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BEFORE THE
U.S. SENATE COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
S. 2431, S. 2687, AND OTHER PENDING LEGISLATION
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Chairman Tester, Ranking Member Moran, and Committee Members, thank you for giving the Department of Veterans Affairs (VA) Office of Inspector General (OIG) the opportunity to discuss S. 2687, which would strengthen the effectiveness of the OIG's oversight of VA programs and operations. This bill would provide OIG investigators and other oversight staff the ability to obtain relevant information from individuals who are not currently employed by VA, but whose testimony could be critical to conducting fair and comprehensive work. The OIG also appreciates this chance to comment on S. 2431, which would require all VA employees to receive training on their responsibilities to report wrongdoing to, and cooperatively engage with, OIG staff. My statement on behalf of the OIG provides an analysis of the OIG-related measures before the Committee today. It highlights both prior OIG work in which testimonial subpoena authority would have had a significant impact and why the training bill would help ensure all VA employees properly report indicators of serious wrongdoing, risks to patient safety, and misconduct affecting the welfare of veterans, their families, and caregivers.

S. 2687—THE STRENGTHENING OVERSIGHT FOR VETERANS ACT OF 2021

The Strengthening Oversight for Veterans Act of 2020, S. 2687, would give the VA Inspector General the authority to require by subpoena the attendance and testimony of individuals as necessary to enable the OIG to perform its authorized oversight functions. The OIG thanks Chairman Tester, Senator Boozman, and Senator Manchin for introducing this much-needed bill.

Analysis of Legislation

This bill would give OIG personnel an important tool to conduct comprehensive and effective oversight of VA's activities and potential harm to veterans and VA employees, which is why the OIG strongly supports its passage. It is critical that OIG staff consider all available information from individuals with knowledge of serious misconduct, fraud, and inefficiencies that risk the care and safety of veterans and their families. Testimonial subpoena authority strengthens the OIG's ability to gather information critical to allowing VA to hold responsible individuals accountable.

Under present legal authorities, the OIG can obtain documents and other materials from VA and other federal agencies and can subpoena such records from nonfederal individuals and entities. The OIG also may compel VA employees and contractors to speak with OIG staff in connection with the OIG's work, except when an individual claims constitutional protection against compelled self-incrimination.[1] However, the OIG has no mechanism to compel former federal employees or other individuals with potentially relevant information to provide testimony in support of OIG oversight activities. S. 2687 would give the OIG the authority to obtain sworn statements from such individuals, including former federal employees, former employees of current federal contractors, employees of former federal contractors, and others who do not have an employment or contractual relationship with VA.

This authority would entrust the VA OIG with the same tool afforded other OIGs that conduct oversight of large healthcare delivery and contracting organizations: the Department of Defense and the Department of Health and Human Services.[2]

The OIG recognizes the gravity of this authority and is committed to using it prudently and with appropriate controls. This legislation includes important external checks and tracking mechanisms to ensure the OIG makes responsible use of the authority. First, it requires the OIG to provide the proposed witness notice of its intent to issue a subpoena, giving the witness the opportunity to testify voluntarily. Second, it requires the OIG to notify the US Attorney General before issuing a subpoena and gives the Attorney General up to 10 days to object if the subpoena may interfere with an ongoing investigation. The OIG must also endeavor to arrange the interview in a location convenient to the witness. Additionally, the OIG would be required to report to Congress in the OIG's mandated semiannual report the number of testimonial subpoenas issued, the number of individuals interviewed pursuant to the subpoenas, the number of times the Attorney General objected to the issuance of a subpoena, and any other matters the OIG considers appropriate related to this authority.

The lack of subpoena authority for witness testimony has hampered prior comprehensive oversight efforts. The following are several examples of occasions on which OIG personnel have been unable to fully analyze potential wrongdoing because they were unable to interview essential participants as they left federal employment before or during the OIG review.

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[1] For VA employees, *see* 38 C.F.R. §0.735-12(b). For contractors, *see* Federal Acquisition Regulation, 48 C.F.R. §52.203-13.

[2] For Department of Defense authorities, *see* 5 U.S.C. App 3 §8. For Department of Health and Human Services authorities, *see* 42 U.S.C. §1320a-7a(j).

Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina

An OIG healthcare inspection team evaluated deficiencies identified in the practice and oversight of a radiologist working on a fee basis.[3] The concerns were identified in response to the OIG's prior work on the facility's deficient examination of the radiologist's credentials, the radiologist's provision of inadequate health care, and the facility's delayed evaluation of that care.[4]

The OIG reported in 2019 that when the radiologist began providing services in 2014, the chief of imaging, the radiologist's supervisor, conducted inadequate oversight. When the chief of imaging finally reviewed the radiologist's work, it was noted as "unsatisfactory" and raised concerns about the radiologist's diagnostic interpretations. The facility did not review the radiologist's work until after 2016 and did not alert regional leaders to the clinical failures until 2018, which was after the OIG initially identified the concerns. In the interim, the radiologist left the facility, preventing OIG staff from compelling testimony and conducting a more complete review of the clinical failures. Two patients received disclosures that mistakes affected the health care they received from the facility resulting from the radiologist's deficient practices, and dozens of other images were not read to standard. Had the OIG been able to compel the former radiologist, it could have more fully assessed whether additional corrective and preventive measures were needed by both VA and other medical oversight authorities stemming from the radiologists' poor performance.

Alleged Improper Release of Procurement Information

The OIG investigated allegations that current and former VA employees provided confidential VA procurement information to contractors, which would provide the contractors an advantage in the procurement process.[5] In the fall of 2017, VA issued a request for information as part of an acquisition process related to the VA STOP Fraud, Waste, and Abuse (FWA) initiative. The VA Improper Payments Remediation and Oversight Office developed criteria and ranked 37 respondents submissions. A former VA employee allegedly obtained the rankings and approached two potential contractors, telling them he could use his knowledge of VA to help them win contracts to support the STOP FWA initiative. The OIG sought testimony from the former VA employee, who declined to speak with OIG investigators. The OIG ultimately determined there was insufficient evidence to substantiate the allegations. Had the

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[3] *Facility Hiring Processes and Leaders' Responses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina*, September 30, 2019.

[4] *Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center, Asheville, North Carolina*, October 16, 2018.

[5] *Alleged Improper Release of Procurement Information*, May 1, 2019.

OIG been able to compel the former employee's testimony, evidence may have been developed sufficient to support a criminal referral or to recommend administrative action to VA.

Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System, Biloxi, Mississippi

The OIG conducted an inspection in response to multiple allegations of a thoracic surgeon's poor quality of care.[6] Before hiring the surgeon in August 2013, facility leaders knew of malpractice issues and the surgeon's prior relinquishment of a state medical license to avoid prosecution of a disciplinary case. Still, the facility director hired the surgeon. Facility leaders failed by granting and continuing the surgeon's clinical privileges without required evidence of competency. The surgeon was removed in October 2017 without following required processes, including notifying external reporting agencies. As a result of not following requirements, facility leaders could not report the surgeon to the National Practitioner Data Bank and were delayed in reporting to state licensing boards. These failures led the OIG to review service file documentation for 50 other facility care providers, which showed deficiencies in facility oversight responsibilities. The facility leaders at the time the surgeon's initial privileges and credentials were granted had left VA employment before they could be interviewed by the OIG and were, therefore, unavailable to detail their actions and decisions to OIG staff. The inability to compel their testimony limited the OIG's ability to delve into hiring and clinical privileging oversight processes and recommend improvements that might help safeguard other VA patients.

Review of Improper Dental Infection Control Practices and Administrative Action at the VA Medical Center, Tomah, Wisconsin

In connection with the OIG's review of a VA provider's improper dental infection control practices, the OIG was unable to conduct a detailed interview with the dentist, who was the central person identified in the allegation. Moreover, OIG staff were unable to interview that individual's supervisor, the chief of dental services, since both left federal service during the course of the review and declined voluntary interviews.[7] By moving beyond the OIG's reach, these individuals' refusal to be interviewed hampered the team's ability to fully investigate the alleged safety issues and address a key objective of the inspection: to identify all factors that might have contributed to facility leaders being unaware of the dentist's improper sterilization practices. The inability to speak with them also prevented the OIG from fully examining how the dental clinic was supervised. The OIG determined the dentist potentially exposed 592 veterans to blood-borne pathogens as a result of improper dental sterilization practices.

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[6] *Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System, Biloxi, Mississippi*, August 28, 2019, and *Inadequate Intensivist Coverage and Surgery Service Concerns, VA Gulf Coast Healthcare System, Biloxi, Mississippi*, March 29, 2018.

[7] *Review of Improper Dental Infection Control Practices and Administrative Action, Tomah VA Medical Center, Tomah, Wisconsin*, September 7, 2017.

S. 2431—THE DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL TRAINING ACT OF 2021

The OIG is grateful to Senator Hassan and Senator Boozman for introducing S. 2431 in July 2021 to ensure every VA employee knows how to respond to OIG requests for information and when and how to properly report indicators of serious wrongdoing, risks to patient safety, and misconduct affecting the welfare of veterans, their families, and caregivers.

Analysis of Legislation

S. 2431 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, S. 2431 would allow the Inspector General to send at least two messages a year via VA's email system to all personnel in the VA directory on engaging with the OIG and how to report issues.

Although the VA secretary signed a directive mandating this training that commenced on September 22, 2021, which is an important step in improving VA's culture of accountability, this legislation is still needed. Mandated training should not be dependent on the VA Secretary serving at any given time. Amending Title 38 would make the training mandate permanent and add the important provision of permitting the Inspector General's access to the email system, which can be used for alerts and other important communications.

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 save millions of dollars each year for VA, and help ensure veterans are receiving the benefits and services they deserve.

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 that allowed him to work while impaired for years.[8] He misdiagnosed about 3,000 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 of a perception that others had reported him, or they were concerned about reprisal. Any one of these breakdowns could cause harmful results. Because they occurred together and over an extended period of time, the consequences were devastating. In addition to saving lives, OIG reports routinely detail where veterans' health care has not been at the quality expected. This training can help spark additional reporting that can improve veterans' access to quality health care and prompt, accurate benefits processing.

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

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

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 VA Puget Sound Health Care System staff discovered missing bronchoscopes valued at over $100,000. Three ventilators valued at $30,000 were also missing, and some of the items were found on a VA employee's eBay account. A former VA employee was imprisoned for the thefts.[9]

In prior years, OIG staff have seen personnel in VA medical facilities give up on reporting that inventory and other critical supply chain systems were not working.[10] These systems' failures can put patients at risk and make it difficult for staff to do their jobs, in addition to wasting resources. 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 timely report serious misconduct, failed systems, and suspected crimes—in part because they lack a basic understanding of the OIG's authority and the 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. There have also been instances when VA employees have mistakenly believed they need supervisors' approval to respond to requests for data or other information from the OIG, or they have lacked candor or responsiveness.

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.[11]

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[9] 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.
[10] *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.
[11] 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.

S. 2431 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 when to report misconduct and potential crimes to the OIG and when 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.

CONCLUSION

The OIG strongly supports S. 2687, The Strengthening Oversight for Veterans Act of 2021, and appreciates this Committee's consideration of the legislation. Obtaining testimonial subpoena authority would strengthen the OIG's ability to conduct rigorous and thorough oversight of VA programs and operations. The OIG also strongly supports and is grateful for the opportunity to comment on S. 2431, The Department of Veterans Affairs Office of Inspector General Training Act of 2021. Its passage would empower VA employees 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 Tester, this concludes my statement. I would be happy to answer any questions you or other members of the Committee may have.