STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
LEARNING FROM WHISTLEBLOWERS AT THE DEPARTMENT OF VETERANS AFFAIRS
JULY 23, 2019

Chairman Pappas, Ranking Member Bergman, and members of the Subcommittee, thank you for the opportunity to discuss the role of the Office of the Inspector General (OIG) in receiving complaints; evaluating them; and protecting those who report allegations of waste, fraud, abuse, and other wrongdoing regarding the programs and operations of the Department of Veterans Affairs (VA).

The OIG is committed to serving veterans and the public by conducting oversight of VA programs and operations through independent audits, inspections, reviews, and investigations. We rely heavily on allegations, complaints, and information from VA employees, veterans and their families, Congress, and the public when deciding where to focus our resources. The OIG treats all complainants as whistleblowers as we respond with respect, safeguard confidentiality, and diligently evaluate their concerns.

An individual's decision to bring allegations forward should not have to be weighed against possible adverse actions. *The Whistleblower Protection Act* prohibits reprisal against public employees, former employees, or applicants for employment for reporting a violation of law, rule, or regulation. That prohibition extends to reports of gross mismanagement and waste of funds, abuse of authority, or a substantial and specific danger to public health or safety.[1]

BACKGROUND

VA is the second-largest federal agency with a budget for fiscal year (FY) 2019 of over $200 billion and more than 395,000 employees and contractors. In contrast, the OIG has a staff of approximately 950 employees and a budget for FY 2019 of $192 million.[2] The size of the OIG relative to VA presents significant challenges for conducting oversight. The OIG operates a hotline to receive whistleblower complaints and other complaints that is staffed by a dedicated team. The hotline received more than

[1] P.L. 101-12, April 10, 1989.

[2] The OIG is actively hiring to further expand our oversight activities.

35,000 contacts in FY 2018 and over 15,000 contacts for the first six months of FY 2019. Every contact is reviewed and processed by an analyst upon receipt. We receive information via telephone, fax, regular mail, and through a web submission form on the OIG's internet site. In addition to the OIG's many outreach efforts, a link to the submission form is prominently displayed on the OIG's website. There are also posters in VA facilities on how to contact the OIG. As the result of site visits and other engagements with stakeholders, OIG staff may also be contacted by individuals directly with information or allegations of wrongdoing. These contacts are also routed through the hotline for tracking and potential follow-up.

The OIG does not investigate complaints that are unrelated to VA programs and operations or issues and may forward such complaints to other Offices of Inspector General or to other investigative agencies. We also typically do not accept complaints that are more appropriately addressed through other legal or administrative forums, including claims of whistleblower retaliation.

The OIG does not generally investigate claims of whistleblower retaliation. We will investigate the underlying complaint but not whether the individual was reprised against for making a protected disclosure. *The Whistleblower Protection Act* vests the authority to provide relief for violations in other specific entities. The OIG does not investigate allegations of whistleblower reprisal made by VA employees or applicants because the OIG cannot provide direct relief to those individuals. It has been our longstanding policy to refer complainants alleging whistleblower retaliation to the Office of Special Counsel (OSC) or directly to the Merit System Protection Board (MSPB), if appropriate. OSC not only has the authority to investigate, it also has the authority to seek corrective action through the MSPB on behalf of an employee or former employee. We now also have the option of referring VA employees to VA's Office of Accountability and Whistleblower Protection (OAWP), which has statutory authority to investigate allegations of retaliation and make recommendations to the Secretary for disciplinary action.[3]

There is an exception to this general rule, the OIG will investigate appropriate complaints alleging retaliation against employees of VA contractors for engaging in protected activity. VA contractors are also protected against whistleblower retaliation but, because they are not VA or government employees, do not have recourse through the OSC or MSPB.

INTERACTION WITH COMPLAINANTS

The OIG hotline staff work with personnel from within the OIG's oversight directorates with the relevant expertise to engage in an extensive triage process. Together they determine the best course for disposition and identify the most critical and impactful issues for priority attention, particularly individuals at imminent risk of harm.[4] Allegations become cases based on a variety of factors, including

[3] P.L. 115-41, June 23, 2017.

[4] The OIG has five directorates that carry out oversight activity – Office of Investigations, Office of Audits and Evaluations, Office of Healthcare Inspections, Office of Contract Reviews, and Office of Special Reviews.

issues having the most potential risk to veterans, VA programs and operations, and for which the OIG may be the only avenue of redress. Specifically, the hotline accepts information and complaints that result in reviews of the following types of misconduct:

- VA-related criminal activity
- Systematic or other patient safety issues
- Gross mismanagement or waste of VA programs and resources
- Misconduct by senior VA officials

Allegations that are not selected by an OIG directorate for review may be referred by the OIG hotline to VA for additional information or action. When we do refer a complaint to VA, we may do so either as a case referral or a non-case referral. A case referral requires that the VA office or facility to which the matter is referred review the matter and respond back to the OIG about its findings and any actions taken. The appropriate OIG directorate reviews that information and determines if it is responsive and appropriate. If so, the OIG will close the referral. If not, the OIG may ask for additional information and clarification or may decide to open our own review of the matter. This practice acts as a force multiplier and allows the OIG to provide oversight of significantly more issues than if it relied solely on its own resources for all review activity. A non-case referral is for matters that we believe need to be brought to VA management's attention but do not rise to the level of requiring additional OIG oversight of the response.

Examples of OIG Work

There are countless examples of how whistleblowers and other complainants have driven change, not only for the matter under review, but oftentimes at the systems level through changes in policies, practices, and personnel. The following are three such examples:

- Washington DC VA Medical Center – The OIG received allegations from a whistleblower describing medical supply shortages at the Washington DC VA Medical Center. In response OIG staff went on site and confirmed serious deficiencies. The OIG staff further determined a more extensive review was warranted. As the OIG's involvement became evident, additional complainants came forward with other allegations. The hotline staff continued to monitor all allegations relating to the facility and helped inform the scope of a comprehensive review. This work highlighted deficient conditions that required VA to take actions that resulted in reductions in cancelled surgeries, improvements in the facility's cleanliness and in sterile processing of surgical instruments, advancements in supply availability, better financial management, and increases in the consistency of patient safety event reporting and follow-up. This review, while narrow at its start, expanded due to additional information received from whistleblowers. The information obtained was the basis for a published report on how to ensure core hospital systems function effectively to support quality patient care and protect government resources. The report

and its 40 recommendations, which were the subject of several congressional hearings, provide a roadmap for the more than 140 VA medical centers nationwide.[5]

- Veterans Crisis Line (VCL) – The OIG conducted an inspection of the VCL in 2016 and again in 2017, the latter in part because of additional allegations received regarding care provided to a specific veteran and VHA's inability to implement the OIG's 2016 recommendations. Those inspection findings prompted changes to the leadership structure and to VCL operations that improve the services offered to veterans.[6]
- Millions of dollars were identified in an audit that was sparked by allegations made by a VA employee to our hotline that artificial limb and device orders were being improperly billed, resulting in VA overspending by more than $7 million over three years.[7] As a result of that audit, VA agreed to put controls in place to prevent waste and ensure that taxpayer dollars are being properly spent.

Communication with Complainants

Because complainants can contact the OIG through various methods, the way in which the OIG communicates back to them will vary. If they call, the OIG hotline analyst listens carefully and asks probing questions to ascertain as much relevant information as possible. The information is then forwarded to the OIG personnel who can determine next steps. OIG staff also advise the caller of the other agencies that should be contacted if there is an allegation of retaliation or other matter not within our jurisdiction. This will be annotated in the electronic file for that contact. If they contact the OIG hotline through mail or fax they will, at minimum, receive either a standard response or a semi-custom response.[8] A web submission will generate a screen explaining the process, including advising that it generally takes six weeks for a response if we take action, and providing information on the types of complaints that the OIG is not authorized or best situated to address. For example, the form advises complainants that whistleblower retaliation complaints should be addressed to OSC. The OIG's website also identifies other offices that complainants may contact regarding personnel issues (including retaliation), such as MSPB, OAWP, VA's Office of Resolution Management, and the Equal Employment Opportunity Commission.

The OIG treats all whistleblowers and others who provide information to the OIG with the utmost respect and dignity, including protecting to the fullest extent possible the identities of individuals who wish to remain confidential or anonymous sources. When a case is opened, the OIG notifies the

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[5] *Critical Deficiencies at the Washington, DC VA Medical Center*, March 7, 2018.

[6] *Health Care Inspection – Evaluation of the Veterans Health Administration Veterans Crisis Line*, March 20, 2017.

[7] *Use of Not Otherwise Classified Codes for Prosthetic Limb Components*, August 27, 2018.

[8] A semi-custom response provides general information as well as specific information related to the issue that the complainant brought forward. The OIG is in the process of making further improvements to this procedure.

complainant, if known, in writing or via email. For a number of reasons, including privacy issues, the OIG cannot provide updates to requests from complainants for the status of cases. The complainant is notified when the case is closed. The OIG does not provide complainants the complete results of cases when they are closed. However, complainants are provided with specific information on how to request the results of their case under the Freedom of Information Act. Complainants generally will not be entitled to receive information on disciplinary or adverse action taken against subjects of their complaints because of privacy rules that limit disclosure of that type of information.

Whistleblower Protection Coordinator

The OIG also plays an important role in helping whistleblowers access other potential avenues for redress. Under the *Whistleblower Protection Coordination Act*, the OIG must designate a Whistleblower Protection Coordinator.[9] The coordinator cannot represent or advocate for the whistleblower, but educates employees on the following:

- Prohibitions against retaliation for protected disclosures
- Rights and remedies against retaliation for protected disclosures
- Roles of various entities to include the OIG, the OSC, the MSPB, and other relevant offices such as VA's OAWP
- Timeliness and availability of alternative dispute mechanisms and avenues for potential relief

INTERACTION WITH OTHER AGENCIES

The OIG interacts with other oversight entities to ensure that all available resources and protections are available to complainants. As previously discussed, there are many agencies that complainants can go to for redress. The OIG's website includes Frequently Asked Questions related to hotline inquiries that outline the types of complaints that are addressed by the OIG as well as other offices and provides contact information for those entities. This information is also provided to individuals who call or write to the OIG hotline when applicable. Although the OIG refers individuals contacting our hotline to many agencies, we have formalized the exchange of information particularly for allegations of retaliation, for which the OIG refers complainants to OAWP and OSC.

Office of Accountability and Whistleblower Protection Coordination

Among OAWP's responsibilities under the Accountability and Whistleblower Protection Act of 2017, is the receipt, review, and investigation of allegations of misconduct, retaliation, or poor performance involving senior leaders; employees in a confidential, policy-making position; or supervisors accused of whistleblower retaliation. The OIG is conducting a review of VA's implementation of the Act, which also includes OAWP's first two years of operations and expects to publish a report in September.

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[9] *The Whistleblower Protection Coordination Act*, P. L. 115-92 (June 25, 2018), applies to all federal OIGs.

OIG hotline staff may refer complainants to OAWP who are seeking assistance. Similarly, OAWP staff refer complaints that are more appropriately addressed by the OIG, such as allegations of serious criminal misconduct, to the OIG's hotline.

Office of Special Counsel

OSC is a federal agency with authority to review allegations of prohibited personnel practices, including reprisal for whistleblowing. The OIG has designated our Counselor's office as the liaison to OSC. That office coordinates any action the OIG may take on the underlying allegations from the whistleblower and provides information to OSC.

CONCLUSION

The OIG values whistleblowers and the information they provide as it helps explore areas for potential oversight of VA. It is incumbent upon VA stakeholders to protect whistleblowers from retaliation and foster an environment where no one fears the consequences of reporting any concern, problem, or ideas for potential improvement. The OIG encourages all whistleblowers to contact us with their concerns and will treat them with respect, dignity, and in confidence to the greatest extent possible.

Mr. Chairman, this concludes my statement, and I would be pleased to answer any questions you or other members of the Subcommittee may have.