DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

STATEMENT OF DEPUTY INSPECTOR GENERAL DAVID CASE
OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS, U.S. HOUSE OF REPRESENTATIVES
HEARING ON
PENDING LEGISLATION
JULY 12, 2023

Chairwoman Kiggans, Ranking Member Mrvan, and Subcommittee Members, thank you for the opportunity to appear before you today to discuss the need for H.R. 2733, which would require all new VA employees to receive training on their responsibilities to report crimes and serious wrongdoing to the Office of Inspector General (OIG) and cooperatively engage with its oversight staff. My statement provides an analysis of this measure and why it would help ensure VA employees properly and promptly report suspected wrongdoing; risks to patient safety; and misconduct affecting VA's programs, benefits, and services. By providing training on reporting wrongdoing and opportunities to improve, we believe that it will ultimately improve the quality and timing of services and benefits received by veterans, their families, caregivers, and survivors. The OIG thanks Representatives Underwood, Womack, Pappas, and Joyce (OH) for introducing H.R. 2733 in April.

H.R. 2733 – DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL TRAINING ACT OF 2023

H.R. 2733 mandates that all new VA employees receive training during their first year of employment at VA on how to engage with the OIG. In addition, the bill 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 matters related to interacting with OIG personnel and how to report matters to its hotline. These matters not only involve potential crimes, patient safety concerns, waste of VA resources, and abuse of VA authority, but also issues that compromise the effectiveness and efficiency of VA programs and operations.

The OIG is grateful that Secretary McDonough mandated in September 2021 that all employees complete 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, or on the OIG's ability to periodically communicate with all VA employees if needed to advance oversight efforts.

The Senate is considering some additions to the language of the bill introduced in the House. The additions reinforce that VA employees have a duty to cooperate with the OIG and should be fully informed of whistleblowers' rights, including the right to report wrongdoing to Congress as well. The Senate language also reiterates the authority of the inspector general to subpoena the attendance and testimony of witnesses, including former VA employees, as needed to carry out the duties of the office.[1]

The OIG has no objections to these changes.

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 VA personnel have been told that they cannot share information with OIG staff 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.

In several other instances, VA personnel have provided incomplete, significantly delayed, or potentially misleading information to the OIG. One example is the OIG's healthcare inspection released in 2021 examining training that VA employees received on the new electronic health record system.[2] In that inspection, the then Office of Electronic Health Record Management's Change Management group initially provided what appeared to be inaccurate and possibly misleading summaries of data instead of the underlying raw data the OIG had repeatedly requested. The OIG investigated the circumstances of VA's response to the OIG's information requests. The investigators determined that although Change Management leaders overseeing the training did not intentionally seek to mislead OIG staff, the leaders' carelessness resulted in delayed and inaccurate information being submitted that impeded oversight efforts.[3] The training the OIG has developed and that would be required by H.R. 2733 might have prevented the issue by making VA employees acutely aware of their duties and responsibilities to provide timely, accurate, and complete information in response to OIG requests.

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

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[1] This authority is pursuant to the provisions of section 312 of title 38 of the United States Code.

[2] VA OIG, *Training Deficiencies with VA's New Electronic Health Record System at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, July 8, 2021.

[3] VA OIG, *Senior Staff Gave Inaccurate Information to OIG Reviewers of Electronic Health Record Training*, July 14, 2022.

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 leadership, which allowed him to work while impaired for years.[4] He misdiagnosed about 3,000 patients, with errors resulting in death or serious harm, and is currently serving a 20-year prison sentence.[5] 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 car.[6] Staff had not properly managed the veteran's care, and they failed to report to facility safety staff numerous prior elopements. Facility safety staff also failed to take actions after other reported elopements by the same patient. Because indicators of a problem went unreported and then were unaddressed over an extended period of time after notifications were made, 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.[7]

In prior years, OIG staff have seen personnel in VA medical facilities stop reporting that inventory and other supply chain systems were not working.[8] 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

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[4] VA OIG, *Pathology Oversight Failures at the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*, June 2, 2021.

[5] US Department of Justice, "Fayetteville Doctor Sentenced to 20 Years in Federal Prison for Mail Fraud and Involuntary Manslaughter," press release, January 22, 2021, https://www.justice.gov/usao-wdar/pr/fayetteville-doctor-sentenced-20-years-federal-prison-mail-fraud-and-involuntary.

[6] VA OIG, *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.

[7] US Department of Justice, "Veterans Affairs Respiratory Therapist Sentenced to Prison for Stealing and Selling Medical Supplies," press release, January 11, 2021, https://www.justice.gov/usao-wdwa/pr/veterans-affairs-respiratory-therapist-sentenced-prison-stealing-and-selling-medical.

[8] VA OIG, *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.

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 the OIG has found that 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 the misperception that the OIG routinely shares complainants' identities with VA. It does not. And there have also been instances when VA employees have mistakenly believed they need supervisors' approval to respond to requests for data from the OIG, or they have lacked candor or responsiveness when speaking with OIG staff. Training mandated by H.R. 2733 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 $800 million of nonexistent personal protective equipment to VA. The OIG stopped the criminal scheme before VA handed over any funds, and the vendor was sentenced to more than 20 years in prison for this scheme and an unrelated Ponzi scheme.[9]

H.R. 2733 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.

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[9] US Department of Justice, "Former Rochester Man Going to Prison for More than 20 Years for His Role in Ponzi and COVID-19 Fraud Schemes," press release, August 10, 2021, https://www.justice.gov/usao-wdny/pr/former-rochester-man-going-prison-more-20-years-his-role-ponzi-and-covid-19-fraud.

The proposed additions by the Senate would also ensure VA employees are directed to information on the rights of federal whistleblowers to report to Congress and on the OIG's authority to compel testimony from former VA employees and contractors if certain criteria are followed.

Following the Secretary's September 2021 memorandum directing VA employees to take the training, over 385,000 VA personnel have taken it as of June 26, 2023. Post-training survey results indicate that more than 74 percent of employees agreed or strongly agreed the training was useful, appropriate, and met other measures of satisfaction. Another 24.4 percent provided neutral responses. Only about 1.6 percent of VA employees taking the training disagreed or strongly disagreed with its usefulness. The OIG is working with VA's Institute for Learning, Education, and Development staff to periodically review course survey information to help ensure continuous improvements.

CONCLUSION

The OIG appreciates the support that the Committee and full House demonstrated to the OIG in the 117th Congress with the passage of similar legislation to train VA employees on cooperating with and reporting to the OIG. The passage of H.R. 2733 would similarly empower VA employees to assist the OIG in improving VA's operations and using taxpayer dollars to the greatest effect; helping to protect patients and improving their care; and ensuring veterans and others receive services and benefits for which they are eligible. Chairwoman Kiggans, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.