committee when we see a Diana Rubens situation, when we see an egregious failure by a doctor or a prescriber in some part of the VA, there is going to be an intensive focus on that to see if it signals that in fact we are turning the corner or whether there are still systemic problems. And so I just think it is important to say that.

And one other thing is just another imperfect analogy. I was on the city council in El Paso for six years and I was typically the dissenting vote on personnel issues that we would handle in executive session. The attorneys would always say, you know what, this employee whose violation was from the trivial to the more serious, it is much cheaper for us to settle with them, to put them in another job, to move them to the sanitation department instead of to fire them. I am always that one or maybe joined by one other colleague vote to spend perhaps, you know, two to three times what it would cost to keep the employee to send a signal throughout the organization and hopefully change the culture that, if you screw up here, you are out of here and we will take the extra expense.

So just speaking for myself, there's greater tolerance perhaps on the Committee, but certainly with me to spend a little bit more up front to get the culture right, even if it costs us in legal proceedings

and, you know, protracted proceedings to get these bad actors out of there.

Mr. GIBSON. Yes, sir.

Mr. O'ROURKE. I want to also commend you and the Secretary and the Undersecretary for Health for the excellent plan that you presented to us, I guess it was last month, the end of last month, to reform the way that care is delivered. And I would challenge the conclusion that you have reached that we will never be able to keep pace with demand. I think the plan that you presented which maximizes what I think are the core competencies with the VA, with what we can have complementary in the community can help us to see more veterans more effectively, more efficiently, and I think we can get closer to a more reasonable wait time. And so, just I hope that that ultimately becomes your conclusion as well, or maybe I misinterpreted what you said.

Mr. GIBSON. I hope we deliver on the outcome you have just described.

Mr. O'ROURKE. Right.

Mr. GIBSON. The question will be, how do veterans respond with their demand for care. You know, if you fix demand, I am confident that we can shorten wait times, absolutely confident.

Mr. O'ROURKE. So I want to use this remaining year that you have and the administration has and the Secretary has to leave those indelible changes that are going to ensure that this culture that we have to change, the performance we have to change, the outcomes we have to change, you are not going to get them all to where they need to be in this year, but I want to do the most possible within this year to get us as far along on the path as possible.

To that end, and I know I didn't leave you a lot of time, in terms of going forward prospectively when we are hiring, what are you looking for, what kind of decisions are we making in hiring so that we don't have these problems going forward? So that we are hiring the right people into the right culture for the VA.

Mr. GIBSON. I would tell you my own personal perspective, you look at values, will and skill. And if you can't find people that share your organizational values, if you have people that don't have the willingness to do the job, then it is a nonstarter. People may or may not have the skill, in hiring you expect that people will have the skill, but as we bring people into the organization, I didn't allude to this earlier, but in the majority of those instances where the IG did not find misconduct in locations where there were questions about scheduling, the conclusion was the people weren't trained. And if you look across VHA, there is no standard training for a medical support assistant, it is all over the board. We have tried to plug that problem by rolling out, you know, many thousands of man hours of additional training. But the ultimate solution is to roll out an enterprise-wide, and we have got one identified, two-week, face-to-face, hands-on training program for schedulers. It is hard to justify firing somebody if you haven't trained them to do their job.

So that is one of the obligations that we have. We agree that we need to hire the right person, but I would also tell you we have got to make sure that we do our part to train them to do the work.

The CHAIRMAN. Dr. Abraham, you are next.

Mr. ABRAHAM. Thank you, Mr. Chairman. And thank you, Deputy, for being here with Ms. Flanz.

Mr. GIBSON. Yes.

Mr. ABRAHAM. I just want to kind of hit some points that you made during your opening statements. You alluded to that we need to have a little more patience, we need to get some more discipline established. And I think I could give you a good argument that both the veteran and this Committee has the patience of Job waiting for these things to occur. So we are still waiting.

I want to appeal your previous life as a leader of combat troops, a leader of business. If you as a platoon leader had come to your company commander and say, if you had troops in combat and said, well, sir, give me more time and we need more discipline, the outcome would have been much more severe than the Committee is doling out now. And I don't think it is too far of a stretch to say that our veterans now are like troops in combat. The longer that they are having to wait, ravaged with disease, whether it be diabetes, heart disease or anything, we are losing lives. And we don't mind patience to a point, but it is to the point now that daily our veterans are dying, waiting for the VA, you as the leader, to get these things done, daily we know veterans are dying. And again, this is not making a better washing machine in business, these are actually lives we are dealing with.

You alluded also in your statement that we need to look at more of the strategic, the broad, the long-term game, and I certainly agree with that. But again, going back to your role as a combat commander, you know if you didn't have tactical victories, the strategical long game meant absolutely nothing.

So I guess the questions are two. One, you alluded to the IG report. And I am a little concerned that, I guess you do have the authority to usurp what the IG recommends and I guess that is in your broad authority as Deputy Secretary and Mr. McDonald's as being Secretary, but is there a standard operating procedure, as Mrs. Walorski alluded to, as when you get these reports, do you have to do certain things in the objective checkbox, so to speak, as to we have got to handle it this way, or can you go off on any road you want?

And my second question, and then I will leave you all the time you want to answer. You also alluded in your opening statement about the Mr. Frederick Harris, the VA employee that has been charged with manslaughter at the Alexandria Hospital in Louisiana, that is in my district. I would just ask what his current status is at the department right now.

Mr. GIBSON. If I can take that one first. I have no idea, but I assure you, before the day is out, I am going to find out.

Mr. ABRAHAM. I would appreciate that.

Mr. GIBSON. I would be glad to let you know too, because I am as interested as I suspect as you are.

Mr. ABRAHAM. Okay. Thank you, sir.

Mr. GIBSON. If I can make one quick comment about sense of urgency, believe me that we have a sense of urgency.

Mr. ABRAHAM. And I don't argue that.

Mr. GIBSON. As we waded into the access crisis, it was all hands on deck, we are focused on improving access to care. My comments

earlier go to really reenforce that to ensure that veterans that need care urgently are receiving care urgently. So—

Mr. ABRAHAM. And I think we just want to see some tactical victories here.

Mr. GIBSON. Believe me, we are—well, I would say seven million more completed appointments is at least a tactical victory.

Mr. ABRAHAM. But my veterans, I know the four and five days for primary care, for mental health. But it is like, as you have heard here, when we go back in our districts, we don't have one or two veterans come up to us and say we are waiting, we have dozens that say I cannot get an appointment.

Mr. GIBSON. Yes, sir.

Mr. ABRAHAM. And again, we throw our hands up in there and say, well, we are trying. Well, that is not good enough for our veterans.

Mr. GIBSON. And I agree with that. And in your part of the country one of the things we have been doing is enhancing our facilities there, so that we can provide more ready access to care. That is part of what as a leader I have to do is to create the conditions that enable those front-line staff to meet or exceed the expectations of veterans and we are, believe me, focused on doing that. Focused on correcting the problems in care in the community, as we have discussed here two weeks ago, so that that is a more effective tool as well to ensure that veterans are getting the care they need when they need it.

So there is, believe me, a sense of urgency.

Your question as it relates to IG reports. There are essentially always a set of findings or conclusions or recommendations that the IG has, and we have a discipline process that we go through and respond to those and provide regular updates to those. In the case of this particular instance, there were recommendations that the Secretary or the Undersecretary consider whether or not there is any appropriate accountability action that needs to be taken. And I can assure you, whether they recommended it or not, we would have been doing that anyway. The mechanism by which we do that oftentimes involves launching a separate investigation.

I would tell you in the particular case of the relocation, we found the information and the evidence that we needed in the investigative material that the IG gathered. So we did not have to go do a separate and independent investigation of those particular matters to move through a very deliberate process, but as expeditious as we can, notwithstanding the delay that we cost ourselves by our own administrative error to get to the appropriate conclusion.

Mr. ABRAHAM. I am out of time, but we are continuing to wait impatiently, as you know.

Mr. GIBSON. Yes, sir.

Mr. ABRAHAM. Thank you, Mr. Chairman.

Mr. GIBSON. I understand.

The CHAIRMAN. Undersecretary, just for the record, we had written a letter to Secretary Shinseki back in 2013 and then I wrote a letter to Secretary McDonald in October of this year, Ms. Flanz, you may be aware of this in regards to that particular issue, and I have not gotten a response on either. So I appreciate your willingness to dig into it and let us know what is going on.

Mr. GIBSON. I will do that. Yes, sir.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman.

And, Deputy Secretary, as always, thank you for being here.

Mr. GIBSON. Yes, sir.

Mr. WALZ. And I thank my colleagues in building on what they are saying. I understand the complexity, Mr. O'Rourke was very clear about that, the complexity of your job, tens of thousands of personnel actions. We certainly don't expect, nor it be not a good use of your time to be focusing on all of those. But I think you are hearing it from my colleagues, there are times when that large, systemic reform that we are all looking for is jeopardized, and it is the small chips in the things.

And one of the things is, is that I think we do have a responsibility in this job to channel our constituents and that is what you are hearing.

Mr. GIBSON. Yes, sir.

Mr. WALZ. And my constituents say, when you see these guys, will you ask them this. And so while it may seem petty, it is not petty. Perceived reality is reality.

And I have to say, I have tried to balance this accountability and due process, looking at pieces of legislation. As I heard, we didn't need the SES reform bill because you had all the tools. Well, apparently we did. Others have been offered that I have pushed back against, but it is challenging when I see this happen.

I am just trying to understand this latest issue. This was every veteran in the country was watching this. We did an unprecedented step that pained us to issue subpoenas. We were told that there would be accountability and now this plays out. And I have to tell you, my veterans have no faith that it is going to work, they don't believe this. And I am just trying to understand.

And in the midst of this for perceived reality, sending one of these people to Phoenix of all places afterwards? Can you take me through the personnel steps of how this unraveled? And I certainly understand things can happen, but in this one, this would have been one that I would have personally walked all the way through, I am just saying, because now we can't get at stuff.

And I think there is reason to be optimistic, I agree with Mr. O'Rourke. That hearing last week was the best hearing we have had in this Committee in two years. It was optimistic, it was visionary, it was getting at the heart of this. Veterans came up to me who watched it and said that they felt things were changing. And I haven't been more optimistic on electronic medical records than maybe in eight years than I am right now. There are important things happening, positive things happening for veterans, but it is all being undermined.

So how did we end up in this mess? And yes, it is parochial, it is in my backyard. I made the case of this and I promised my veterans there would be accountability. You heard the frustrations. And I will let you, as I said, you are the person who needs to do this, because you have earned and have the trust and faith of folks, but right now this thing is a mess.

Mr. GIBSON. As I have said before, my careful review of the entire body of evidence does not support the conclusions reached in

the IG. Folks that have no familiarity with this case other than the report that they read from the IG, I can understand precisely why they share the concern that you are expressing right now. And I made the decision that I made with the full, painful awareness that this was a decision that was not going to make people happy in any way, shape or form, but I did what I believed what was the right thing to do.

And as I mentioned earlier, I look forward to coming back. I will sit down with any Member, come see you one-on-one, if you would like, or any Member one-on-one or the group in total to walk through the decision process, walk through the evidence, and share the entire body of evidence, unredacted, all the evidence that was used to substantiate the decision that was made.

Mr. WALZ. Well, that may be important, because we have got to get this. And I have to go back, because you can't do that for each and every veteran, I have got to go back and stand in front of them. And I am not interested in a witch hunt, I do believe that due process is important. It is a morale issue, it is a fairness issue.

Mr. GIBSON. Yes, sir.

Mr. WALZ. I can't pass judgment and judge, jury and executioner on an employee of yours, I understand that. It is just a combination of things and it appears like the lack of a sense of urgency. And I don't know how to convey that more to folks that this is changing, because it is undermining veterans' faith in the really important, critical work you are doing.

Mr. GIBSON. Thank you for raising that particular issue and, if I may, if I can mention two quick points.

The first thing that I want to say to the entire Committee, my personal perception has been and continues to be that historically VA did not consistently take appropriate disciplinary action in the face of misconduct or management negligence, period. We have not historically done that. That is one of the reasons I created the Office of Accountability Review was because I did not have confidence that if I pushed those decisions out into the field, that we would get the outcomes that we needed. There was a resetting and recalibration of accountability actions and the process associated with that, and that is why I created the Office of Accountability Review, that is why I personally am the proposing and deciding official on every senior executive action, the serious actions for removal or removal from a senior executive service, because I am trying to model a leader's behavior and accountability for those leadership actions. And a senior executive see themselves being held to that account, to that standard, I am hoping that then gets modeled elsewhere in the organization. And we certainly talk about that robustly.

I agree with you that it takes too long, I agree with you that we are having to wait too long, and that is the impetus behind my decision to say we are not going to wait any longer. Where there is an issue—we knew that there was an issue around the relocation expenses months before the IG released their report. But what did we do? We waited for the IG to go through all the process. That is not how we are going to approach it. And I am telling you, we are already doing this. There are already AIBs underway or OMI inspections underway, Office of Medical Inspector inspections that are underway right now where we know that the IG is already in

the facility, but we are in there as well. And I have said, please don't get in our way, because we are going to go in, we are going to gather whatever evidence we need. If we can do that cooperatively with the IG, that's great. But we are going to move ahead, we are going to take the action that we can take. If the IG comes back with a different finding and different evidence, fine, then it will give us the opportunity to consider any additional action.

Mr. WALZ. Thank you, Mr. Chairman, for the extra time.

And I know I am not telling you anything new, Deputy Secretary, but, boy, I would lean forward into this.

Mr. GIBSON. Yes, sir.

Mr. WALZ. If you don't do it, I think you are going to jeopardize not only the public's trust in this, you are going to violate the due process rights of others, because the hammer is going to come in a way that is not going to be helpful.

Mr. GIBSON. Yes, sir.

Mr. WALZ. I yield back.

The CHAIRMAN. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman.

Secretary Shinseki resigned only after this, I think the White House saw that this Committee unanimously voted to subpoena records related to or communications related to the appointment wait time scandal. Then you and Secretary McDonald come in, really didn't make changes in the bureaucracy, became part of the bureaucracy, defended the bureaucracy. Problems have only really come to light through either whistleblowers or through things just blowing up.

Then you had a President who in the last State of the Union, after scandal after scandal, said of the VA one sentence in the State of the Union speech, he said that the Veterans Administration has had some bumps in the road, but veterans are getting state-of-the-art health care. That was it.

I think you are doing the best you can do, I think Secretary McDonald is doing the best that he can do, but you are both placeholders and you don't have the authority from the White House, you don't have the support from the President to make the kind of changes that need to be made. You know what needs to be done, Secretary McDonald knows what needs to be done, but you absolutely don't have the support nor the authority to do so.

So this agency of the Federal Government was in crisis when you came in, it will be in crisis when you leave. You give great spin here, I appreciate it. I really think you are trying to do the best you can do. But again, you absolutely have no support from the White House, no ability to make a difference. We will just do the best we can between now and the next administration in terms of logging the problems.

But if you take the issue, I mean, we had in my district the largest cost overrun in the history of the Veterans Administration in a construction. The problems were known since April of 2013 when there was a GAO report. Yet even since then the management on that project received bonuses. Nobody has been disciplined. The AIB has been done for five months, yet Congress has not received it. There is no confidence anymore in this Committee, there is no confidence and trust among the veterans of this country, nor

should there be. We are just treading water and that is where it is going to be between now and the end.

Can you tell me when the AIB, when you are going to give it to the Congress, this Committee, on the Aurora construction issue?

Mr. GIBSON. As I mentioned to Congresswoman Rice earlier, the plan had been to wait until the IG completed their investigation, we are not waiting. I have directed that we move ahead with the evidence that we have, including that AIB, to consider any appropriate administrative actions on any employee that remains at VA, and we are doing that right now. I expect that that is not going to take an extraordinarily long period of time, but I don't have an absolute deadline by which I have instructed folks to complete it, but it is relatively soon. We have waited too long for that already.

Mr. COFFMAN. Mr. Chairman, I think it is a tragic situation we are in right now that the veterans of this country are not getting the benefits that they have earned and the taxpayers are not getting the value of their hard-earned tax dollar, and I just don't see that changing between now and the next administration.

I yield back.

The CHAIRMAN. Dr. Benishek.

Mr. BENISHEK. Mr. Chairman, thank you.

Thanks for being here, Mr. Gibson.

Mr. GIBSON. Yes, sir.

Mr. BENISHEK. I was a little disturbed by your written testimony as well. I don't think we really want to see people fired, we want to see the VA be successful. And, frankly, it seems to me that we have come to the conclusion that the VA is unable to remove people that are not doing their job as we see it to be done.

I am just going to give you one example that really kind of eats at me and that is, you know, the Inspector General has told the VA eight separate times over the last 30 years they need a central plan to hire physicians. And each time the VA has agreed with the Inspector General that that is the case and that they are going to do it, but over 30 years there is no plan to hire physicians centrally. They each are hired by each individual medical center even today. And then in a Subcommittee hearing when I brought this up they said, well, we might have a plan to do it, that plan in three years. And then I said, well, who is in charge of that? And I could not get an answer.

So that is the accountability that we are talking and I am talking about is that 30 years and this plan isn't done. I know you weren't here, but it is very frustrating to see that. And we want to see people who actually do the job and get these kind of things done. And I have got to assume that, unless somebody is removed and somebody is made accountable to make that happen, all kinds of stuff like this aren't going to happen. So that is the frustration.

I mean, last month Danny Pummill, the veterans benefits exec, said it is almost impossible to discipline most VA employees. Do you agree with that?

Mr. GIBSON. I think there are processes that you have to follow, but I don't think it is impossible.

Mr. BENISHEK. What can I do as a Congressman, is there something legislatively that we can do to make it easier for you to get this kind of stuff done?

Mr. GIBSON. The issue particularly as it relates to serious discipline actions has to do primarily with the evidentiary standard that we have to meet, because employees have the right to appeal those decisions. So when they are appealed, we appear before the MSPB, the Merits System Protection Board, and have to justify our actions based upon the evidence that was the foundation of those actions.

Mr. BENISHEK. Well, it seems to me that you said this in the past too, that it is very difficult to fire somebody in the VA. I mean, can we change this? I think I asked that question already, but you kind of give me like long answers. I mean, what should be changed to make this easier?

Mr. GIBSON. I think there are processes that cut across the entire Federal Government that are associated, long established and associated with disciplinary actions in the Federal Government that have lots of public policy implications associated with them, and we operate in that context. Some of the comments that were made earlier about ensuring that we have assigned the appropriate objectives and measurable goals that people need to have in their performance evaluation gives us the kind of quantitative information we need to be able to take that action.

Mr. BENISHEK. Okay. Now, let me just go on, because we don't have much time, Mr. Gibson. I know you said repeatedly that the VA won't tolerate whistleblower retaliation. Has anybody been fired for whistleblower retaliation?

Mr. GIBSON. There have been, and I will ask Meghan to correct me if I get it wrong, ten instances of retaliators that have been disciplined, up to including removal.

Mr. BENISHEK. All right. Can we find out who that is then? Because we are just not aware of any of that here, I don't think.

Ms. FLANZ. I believe that was one of the data points requested in a letter from the Committee in October and we compiled some data that is getting ready to come over to the Committee.

Mr. BENISHEK. All right. I will yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much. Members, we were not going to a second round, if that is okay. We will end with Ms. Brown and my closing comments.

Ms. Brown?

Ms. BROWN. Thank you.

As we prepare to leave Washington, I know I am getting ready to date myself here, but when I was coming up it was a program on TV, "Badge 714," and they used to say, "The facts, ma'am, just the facts." And I think that this is what you are trying to say to us, Mr. Secretary, not what you read in the paper or the rumor mills, but you have to make your recommendation based on the facts.

Can you respond to that?

Mr. GIBSON. Yes, ma'am, you are right. Any deciding official is obligated to consider the evidence and the only evidence in taking a disciplinary action against the Federal employee.

Ms. BROWN. I also want to extend this comment to all of the veterans that might be listening. You know, under this administration, under this President, we have had the largest increase in VA funding in the history of the United States of America.

Mr. GIBSON. Yes, ma'am.

Ms. BROWN. Now, this President has not gotten the credit for it. It was under this President and the Democratic House and the Democratic Senate.

And I also want to extend season's greetings to General Shinseki who, you know, he opened up the VA for additional people that did not have to prove their cases, but we as a Congress then beefed up to give the VA the additional resources that they need to take care of it. So it is a blame-blame game. But as we move forward, I do want to let the veterans know and the people that take care of our veterans that we appreciate them soldiering up, and that we need to let the veterans know and the people that work at the VA that we appreciate what they do to take care of our veterans.

Mr. GIBSON. Yes, ma'am. And I would add my own expression of gratitude both for the President's consistent and steadfast support of VA and veterans, and also this Committee, this Committee's steadfast support. I know we don't always see things exactly the same way, but I have never doubted the Committee's motives and what are the ultimate objectives that we are trying to achieve here, and that is better outcomes for veterans.

Ms. BROWN. And I agree with that. And I want to thank the Chairman for his leadership on this Committee.

And in my last question to you, I am still concerned about the comments. I recently, last night, I went to the theater and, before I went in, they checked my purse. In addition to that, I had to have a clear bag going into the facility. So I would like to know how we can begin the dialect of guarding the VA facilities to make sure that we are proactive and that we don't have another incident or we don't have an incident that we are sitting here talking about, what is it we can do to give you the assistance that you need to make sure that we take care of the veterans and the employees and make it a very safe place to work?

Mr. GIBSON. Yes, ma'am. What I would suggest is that perhaps we bring a couple of our key leaders over and walk through the comprehensive situation that we face and what some of the potential improvements are to the security posture of the department, because it is something that we have been very focused on particularly in the wake of what happened in El Paso.

Before you got here, sir, I talked a little bit about what happened in Denver last week where we had a much different and more positive outcome than we had in El Paso, fortunately.

Ms. BROWN. Thank you again for your service.

And, with that, I yield back the balance of my time.

The CHAIRMAN. Thank you very much, Ms. Brown.

Mr. Secretary, would it be inappropriate for Ms. Brown and I to invite the President to join us on a visit to the central office?

Mr. GIBSON. Sir, I can assure you that is your call.

The CHAIRMAN. I think we will do that, because I have made the comment a couple times that he has not been to the central office and whether his schedule has allowed it or not. But we are all trying to resolve the issues that are out there. VA will never be perfect and we don't expect you to be perfect. Anecdotal evidence is brought to us all the time. Somebody handed me a note a second ago about a combat helicopter pilot, Navy captain, PTSD for over

20 years in San Diego, his psychiatrist has left. He couldn't get his prescription renewed and was told that the next appointment he could get was 60 days. I mean, little things like that, you know, can turn into a huge snowball.

Mr. GIBSON. Those are big things. That's not a little thing, that is a big thing, and I know you see it that way. Please let me know.

The CHAIRMAN. Well, we will get you the appropriate information.

Mr. GIBSON. Thank you.

The CHAIRMAN. And, again, nobody on this Committee expects you to be able to handle every single individual issue that is out there, because some cannot be handled. And Ms. Brown is correct, I used a curse word at the beginning, because I was a little upset. I don't think you meant what you said, but maybe you did. But I would ask unanimous consent that you strike the word damn from the record and put dang, d-a-n-g. Hearing no objection, so ordered.

And, again, I think we can all agree from a political perspective that we want VA to be the very best it can be.

Mr. GIBSON. Yes, sir.

The CHAIRMAN. We want to give you whatever tools are necessary. The whole idea on the disciplinary side, it just looks like it is so hard to do anything. Whether it is reprimands, I mean, I have been looking at your list, I see reprimands that are appealed by individuals. And, you know, I saw one where somebody was going to be suspended for less than 14 days and they left, they left the department. I mean, I just don't get how that process works, if we can help streamline it. And I know it is all across, it is not just VA. It is all across the Federal Government, it is not just your rules and regulations.

But I would ask unanimous consent that all Members would have five legislative days with which to revise and extend their remarks and add any extraneous material. And without—oh, Ms. Brown?

Ms. BROWN. Yes, just in closing. Mr. Chairman, I think it should be a bipartisan meeting with the President, and maybe we all could maybe go to the White House because of security or vice versa, but I think that would be a good thing to do.

The CHAIRMAN. Well, again, I think it is important that the President goes to the central office and that is why I asked the issue. And if he can walk across the street for lunch as he did a couple of weeks ago, he can certainly walk across the street to go to the central office. But it does need to be bipartisan and all the Members need to be there.

Ms. BROWN. I mean the Senate, I mean bicameral. Yeah, we need to invite the Senators.

The CHAIRMAN. I don't know about the Senators.

Mr. GIBSON. Just for the record, the President did come to the central office to announce Bob's nomination. So he has been there before.

Ms. BROWN. We are speaking of one of our town hall type meetings and discussions with him and I think that would be good, good for the country.

The CHAIRMAN. This hearing is adjourned.

[Whereupon, at 12:33 p.m., the Committee adjourned.]

APPENDIX

Prepared Statement of Corrine Brown, Ranking Member

- Thank you, Mr. Chairman.
- In order for veterans to receive the benefits and services we have promised them, it is essential that VA employees be treated fairly.
- Part of this fairness, I believe, is that bad employees must be held accountable for their actions and for not doing all they should be doing for our veterans.
- I am concerned that there is a perception that there is no accountability within VA, and that the agency is not using its current authorities to manage its workforce effectively.
- There is no excuse not to hold employees accountable when their actions harm veterans.
- Time and again, VA employees themselves have come forward to blow the whistle on wrongdoing at the VA.
- We need to do all we can to protect whistleblowers. These brave VA employees have played a crucial role in shining a light on problems within the VA.
- But in my view, providing VA with unfettered authority to remove employees will do more harm to whistleblowers than it will be effective in removing bad employees.
- Employees who are brave enough to come forward to report problems should be thanked, not punished.
- VA employees, like all federal employees, are guaranteed the Constitutional due process right to fair notice and an opportunity to respond before losing their jobs.
- VA needs to do a better job of rooting out malfeasance, and setting up systems that incentivize all VA employees to provide veterans with the best possible care.
- VA must take steps, today, to change the perception that there are no consequences for not doing your job.
- Basic fairness and civil service protections do not prohibit VA from holding its employees accountable to veterans.
- Today, we must demand accountability from VA leadership.
- Accountability for protecting whistleblowers; accountability for rewarding good employees, and accountability for punishing bad employees.
- Accountability, quite simply, for using the authorities that VA currently possesses to effectively manage the over 300,000 VA employees - one-third of whom are veterans themselves.
- Let's use the opportunity before us today to discuss how VA can do a better job, while protecting the basic concept of fairness that we all expect from our government.
- Thank you, Mr. Chairman. I yield back the balance of my time.

Prepared Statement of Sloan Gibson

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 reorga-

nization, 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.

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

[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.

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.
  - o 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.
  - o 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 find-

ing 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.

Statement For The Record

OFFICE OF INSPECTOR GENERAL

Mr. Chairman and Members of the Committee, thank you for the opportunity to provide a statement for the hearing record that will clarify the role of the Office of Inspector General (OIG) regarding VA's actions to hold VA staff accountable in

general and specifically with respect to the OIG's recent report, Administrative Investigation: Inappropriate Use of Position and Misuse of Relocation Program and Incentives in VBA.

As the Committee knows the OIG conducts many types of reviews-audits, inspections, evaluations, and administrative and criminal investigations. While most of our reports include specific recommendations for VA to take in response to our findings, with regard to administrative investigations or any report that has findings that may require individual accountability, we use more general language so as not to interfere with the due process rights of employees who may be subject to administrative action. We reiterated this position in our statement for the Committee's October 21, 2015, "An Examination of the VA Office of Inspector General's Final Report on the Inappropriate Use of Position and the Misuse of the Relocation Program Incentives" hearing when we said:

> Our statements and comments will be limited in order to preclude any allegation that our testimony unduly influenced VA or the Department of Justice regarding potential administrative or criminal action.

We would like to clarify the role of the OIG with respect to the VA's responsibility to hold people accountable. The OIG's role is to provide oversight of VA's programs, operations, and people. Inspectors General have no authority or responsibility for program functions. It is a VA program function to take any type of action, be it writing a policy, educating and training staff, or taking disciplinary or performance based administrative actions.

We agree with VA's statement that it "cannot rely wholesale on an OIG report to impose discipline." Our reports are not evidence; rather they are a summary of the evidence obtained and reviewed by OIG staff. It is VA's obligation to request and review all documentation and other evidence that the OIG obtained relating to the report and to conduct additional work if necessary before taking administrative action. We fully recognize that the standards for administrative action require this as well as applying the evidence for a different purpose. However, we take exception to the inference that we based the subject report on "unsworn hearsay conclusions." All interviews conducted during the work on this report were sworn and taped interviews conducted by experienced senior OIG staff.

The Inspector General Act requires that OIG's post issued reports on their websites within 3 days. We cannot control nor can we be influenced by what the media and others publicly state about the report. There is nothing in the OIG's press statement for the subject report that was not published in the report. Further, it is the longstanding practice to include the names of senior officials and this report is no different from other reports on OIG administrative investigations.

We would also like to take this opportunity to clarify some information regarding the OIG's investigations into scheduling and access data manipulations and differences in the number of investigative cases. We have been working diligently on finishing the investigations we opened on scheduling and wait time manipulations. We provided VA's Office of Accountability Review with 77 reports related to 73 sites of care. However, in 52 of those 77 reports, we did substantiate some type of scheduling issue ranging from outright data manipulation to intentionally game the system to simply not following VA policies and procedures. We have 36 open investigations involving 33 sites of care remaining. These numbers in some cases reflect that the OIG opened more than one investigation at a particular Veteran Health Administration facility. Unrelated allegations pertaining to a unique site were worked under separate case numbers to ensure thorough tracking of each allegation and corresponding investigative work. Past experience has proven that rolling unrelated allegations into a single report is not only cumbersome and may delay the issuance of a report, it also unnecessarily creates Privacy Act concerns when the VA used evidence supporting reports of investigation to initiate multiple unrelated administrative actions.

In conclusion, different views on the weight of evidence are indicative that the OIG work was conducted independently and without influence by VA. Now that VA has corrected their administrative errors by making all evidence available to the individuals involved, we expect VA to take appropriate steps to protect the due process rights of these individuals as well as all employees as they move forward with appropriate accountability actions.

○