OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS
STATEMENT FOR THE RECORD
SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE
HEARING ON"WATCHDOGS NEEDED: TOP GOVERNMENT INVESTIGATORS LEFT UNFILLED FOR YEARS"
JUNE 3, 2015

The VA Office of Inspector General (OIG) was not among the invited witnesses at the Committee's June 3, 2015, hearing, "Watchdogs Needed: Top Government Investigators Left Unfilled for Years," despite being the subject of undeserved, unfounded, and unsupported criticism. To set the record straight, we are submitting this statement for inclusion in the hearing record. We make this request trusting in the Committee's respect for the principles of transparency and fairness.

STATUS AND INDEPENDENCE OF ACTING INSPECTORS GENERAL

The OIG takes exception to Chairman Ron Johnson's characterization of the job status, independence, and inherent conflict of interest when individuals serve as Acting Inspectors General. Under *The Federal Vacancies Reform Act*, the "first assistant" to a vacant office required to be filled by Presidential appointment with Senate confirmation (PAS) automatically serves in an acting capacity for 210 days. By law the Deputy Inspector General becomes the acting Inspector General for a period of 210 days. In the absence of a nomination by the President, the VA Deputy Inspector General continues to serve in his official capacity as the OIG's Chief Operating Officer without any impairment to his objectivity, integrity, and independence either from the VA Secretary or Congress. Contrary to the Chairman's assertion that "they [Acting Inspectors General] can be removed by the agency at any time," the VA Deputy Inspector General is a career Senior Executive with statutory protections to due process and appeal rights under Title 5, United States Code. Furthermore, since enactment of *The Inspector General Reform Act of 2008*, for purposes of the Senior Executive Service, the VA OIG is considered a separate agency from the Department of Veterans Affairs, and the Inspector General, and not the VA Secretary, is the designated agency head with the functions, powers, and duties to take actions against members of the OIG Senior Executive Service.

HEALTHCARE ADMINISTRATIVE CLOSURES

We also take exception to the Chairman's assertions that the OIG did not release 140 reports to the public and to Congress. The 140 reports in question were administrative closures of healthcare inspections that have been published on the VA Office of Inspector General public website and provided to Congress. We made the decision to publish our healthcare administrative closures to lay out the basis for our decision-making and to show that we had sound reasons in closing these inspections. Furthermore, we made no secret at the time these inspections were closed that a small segment of OIG work efforts did not result in published reports; since 2002, the OIG has listed the total number of healthcare administrative closures in our *Semiannual Report to Congress*, which is sent every 6 months by the VA Secretary to key Members of Congress involved in Government oversight, including the Chairman and Ranking

Member of the Senate Homeland Security and Governmental Affairs. In fact the OIG *Semiannual Reports to Congress* were the original source for media reports on the 140 administrative closures that first generated congressional interest in them.

LEGACY OF OBJECTIVE REPORTS AND TESTIMONY ON PROBLEMS IN VA PROGRAMS AND OPERATIONS

The OIG's history of reports including audits and evaluations, administrative investigations, and healthcare inspections shows that we do not shy away from reporting the facts as they are, no matter what predetermined notions VA, Congress, or the public may have. Within the last 2 months alone, we published two reports on the Philadelphia VA Regional Office, VA's Patient-Centered Community Care Contracts, and improper access of VA networks from foreign countries, which have been characterized as "scathing" by the media and Members of Congress. These reports should lay to rest any questions about our independence from VA and our ability to identify and report problems in VA. In fact, House Veterans' Affairs Committee Chairman Jeff Miller stated that our May 2015 Philadelphia VA Regional Office report "is as bleak as it gets, full of systemic malfeasance and deliberate data manipulation."

On June 11, 2015, OIG officials testified at a hearing before the House Veterans' Affairs Committee on VA's fiduciary program where we warned that veterans and their VA-derived estates are at unnecessary risk. Weeks earlier we told this same Committee that VA's $3.8 billion purchase card program required significant strengthening to prevent further misuse of taxpayer dollars intended to serve veterans and their families. On April 29, 2015, we told the Senate Veterans' Affairs Committee that the Veterans Health Administration (VHA) is at risk of not performing its most important mission of providing veterans with quality health care because VHA leadership has too often compromised national VHA standards to meet short term goals.

The frequency of OIG witnesses at congressional hearings—nine in the past 3 months—is a clear indication of the respect for the quality of our work and independence. With more than 1,900 reports—each of which was shared with the Homeland Security and Governmental Affairs Committee—and more than 70 appearances at congressional hearings in the last 6 years, the VA OIG is among the most prolific in the Inspector General community in terms of transparent reporting on the programs and operations within a Federal Department and making recommendations for corrective action.

ACCESS TO OIG AND VA RECORDS BY CONGRESS

What was described at the June 3rd hearing as "fighting to keep documents from Congress" is more accurately described as a debate over the rights of Congress to obtain Executive Branch records and statutory prohibitions on the release of veterans' private medical records under VA statutes including 38 USC §§ 5701, 7332, and 5705. The plain fact is that when Chairman Johnson's personal staff received allegations in 2011 and 2014 about prescribing practices at Tomah they failed to contact the OIG. The belated contact with the OIG is one of only two contacts on veterans' issues we have ever received from Chairman Johnson's personal or Committee staff since he assumed office in 2011.

INACCURATE AND UNSUPPORTED PROJECT ON GOVERNMENT OVERSIGHT TESTIMONY

We also take exception to the written testimony of a hearing witness, Danielle Brian, Executive Director, Project On Government Oversight (POGO), which is replete with inaccuracies and assertions supported, not by factual evidence, but by footnotes to media reporting. What POGO expressed during this hearing and in public statements are opinions based on unverified and non-transparent information. One of the best examples is the hotline POGO established in May 2014 to receive allegations relating to waiting times at VA medical facilities.

On May 27, 2014, the Executive Director of POGO was quoted by the *Arizona Republic* as stating that “500 people had contacted a hotline set up for VA whistleblowers a week ago and more than a third were employees.” She was further quoted as saying that “many complainants reported manipulation of wait time data, apparently orchestrated by middle managers without any directive from headquarters. POGO refused to provide the information relating to waiting times to the OIG despite the fact that the OIG was conducting a VA-wide review on waiting times and issued a subpoena to POGO for the information.

Less than 2 months after her statements to the *Arizona Republic,* Ms. Brian submitted a 9-page letter to the Acting VA Secretary in which she states that POGO received contacts from “nearly 800 current and former employees.” However, Ms. Brian’s letter focused entirely on unverified complaints of retaliation from 15 of these nearly 800 individuals, with no mention of complaints related to wait times and possible patient harm. The letter shows that 13 of the 15 individuals were anonymous current or former employees who worked at unidentified VA facilities. As noted in the third paragraph on page 3 of the letter, POGO could not look into the claims of the anonymous complainants but “when their accounts are combined with *stories* from former employees and current employees who did provide contact information, a disturbing picture begins to form.” In other words, POGO reported to the Acting Secretary a few unrelated and unverified stories of people who claimed retaliation. The information provided VA was not actionable because it provided insufficient information for VA to take action and effect changes. We sincerely hope that no veterans were harmed by POGO’s failure to disclose allegations of poor patient care and wrongdoing by managers with respect to the manipulation of wait times.

Ms. Brian’s written and oral statements at the June 3rd hearing were similarly unusable because, as discussed below, they were based on media reports, personal opinion, gossip, and hearsay, not facts and evidence. With no access to VA personnel or records, especially medical records, POGO does not have the capability to evaluate the medical care and treatment provided veterans at VA facilities nor can they verify the stories related by complainants.

Uninformed and Misleading Criticism of OIG Phoenix Health Care System Investigation - Ms. Brian’s lack of knowledge of the facts surrounding the OIG’s 2014 investigation of patient wait times at the Phoenix VA Health Care System did not stand in her way of criticizing our investigators for not interviewing the former Phoenix Director who allegedly ordered the falsification of patient records. Before repeating this criticism

in the future, we direct Ms. Brian to the Fifth Amendment to the United States Constitution that affords American citizens the right to decline to answer questions that might incriminate them in a criminal matter. Ms. Brian also attacked the independence of the OIG when she dismissed our statement that VA does not dictate the final content of OIG reports, and that any changes made to the Phoenix report were part of the standard agency-OIG dialogue during the review and comment process utilized across the Inspector General community. Her statement is based entirely on a quote attributed to the Chairman of the House Veterans' Affairs Committee, published in the *Washington Examiner*. Ms. Brian does not cite any documents or other credible evidence to support her statement and does not appear to have made any effort to obtain corroborating evidence. Neither she nor POGO submitted a request to the OIG under the Freedom of Information Act for records relating to this or any other statement in her testimony. In fact, there is no evidence to support the statement attributed by the *Washington Examiner* to Chairman Miller because it is simply not true.

Mischaracterization of Healthcare Administrative Closures - Another dubious reference in the POGO Director's testimony is a quote from *USA Today* concerning 140 healthcare administrative closures completed by the OIG since 2006, some of which "substantiated complaints of serious harm or death." By our accounting, 52 percent of these healthcare inspections were unsubstantiated, 46 percent were already appropriately addressed by VA, and 4 percent involved Tort Claims where we terminated our work so as to not interfere or impede the VA Regional Counsel's investigation. Had she read the administrative closures posted on our public website, she would have known that none of the closures "substantiated complaints of serious harm or death," that VA had not previously identified and corrected prior to the OIG's inspection. She also ignores the fact that the number of administrative closures has been reported in the OIG's *Semiannual Reports to Congress* since 2002.

Unfounded Claim of Whistleblower Reluctance Refuted by Growing Number of Hotline Contacts - To support her opinion that the presence of acting Inspectors General has a chilling effect on agency whistleblowers coming forward, Ms. Brian proffers flimsy evidence of an unsupported statement from one person, a former VA employee who stated that the OIG is "not trusted by most employees and usually used in the VA as retaliation." Had Ms. Brian familiarized herself with the OIG's December 2014 report, *Review of Allegations Regarding the Technical Acquisition Center's Award of Sole-Source Contracts to Tridec for the Virtual Office of Acquisition*, she would have realized that the source of this quote was the subject of the OIG's report that found substantial wrongdoing by this same person, hardly an objective disinterested party. Neither Ms. Brian nor POGO submitted a request to the OIG under the Freedom of Information Act for the evidence supporting our *Tridec* report. Had they submitted such a request, POGO would have received documents identified in the report that fully support the report's findings and conclusions. Relying on a document by another OIG that explicitly states it did not rely on our evidence is simply irresponsible. In fact, these same documents were submitted to the Chairman of the House Veterans' Affairs Committee.

We believe the sheer number of contacts received by the OIG Hotline undercuts POGO's notion that people are reluctant to come forward with complaints. As reported in our *Semiannual Report to Congress* for the period of October 1, 2014, through March 31, 2015, the OIG Hotline received over 22,000 contacts. In fiscal year (FY) 2014, the Hotline received over 39,000 contacts. Since FY 2014, over 7,800 of those contacts came from VA employees. Whistleblowers are the lifeline of OIG organizations, and we take great efforts to protect their identities, understand their concerns, objectively seek the truth, and pursue accountability and corrective action from VA.

Unsupported Assertions on Effect of Interim Leadership - Ms. Brian stated that because Inspectors General who occupy PAS positions undergo a rigorous vetting process and are selected "without regard to political affiliation and solely on the basis of integrity and demonstrated ability," an Inspector General who survives the confirmation process will typically be more credible in the eyes of agency leaders and employees, congressional overseers, and members of the public. Ms. Brian does not cite any study or review that POGO or any credible entity conducted to support her opinion. It is the work of the organization that renders an Office of Inspector General credible, not any single individual.

Ms. Brian asserts on page 3 of her written statement that a "permanent Inspector General, who enjoys the protections of *The Inspector General Act* and related laws, can devise a long-term strategy to address the most important and, at times, embarrassing problems that confront her agency." This line of reasoning ignores the fact that acting Inspectors General are career Federal employees entitled to due process under Title 5 of the United States Code.

Ms. Brian concludes that "acting IG's are more likely to favor short-term projects that do not rock the boat, essentially serving as a caretaker until a permanent IG takes over." Her opinion is based on what "current and former IG staff have told POGO." Ms. Brian did not identify the employees who made these statements or even the number of employees, the agencies they were associated with, or when POGO obtained this information. More importantly, POGO did not conduct any work to verify the information. At a minimum, POGO could have compared the *Semiannual Reports to Congress* of individual OIGs to determine the validity of these assertions. A review of the *Semiannual Reports to Congress* for the VA OIG will show significant arrests, convictions, audit and inspection reports, recoveries, and other monetary benefits that have not changed since the former Inspector General retired on December 31, 2013.

CONCLUSION

Everyday VA OIG employees put forth their very best effort to help VA deliver on its promises to America's veterans by carrying out independent oversight of the Federal government's second largest Department. To have their work misrepresented as being erroneous or lacking independence disrespects their honest labor and ignores a legacy of reporting that has generated significant improvements in VA's delivery of service to veterans, whether under permanent or interim leadership.