U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
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WASHINGTON, DC 20515
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July 15, 2024

The Honorable Denis R. McDonough
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

I am writing to express my concern over the situation at the Department of Veterans Affairs (VA) Eastern Colorado Health Care System in Aurora (Eastern Colorado VA). Last month, I received two VA Office of Inspector General (OIG) and one VA Office of Medical Inspector (OMI) reports highlighting serious leadership failures at the Eastern Colorado VA that, and I quote, undermine the facility's "culture of safety"[1] and "may put patients at risk for adverse clinical outcomes."[2] Accordingly, last week I sent my oversight staff to investigate the situation in-person.

Together, the reports show an Eastern Colorado VA devoid of effective permanent leadership. The OIG highlighted how Eastern Colorado VA senior leaders,[3] failed to practice high reliability organization principles leading to a culture of fear throughout the facility that undermined the stability and psychological safety of Eastern Colorado VA staff. Specifically, the senior leaders failed to be committed to safety, failed to continuously engage in continuous process improvement, and failed to foster a nurturing environment that emphasized trust and respect, leading to facility employees feeling "psychologically unsafe, deeply disrespected, and dismissed."[4]

Facility senior leaders also repeatedly failed to appropriately engage with Veterans Integrated Services Network (VISN) 19 leadership and the VA Central Office prior to making significant patient care decisions, such as resuming cardiothoracic surgeries after an 11 month pause, which violated VA's own policies. Equally disturbing, VISN 19 leadership failed to provide effective oversight, which likely contributed to serious problems throughout the facility. These leadership failures created serious staffing and employee morale issues and created an unsafe environment for veteran patients which ultimately led to hundreds of serious medical procedures being cancelled and the closure of the cardiothoracic surgery division. Although the reports highlight steps the facility and VISN 19 leadership are allegedly taking to

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[1] VA OIG Report, June 24, 2024, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment that Undermined the Culture of Safety*, p. 3.

[2] VA OIG Report, June 24, 2024, *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, p.32.

[3] Defined in the OIG reports as the Facility Director, Chief of Staff (COS), Deputy Chief of Staff for Inpatient Operations (DCOS-IO) and the Associate Chief of Staff for Education (ACOS-E).

[4] VA OIG Report, June 24, 2024, *Leaders at the VA Eastern Colorado Health Care System in Aurora Created an Environment that Undermined the Culture of Safety*, p. 4-5.

remedy these serious failures, I am concerned many of these problems' root causes will not be properly addressed.

First, the reports suggest the numerous failing senior leaders within the Eastern Colorado VA have yet to be held accountable. Although the DCOS-IO and ACOS-E resigned, evidence suggests that both the Facility Director, and the Chief of Staff at the facility, both of whom are allegedly responsible for the facility's serious failures, have yet to be held accountable. Although my oversight team confirmed the Facility Director and Chief of Staff, who allegedly created the dangerous situations, have been detailed away from their positions at Eastern Colorado VA, I have not been reassured that these individuals have been appropriately disciplined. As such, I fear these individuals have simply been transferred to different VA facilities where their horrific leadership will continue, and veterans and VA's dedicated workforce will suffer as a result. This is yet another example that highlights the need for my bill, H.R. 4278, *the Restore Department of Veterans Affairs Accountability Act*, which is designed to ensure you have the tools you need to hold failing VA employees, including senior leaders within the Eastern Colorado VA, and around the country, accountable.

The reports also show many Eastern Colorado VA employees believe leadership is failing them. The facility's All Employee Survey (AES) results are extremely poor. The 2023 AES data, which is the most recent data available, suggests employees do not believe there is effective and ethical leadership present. The data also suggests there is very low workplace satisfaction. As you know, this is extremely concerning as the VA employee experience has a huge impact on the veteran experience. If employees do not feel safe, respected, and satisfied at work, then how can they be expected to provide quality care to veterans? Additionally, a poor VA employee experience can lead to large numbers of VA employees leaving VA. Not only can this impact veteran care, but it can further burden already overworked VA employees leading to a vicious cycle of resignations due to burnout and a hostile work environment. Although my oversight team has been told interim Eastern Colorado VA leadership is trying to shift employees' perceptions of the leadership staff, my oversight team heard directly from Eastern Colorado VA staff that significant issues are still present, especially when it comes to fostering a culture where people are not afraid to report concerns.

Further, I question the innocence of VISN 19 leadership in contributing to the problems at Eastern Colorado VA. The OIG reports repeatedly illustrate how VISN 19 leadership failed to perform adequate oversight of the facility, which allegedly led to VISN 19 leaders having little knowledge on the extent of the issues within the Eastern Colorado VA. Whether this ineffective oversight was intentional, or due to ineffective leadership, it is unacceptable. Their inability to have basic awareness of facilities they are charged with leading is especially unacceptable considering these leaders likely received huge bonuses as part of VA's critical skills incentive bonus payments to nearly all Veterans Health Administration senior executives. If VA's senior executives receive bonuses, they should at least be expected to effectively perform their jobs' most basic duties. I also question if the actions of these leaders have proven that they are not capable of leading VISN 19.

In addition to my concerns that VA is not addressing the root cause of the Eastern Colorado VA's issues, I am also concerned that your headquarters staff waited until June 25, 2024, to share a May 7, 2024, OMI report with the Committee. The OMI report included serious substantiated allegations and patient safety concerns, including one case that mentioned that an expired implant had been placed in a patient. It appears to have taken two explosive Eastern Colorado VA related OIG reports to motivate the administration to air its dirty laundry with the Committee of Jurisdiction. The Biden-Harris Administration must prioritize being forthright about VA's mistakes with the American public and my Committee, rather than sweeping under the rug failures which directly undercut your claims that VA is the best medical provider for all veterans.

As such, **no later than July 26, 2024**, please provide me the following information. Responses are required to reassure veterans and taxpayers that the Eastern Colorado VA is a facility which provides veterans the safe, quality patient care they have earned.

1. Please provide a list and description of all disciplinary actions, fact-findings, administrative investigation board memorandums, and any other internal and external investigations that have been initiated related to the allegations contained in the May 2024 OMI investigation report and the June 2024 VA OIG reports regarding the Eastern Colorado VA.
2. Please provide copies of the previous three performance plans for the individuals serving as the Facility Director, COS, DCOS-IO, and ACOS-E for the Eastern Colorado VA during the period VA OIG examined in their June 24, 2024, report on the Eastern Colorado VA's safety culture.
3. Please provide the duty locations and job descriptions for all senior leaders who were detailed out of the Eastern Colorado VA as part of the June 2024 VA OIG and May 2024 OMI reports on the Eastern Colorado VA. If the detailed individuals were assigned to more than one detail, please provide the location and job description for each of the details.
4. Please provide a list of all Senior Executive Service (SES) employees at the Eastern Colorado VA and VISN 19 that were given CSI bonus payments in September 2023 and the amount each SES employee received.
5. Please provide an explanation for, and documentation related to, the decision to send the OMI Report on the Eastern Colorado VA to the House Committee on Veterans' Affairs on June 25, 2024, over one month after the report was published and one day after the VA OIG published its two related reports.
6. In VA OIG's report titled *Extended Pause in Cardiac Surgeries and Leaders' Inadequate Planning of Intensive Care Unit Change and Negative Impact on Resident Education at the VA Eastern Colorado Health Care System in Aurora*, OIG stated VISN 19's comments disputing the way VA OIG characterized the VISN's oversight over the Eastern Colorado VA's cardiothoracic surgery department was "misinformation." Does VA agree with OIG's finding that VISN 19 leadership was not appropriately aware of the issues with the Eastern Colorado VA's cardiothoracic surgery department?

When producing documents, do not alter them in any way, including but not limited to, the application of redactions or watermarks. Additionally, digital copies should be provided in a format that enables their printing and copying. Please do not hesitate to have your staff contact mine with any questions.

Sincerely,

MIKE BOST
Chairman

Cc: The Honorable Mark Takano, Ranking Member