



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES
HEARING ON
PENDING LEGISLATION
MARCH 30, 2022

Chairman Pappas, Ranking Member Mann, and Subcommittee Members, thank you for giving the Department of Veterans Affairs (VA) Office of Inspector General (OIG) the opportunity to discuss H.R. 6052, which would require VA employees to receive training on their responsibilities to report wrongdoing to the OIG and cooperatively engage with its staff. My statement provides an analysis of this measure and why it would help ensure VA employees properly report suspected serious wrongdoing; risks to patient safety; and misconduct affecting veterans, their families, and caregivers.

H.R. 6052—THE DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL TRAINING ACT OF 2021

The OIG thanks Representatives Underwood and McKinley for introducing H.R. 6052 in November 2021 to mandate training for every VA employee on their duty to respond honestly, promptly, and fully to OIG requests for information.

Analysis of Legislation

H.R. 6052 mandates that all existing VA employees complete training within one year of enactment, and all new employees complete the training during their first year of employment at VA. Importantly, it would allow the Inspector General to send at least two messages a year through VA's email system to all personnel in the VA directory on engaging with the OIG and how to report wrongdoing. Such wrongdoing could include potential crimes, waste, abuse of authority, and issues that compromise the effectiveness and efficiency of VA programs and operations.

The OIG is grateful that the VA secretary signed a directive in September 2021 mandating that all employees complete a one-time training within one year—an important step in improving VA's culture of accountability. However, legislation mandating the training is still needed. Mandated training developed by VA's independent oversight body should not be dependent on the individual serving as VA Secretary at any given time.

The OIG's Right to All VA Records and Accurate Information

While the vast majority of the OIG's interactions with VA personnel are positive and appropriate, there have been instances in which the OIG has been informed that staff have been told that they cannot share information with OIG investigators without first clearing it through supervisors or leaders—contrary to the Inspector General Act of 1978 (the IG Act), as amended. Under that authority, VA employees at all levels have a duty to cooperate with OIG personnel, including providing information and assistance in a timely manner. The OIG must have prompt access to all requested VA records, reports, audits, reviews, recommendations, or other material available to the Department relating to its programs and operations. More broadly, the IG Act authorizes the OIG to request any information or assistance necessary to carry out its duties, which may include access to employees, facilities, systems, and equipment.

However, in several instances, VA personnel have provided incomplete, significantly delayed, or misleading information to the OIG. One example is the OIG's healthcare inspection examining training that VA employees received on the new electronic health record system.¹ In that inspection, staff in the Office of Electronic Health Record Management initially provided what appeared to be inaccurate and possibly misleading summaries of data instead of the underlying raw data the OIG had requested. The OIG is currently investigating the circumstances of VA's response to the OIG's information requests. The training the OIG has developed and that would be required by H.R. 6052 might have prevented the issue because it would empower VA employees by making them aware of their duties and responsibilities to provide accurate and complete information in response to OIG requests.

The OIG appreciates that Deputy Secretary Remy sent an email to all VA employees in December 2021 outlining these duties and VA's commitment to a culture that encourages the reporting of wrongdoing without fear of retaliation. Deputy Secretary Remy's message was in response to the Office of Management and Budget's December 2021 guidance to federal agencies to support the role of inspectors general, and also reminded employees of the value of OIG training.

Examples of the Impact of Improving Reporting and Engagement

Effective oversight depends on VA employees promptly reporting suspected wrongdoing to the OIG and cooperating with OIG staff. Early and effective reporting can save lives, recover or avoid waste of millions of dollars each year for VA, and help ensure veterans are receiving the benefits and services for which they are eligible.

As an example, hospital staff at a VA facility in Fayetteville, Arkansas had concerns about potential substance abuse by the chief of pathology that were not heard and promptly acted on by local management, which allowed him to work while impaired for years.² He misdiagnosed about 3,000

¹ The OIG published the training healthcare inspection in July 2021. See [Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington](#), July 8, 2021.

² [Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas](#), June 2, 2021.

patients, with errors resulting in death or serious harm, and is currently imprisoned. The OIG found a culture in which staff did not report serious concerns about the chief pathologist, in part, because they assumed that others had reported him, or they were concerned about reprisal. At the VA facility in Chillicothe, Ohio, a patient eloped from a community living center and was fatally struck by a driver with a car.³ Staff had not properly managed the veteran's care, and they failed to report numerous prior elopements to facility safety staff. Facility safety also failed to take actions after other reported elopements by the same patient. Because indicators of a problem went unreported and unaddressed over an extended period of time, the consequences were devastating. Simply stated, early and honest reporting to the OIG can save lives and improve the quality of care provided to veterans.

Anyone can be key to reporting—whether it is the person cleaning a VA facility, checking in patients, or providing VA care and services. For example, a purchasing agent uncovered a fraud scheme that involved a chief at a medical facility steering a contract that resulted in more than a half-million dollars in losses for VA. Also, a member of the VA police department reported that VA Puget Sound Health Care System staff discovered that bronchoscopes valued at over \$100,000 were missing from the facility. Three ventilators valued at around \$30,000 each were also missing, and some of the items were found on a then-VA employee's eBay account. That individual was imprisoned for the thefts.⁴

In prior years, OIG staff have seen personnel in VA medical facilities stop reporting that inventory and other supply chain systems were not working.⁵ In addition to wasting resources, these systems' failures can put patients at risk and make it difficult for staff to do their jobs. Failures in information technology systems and poorly executed modernization programs are also a persistent problem that can put veterans at risk of not receiving benefits, services, and health care. The OIG needs early notification of these issues to help VA instill a culture of accountability where employees feel empowered to effect change.

But many VA personnel do not report serious misconduct, failed systems, and suspected crimes in a timely manner—in part because they lack a basic understanding of the OIG's authority and their duty to cooperate with the OIG. The OIG also wants to communicate with VA employees so they are comfortable reporting suspected wrongdoing and can be assured of their confidentiality when they do so. The OIG understands that some employees may have come to believe incorrectly that the OIG routinely shares complainants' identities with VA. And, as mentioned above, there have also been instances when VA employees have mistakenly believed they need supervisors' approval to respond to

³ [*Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio*](#), May 6, 2021.

⁴ US Department of Justice Press Release, <https://www.justice.gov/usao-wdwa/pr/veterans-affairs-respiratory-therapist-sentenced-prison-stealing-and-selling-medical>, January 11, 2021.

⁵ [*Critical Deficiencies at the Washington DC VA Medical Center*](#), March 7, 2018; [*Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia*](#), September 26, 2019.

requests for data from the OIG, or they have lacked candor or responsiveness when speaking with OIG staff. Training mandated by H.R. 6052 would help to dispel these misconceptions.

While VA employees have numerous training requirements, investing in OIG training is offset by the lives and the hundreds of millions of dollars potentially saved. For example, during the pandemic, discussions with a senior VA leader about reporting suspicious activity to the OIG resulted in the leader reporting concerns about a vendor seeking to sell more than \$806 million of nonexistent personal protective equipment to VA. The OIG stopped the criminal scheme before VA handed over any funds.⁶

H.R. 6052 will help ensure that VA employees know when and how to respond to OIG requests and report issues. The training

- details OIG legal authority to oversee all VA operations, services, and care;
- tests staffs' knowledge of what misconduct and potential crimes to report to the OIG and what to report to other VA entities like VA's Office of Accountability and Whistleblower Protection and non-VA entities, such as the Office of Special Counsel;
- advances Congress' commitment to holding VA employees accountable as well as protecting whistleblowers and other complainants;
- proposes ways for VA staff and OIG personnel to work toward improving the effectiveness and efficiency of VA programs and services; and
- empowers VA staff to tell veterans, their families, and caregivers about when to contact the OIG.

Initial employee feedback on the one-time training has been positive since it went live just over six months ago. The most recent data available, from late January 2022, shows more than 11,000 employees had taken the course at that time. Post-training survey results indicate that more than 78 percent of employees agreed or strongly agreed the training was useful, appropriate, and met other measures of satisfaction. Only about 1.4 percent disagreed or strongly disagreed, with the remaining respondents providing neutral responses. Importantly, an average of 81% of employees agreed or strongly agreed that they now understand the OIG's role and when and how to report wrongdoing. The OIG is working with VA's Employee Education Service staff to periodically review course survey information to ensure continuous improvements when possible.

⁶ US Department of Justice Press Release, www.justice.gov/usao-wdny/pr/former-rochester-man-pleads-guilty-charges-related-ponzi-and-covid-19-fraud-schemes, August 10, 2021.

CONCLUSION

The OIG appreciates VA Secretary McDonough's support for the one-time training that is currently being offered, but that training requirement can be withdrawn at any time. It took many years to achieve the support for this mandated training during its development under prior VA Secretaries' leadership. The OIG strongly supports and is grateful for the opportunity to comment on H.R. 6052. Without this legislation, OIG training will always be subject to the approval of the VA Secretary in position at any given time. As an independent oversight agency, the OIG lacks the authority to otherwise require VA employees to be trained and to use the VA email system to directly reach all VA employees. The Department of Veterans Affairs Office of Inspector General Training Act of 2021 would help ensure that VA employees continue to be empowered to assist the OIG in improving VA's operations and using taxpayer dollars to the greatest effect; helping protect patients and improving their care; and ensuring veterans and others receive services and benefits for which they are eligible. Chairman Pappas, this concludes my statement. I would be happy to answer any questions you or other members of the Subcommittee may have.