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Chair

Mr. Neil Ellis

Standing Committee on Veterans Affairs

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● (1530)

[*English*]

The Chair (Mr. Neil Ellis (Bay of Quinte, Lib.)): I'll call the meeting to order. Pursuant to Standing Order 108(2) and the motion adopted on February 6, 2017, the committee resumes its comparative study of services to veterans in other jurisdictions.

In hour one, we have a 10-minute statement, followed by questions and answers. From the United States Department of Veterans Affairs, we would like to welcome, by video conference from Washington, Mr. Robert Reynolds, deputy under secretary for disability assistance.

Mr. Reynolds, we'll give you the floor for 10 minutes and hopefully then ask you some questions.

Mr. Robert Reynolds (Deputy Under Secretary, Disability Assistance, United States Department of Veterans Affairs): Good afternoon. Thank you for affording me the opportunity to discuss some of the things we're doing within the Department of Veterans Affairs.

It's been a couple of years since I testified before all of you. I've been up there a couple of times, but usually when I come up, it's January and February, so it's a little colder.

I'm happy to talk about the Department of Veterans Affairs and some of the new initiatives we are doing. First, I'll put it in context so that everybody understands the organizational structure of the Department of Veterans Affairs.

We are the second largest cabinet in the government, the first being the Department of Defense. VA has three administrations under it. It has our benefits side, which I reside in, our health side, and our cemeteries and memorials side.

Our health side has what is probably the largest hospital network facilities in the world. We have over 1,700 facilities, from big brick-and-mortar facilities all the way to what we call community-based outpatient clinics, along with what we're doing more and more of, which is telehealth benefits. We serve nearly nine million veterans in the health care arena.

Our cemeteries and memorials side would be our smaller administration. We oversee cemeteries for about 4.3 million veterans and their family members who reside on our grounds. We inter about 130,000 a year within our memorial affairs side.

On the benefits side, which is what I fall under, we have seven business lines within DVA. Our biggest one would be disability compensation. In our disability compensation, we provide monetary benefits to just over 4.6 million veterans who are in receipt of disability compensation. Our pension and fiduciary program, which is a program for our wartime veterans, is a smaller program, as it's a means-based one, based on your income. That has about 500,000 veterans.

Our vocational rehabilitation and employment program is a benefit program for those veterans who are service connected for disability compensation but who might need further education. That's actually how I got my undergrad degree. It was through vocational rehab, not our education program. For voc rehab, we have about 135,000 veterans who participate in that program as well. It's really to help those with service-connected disabilities to get back to the daily act of living.

I'm sure you've heard about our education program. It's mostly our Post-9/11 GI Bill. We've given that benefit out to 1.74 million, so it's getting close to two million. That would be not only veterans; this benefit allows you to transfer that entitlement to your spouse or dependant as well.

In our home loan benefit, this past year we did over 705,000 guaranteed loans. It's a great benefit that can be used numerous times throughout your life once you're eligible. One of the keys to that benefit is that, as you know, we've been working hard to end homelessness, and part of doing this in the VA home loan program is that if we become aware you're becoming delinquent on a home payment or are in financial problems, whether you have a home loan with VA or not, we will work on your behalf, the veteran's behalf, with the lending institution to try to keep you in that home.

● (1535)

For example, last year we helped 97,000 veterans stay in their homes, without going to foreclosure, to keep them from becoming homeless. This is a huge benefit, because once you lose your home, typically where do you go next? It's a great program within our home loan benefit.

Another part of that is what we call our specially adapted housing benefit. That is for severely disabled veterans who need a benefit to adapt their home to make it wheelchair accessible or whatever that may be. We did almost 2,000 applications last year in the specially adapted housing program.

We have over six million who are covered under our insurance. Our insurance has a huge coverage, with about $1.2 trillion in coverage for those who have opted for our insurance program.

Our benefits assistance service, our last program, is really our outreach. It's the three phases: I can do face-to-face communicating of benefits; I can do it online—and for many of the systems, we're moving toward self-service capabilities—and I can do it over the phone.

Last year we did a huge initiative. We answered about 20 million phone calls last year, but one of the big problems we had was the blocked call rate. We had a 59% blocked call rate. Veterans couldn't get in. To get an answer to the call, there was a hold of five or 10 minutes or even longer. We reduced that to 25 seconds and a 0% blocked call rate. Really, a lot of that is attributed to driving more services online. That's what we're seeing with today's veterans. They want to do things online. They want it fast and quick. We still need to do some work, though, to get into the mobile app arena, which is what we're looking at as well, but that initiative was huge for us.

There are a couple of other big initiatives.

You might have heard the President and our secretary announce today our electronic health records initiative. We do most everything with DOD in partnership. Today's announcement was a historic one, in that we had worked together to do interoperability with information and data exchange. DOD did a long assessment over a couple of years to determine what application and architecture platform they wanted. They made that decision while VA was still wondering where it was going to go. Today, the secretary and the President announced that we will be going with the same platform and the same software as DOD. That is a huge win-win for service members and veterans, because we will use the same software and the same electronic health record from the moment the service member comes in, all the way through their life cycle, until they use their last benefit, which is memorial affairs.

We have worked on making some huge strides in VBA and VA as a whole. On the benefit side, I know that the last time I testified to you, it was around our backlog. We were really taking a lot on that.... We had a peak inventory of 611,000 claims. That number is down, with the backlog being just under 100,000, at about 95,000 or so. We've made great strides there.

Also, we've automated the process to go completely paperless. We have another initiative now for all of our paper record folders that were in our regional offices. In VBA, we have 56 regional offices, including two in Manila and Puerto Rico. They had paper folders there. We have an initiative now whereby we're taking out the paper folders and sending them to our scan vendor, who is digitizing them and putting them into our application, or what we call the veterans benefits management system, which is what we use to process disability claims.

● (1540)

We've also created a centralized intake claims processing piece, to the point where we no longer accept mail. We learned this from you on our trips up there in terms of how you had centralized your processes. Now, all the mail we receive goes to our intake site, where it is digitized and scanned, and then it becomes electronic for our use. We're looking at doing more OCR technology to pull the data, because you can do a lot more with data than you can with paper.

I've talked about another couple of concepts before, including e-benefits, the joint VA-DOD portal, where we're capturing service members as soon as they enlist and staying engaged with them throughout their life cycle, helping them until they get ready to separate. Also, we had legislation passed in 2011 that now makes it mandatory for all separating service members to attend a separation briefing. We call it the transition assistance program, but it's not just with VA and DOD; it includes the Department of Labor, the Social Security Administration, the Office of Personnel Management, and the Department of Education. It includes our other cabinet organizations, which are all working together to help that service member transition into the civilian sector. We're seeing a lot of benefits from that program.

We still have some work to do. The secretary is really concerned about our suicide prevention efforts. There are too many suicides.

The Chair: If we could get you to wind up on that, we have some people who want to ask you some questions.

● (1545)

Mr. Robert Reynolds: Question away.

The Chair: Thank you for your excellent testimony. I'm sorry to rush you.

Ms. Wagantall.

Mrs. Cathay Wagantall (Yorkton—Melville, CPC): Thank you so much for being with us today.

I was very encouraged to hear about the work being done on your e-health records. We have a real issue here in Canada with the transition from DND to VAC and privacy issues and having that information available so that it is more effectively used.

You were just saying about your new platform that it's new software. Does that mean it's new to VA or new to both departments, and does it mean a transition of information? Are you just starting now with new recruits or do you have a lot of data entry to do in regard to historical information?

Mr. Robert Reynolds: For us, it's commercial, off-the-shelf software. I don't know much on that, but I know that it's new for DOD. It's also new for us.

One of the requirements will have to be that we need all the data transferred over. We need to have that historical medical information if they're going to file any type of disability claim with the Department of Veterans Affairs, because we'll need to know that the event happened while they were in service in order to be able to rate them for disability compensation.

Mrs. Cathay Wagantall: What do you think the timeline is before this becomes operable and effective for you as a tool?

Mr. Robert Reynolds: Hopefully before I retire.

Voices: Oh, oh!

Mr. Robert Reynolds. I would say that it's going to be a few years. We're doing interoperability now, but to do it on the same software platform will be huge. I think we'll be able to collectively realize efficiencies, which at the end of the day will be beneficial to the taxpayers, because we pay for duplication right now.

Mrs. Cathay Wagantall: Okay.

We were down in Washington a few weeks ago. There were comments about the choice program. They were looking forward to giving veterans more say in who they chose as a provider and that type of thing. Can you give me more information on that?

Mr. Robert Reynolds: Sure.

I'm a user of VA health care and DOD health care. I have a choice now to go between VHA or what we call Tricare at the Department of Defense. What we don't have as much is that if I have a specialty or a private physician who I want to use, especially if I'm in a rural part of the country, how do I have that choice to use them and be covered without getting a referral from VHA to say, “Yup, Rob can go see this doctor at this location”?

It's really to help get the treatment and access that much quicker to the veteran, wherever they reside. It's about opening the aperture to the even larger network provider group out there, which includes private. That's what the choice program really is.

Mrs. Cathay Wagantall: Thank you. I appreciate that.

In Canada a lot of veterans organizations have sprung up where veterans are helping veterans. Often, of course, they know the real needs and quite honestly sometimes the best ways to approach as third party providers. Do you have that same kind of dynamic in your program?

Mr. Robert Reynolds: Absolutely. You've probably heard of some of our organizations. It was my privilege and fortune to have been a past national commander for one of our largest ones, Disabled American Veterans, so I know the veterans service organizations quite well. I try to work and leverage that to our benefit.

Like you, we've seen many pop up—for us, after 9/11—and we're trying to see which ones are or are not providing the right service to take advantage of. We include them as trusted stakeholders to help us move this together. One initiative I just kicked off on May 1 in Minneapolis–St. Paul relies on our veterans service organizations to help do the claims process up front for us and submit a fully developed claim that's ready to rate. We guarantee them a decision within under 30 days. Right now our time limit, even though it's a pilot, is at 4.5 days.

● (1550)

Mrs. Cathay Wagantall: Thank you.

Our National Defence surgeon general just came out with a report with regard to an anti-malarial drug called mefloquine, which the United States issued a black box warning as a last-resort drug in 2013 and we ourselves just did very recently.

Can you give me a follow-up on that? What's happening with mefloquine in the United States in terms of soldiers coming forward, veterans coming forward, and any of the potential treatment? We're hearing more doctors suggest that we need to do more to study and come up with sound practices for the treatment of those veterans.

The Chair: Mr. Reynolds, I have to apologize, but please make your answer short. We're right at the end of the time limit.

Mr. Robert Reynolds: I can't give much on the medical side. I can only talk about the presumption side that we've gotten from Agent Orange and the Camp Lejeune water contamination. I really can't talk specifically to that one.

The Chair: Thank you.

Mr. Bratina.

Mr. Bob Bratina (Hamilton East—Stoney Creek, Lib.): Thank you so much for this opportunity today. Perhaps I can start by asking you about some of the differences we saw in our visit to Washington, when we came across certain facilities aimed strictly at combat veterans as opposed to all of the other people who serve in various capacities. What about the distinction there in the services available?

Mr. Robert Reynolds: You're referring to our vet centres, I believe.

Mr. Bob Bratina: Yes.

Mr. Robert Reynolds: Our vet centres were stood up after Vietnam. When our Vietnam veterans came home, they weren't really treated correctly, and didn't trust the government. Their own stood up the vet centres. They have the state criteria of eligibility, which is combat veterans, as you say. They do not share that information with VHA. It's all confidential. It's a trusted location.

Mostly the vet centres have been set up for PTSD. There are over 300 of them in the country, and they're exactly as you saw, completely separate from our health care facilities.

Mr. Bob Bratina: Thank you.

The question of PTSD and suicide is a problem in both of our countries with our veterans. There's an interesting difference, though, in that we're encountering a higher incidence among younger veterans—Afghanistan and so on. To my understanding, in the United States it's the Vietnam cohort that is suffering more. Is that accurate?

Mr. Robert Reynolds: Yes, I would say that's accurate. It's a struggle. You know, one is too many, and I think we're at 20 a day now. We were at 22. Our secretary is getting us to what's called "getting to zero". How do we get to zero? I think it goes to how we get our community involved to help us get to zero. We the government can't do it all, at that point.

Mr. Bob Bratina: It is a terrible problem. My uncle, now deceased, was a Second World War veteran—American aircraft carrier—and I'm wondering about the benefits that accrue to families and wives and so on. Tell me about the programs you have that assist health care givers, the people who are looking after a young veteran, perhaps, and the widows and so on. Can you give me a general overview of the American approach?

Mr. Robert Reynolds: You might have seen in the news, because there have been some heated questions on this, that we have a caregiver benefit. It's actually derived out of our health care side, but that is only for veterans who are from the Post-9/11 GI Bill generation. One of my good friends right now is a quadruple amputee. He has no limbs whatsoever. He was before the Post-9/11 GI Bill. His wife, who has provided caregiver services ever since he lost all his limbs, is not eligible for that benefit. There's a lot of discussion on Capitol Hill on how we make this inclusive for all eras, not just post-9/11.

On the disability comp side, if you are a veteran rated at 100% "permanent and total", and you have that rating for 10 years or more before you pass away, your spouse will get DIC, dependency and indemnity compensation. If you pass away as a direct result of your service-connected disability in under 10 years, he or she will get that as well.

● (1555)

The Chair: I'm sorry to interrupt.

Just procedure-wise, the bells are ringing, and Mr. Bratina has two minutes left. I would need everyone's agreement for him to finish.

Is that okay with everybody? Okay.

You have two minutes, Mr. Bratina.

Mr. Bob Bratina: Okay.

Can you give me that again about the DIC?

Mr. Robert Reynolds: The last part is that if you're 100% permanent and total, we give an extra—an SMC, special monthly compensation. If you're severely disabled, you get extra for housebound care, for aid and attendants and that type of benefit. But you have to be rated as such.

Mr. Bob Bratina: There was another thing that impressed me and I'm sure some of the others. That was the military cultural competency certification for young people, perhaps coming out of a social program in university, who need to know how to talk to veterans. Is that a prominent feature of your work?

Mr. Robert Reynolds: Yes. That's actually part of the transition assistance program, or TAP, where we also do the same with the service members. We try to educate them on how to interact with the civilian sector, too. It's across the board. We're working with employers to help them on why they need to hire vets but also with that service member who's going to become a veteran on how they need to interact with the employers and the community when they get out. It includes resumé writing, job searches, and all of that.

Mr. Bob Bratina: We had the honour of visiting the Walter Reed army hospital. You say there are 1,700 facilities. Are there ones similar in scale to that one in other parts of the country?

Mr. Robert Reynolds: Yes. Walter Reed is an army hospital, or a joint one. It's a DOD hospital. If you went down the road for an hour and a half to Richmond, you'd see the McGuire VA Medical Center, one of our polytrauma hospitals. You saw the Pentagon. McGuire VA Medical Center is the second largest federal building in Virginia, meaning second to the Pentagon, just to give you an idea of its size and scale.

Mr. Bob Bratina: Wow.

Thank you very much.

The Chair: Thank you.

It's unfortunate, Mr. Reynolds, that we have a vote in the House and we have to rush back. I'm sure you're familiar with that, with your background.

Mr. Robert Reynolds: Yes, absolutely.

Mr. Colin Fraser (West Nova, Lib.): Mr. Chair, just in fairness, we could probably agree to a couple of minutes for Ms. Mathyssen to get in at least one question, so each party would have—

The Chair: It has to be everybody.

Do you agree to go for six minutes for Ms. Mathyssen? Can we keep going? Under the rules it has to be—

Mr. Colin Fraser: I don't know about six minutes, but at least she could have a question, so each party could have one.

The Chair: I have to ask the whole committee, under the procedural rules.

Will everybody stay for another six minutes? I need to see your hands.

Mr. John Brassard (Barrie—Innisfil, CPC): At what time is the vote, Mr. Chair?

The Chair: The vote bells are ringing now. I'd say it's in about 25 minutes. I was going to ask if he could come back after for questioning, also.

Mr. Colin Fraser: All right. I didn't know that.

The Chair: Can we stay for six minutes? I need to see the hands. Hands up, everybody. I need to see them.

Some hon. members: Agreed.

The Chair: Okay, we're going to continue on.

Ms. Mathyssen, you have six minutes.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you, Mr. Chair.

Thank you very much, Mr. Reynolds. You began to say something in regard to expanding suicide prevention efforts. I wonder if you could finish that thought or explain that to us.

Mr. Robert Reynolds: Yes. We're trying to figure out how we can get to zero suicides, just as we took on homelessness. Really, I say it takes a community. We're looking at data as well. What are those triggering things—substance abuse or whatever—that have the potential for the individual to be subject to suicidal ideation? How do we become preventive and proactive in that instead of reactive? The medical scientists are looking at the data aspect, and we're looking at the community aspect. When you go into the military, you become a band of brothers, but then when you separate, that band of brothers is no more. You get into a community where, often, people can't relate or understand. For today's service members, everything's quick; everything's on their phones. They're not as connected to the groups and organizations, so how do we bring that all together to, hopefully, get to zero with suicide prevention?

● (1600)

Ms. Irene Mathyssen: Thank you very much.

It's my understanding that a disability compensation package is available to veterans with certain severe physical disabilities but not available to veterans with psychological injuries. I wonder if you could explain that to me. Why is that the case, if it is the case?

Mr. Robert Reynolds: That's not true at all. Probably the majority of our claims are for post-traumatic stress. Out of the 4.6 million service-connected disabilities, PTSD was probably within the top 10.

Ms. Irene Mathyssen: Thank you.

Can a veteran's family member who is suffering from post-traumatic stress obtain individual counselling at the veterans centres?

Mr. Robert Reynolds: If it's a combat veteran, family members are also entitled to assistance at veterans centres along with active duty service personnel, and that really came about only a few years ago. Again, the active service member didn't want to bring that up within DOD, because if they were not fit, there would be other issues. They could come to the veterans centre and they would be cornered off and not share any information, but they could get the treatment they need. That's part of another thing, again, to get to zero for suicide.

Ms. Irene Mathyssen: You're talking about getting to zero for suicide. Have you seen a significant improvement in terms of family interaction when family members can access that?

Mr. Robert Reynolds: Yes. We're seeing that anytime you can incorporate the spouse, especially with the TAP, the transition assistance program I talked about, the service member—I didn't have TAP when I got out—is not thinking about it, but I can assure you their spouse is. She or he is going to make sure you do what you need to do to take care of it.

Ms. Irene Mathyssen: I also wonder about the process for appealing the department's decisions on monetary benefits and health care if benefits are denied. What's the process like in terms of appeals? Is it difficult for veterans? Do they have to go through a prolonged process or is there an ability for the department to help them along, to facilitate that?

Mr. Robert Reynolds: On the appeals process for disability compensation, which you've probably heard about on the news as well, we are hopeful. There is legislation on the Hill. It has passed the House. We're hoping it passes the Senate.

This is so old that it's never been tackled before to really make it easier. You can put in an appeal and just appeal and appeal.... If the legislation goes through, they'll have options for what they can do, which again will empower them a little more to say, “Okay, I want to do this process because I can get a decision quicker than if I just stay in the historical appeals process.” It's a two-way street. A lot of times they'll submit additional evidence down the road, so that could be a new claim or whatever.

We're hoping the legislation passes. Based on the discussions we've had, we are optimistic. We think it will. Then I think you'll see a whole new appeals process within the Department of Veterans Affairs.

● (1605)

The Chair: You have 30 seconds.

Ms. Irene Mathyssen: You talked about supports for people who are in danger of losing their homes. Would there be counselling in addition to monetary support? How do you go about that? When you get into that kind of trouble, it can get pretty dicey.

The Chair: I'm sorry, but you'll have to answer in 30 seconds.

Mr. Robert Reynolds: Again, for us, it's leveraging the data. We know now if you're going to be late on a payment or if you've become delinquent on a payment, and we can reach out to you, if need be.... Let's say you've been in that home for 20 years. You have equity there. Do we engage with the lender and reformat your loan and your payment to get you back to where you can afford your house payments and you're no longer delinquent on your home loan? In some instances, VA even can acquire that property and work out the loan with the veteran to keep them in their home.

Ms. Irene Mathyssen: Thank you so much.

The Chair: I'm going to suspend the meeting. We'll come back after the bells.

Mr. Reynolds, the clerk will stick around and we'll come back for more questions. We do have another witness coming up.

The meeting is suspended.

● (1605)

(Pause)

● (1645)

The Chair: I would like to resume the meeting.

I just want to tell the committee that Mr. Reynolds might come back for some questions. He's going to try to arrange it in his day.

We're going to move to our second hour right now.

We have by video conference from Washington, from the Office of Inspector General, United States Department of Veterans Affairs, Michael Missal, Inspector General. I will just note here that his role is similar to that of the Canadian veterans ombudsman as well as the Auditor General with regard to finance and public accounting.

Mr. Missal, thank you for appearing today. The floor is yours for 10 minutes. Then we'll get into questioning.

● (1650)

Mr. Michael Missal (Inspector General, Office of Inspector General of the United States Department of Veterans Affairs): Thank you, Mr. Chairman, vice-chairs, and members of the committee. I appreciate the opportunity to discuss with you the Office of Inspector General. It really is a tremendous honour to have this opportunity to speak with you today.

First, let me provide a very brief introduction to the history of inspectors general. The Inspector General Act of 1978 established federal IGs at 12 agencies including VA. Today there are 73 federal IGs across the government, about one-third of whom are appointed by the President.

The stated purpose of the IG Act was to create independent objective units at an agency, the primary duty of which was to combat waste, fraud, and abuse in the programs and operations of that agency. It authorized IGs to conduct audits and investigations and to make recommendations for the purpose of promoting economy, efficiency, and effectiveness. IGs have law enforcement powers including the power to make arrests. IGs are also entitled to all records of an agency and can interview employees under oath and subpoena records from outside of the agency.

The IG Act also set up a dual reporting structure by requiring each IG to keep the agency head in Congress fully and currently informed about problems and deficiencies at the agency. IGs are required to provide both the head of the agency and Congress a semi-annual report that includes information on the IG's activities for the previous six months. Thus, IGs make reports to the agency heads and to Congress but do not report to them.

To promote independence of IGs, our budgets are separate from the agency's.

Although IGs do not report to anyone, there are some checks on them, including the ability of the President to remove an IG after notice to Congress, and the requirement that IGs adhere to professional standards.

With respect to me, prior to being the IG, I was in the private practice of law in Washington, D.C., for 29 years. I also served as the chairman of the independent review committee of Vanguard Canada based in Toronto. I was nominated by President Obama to be the IG of Veterans Affairs on October 2, 2015, and confirmed by the United States Senate on April 19, 2016. I've had the honour and privilege of serving as the VA IG since May 2, 2016.

To put in context some of the challenges of my position, let me provide you with some facts about VA. It is the second largest federal agency with over 370,000 employees and a fiscal year 2017 budget of about $180 billion. If VA were a public company, its budget would make it the sixth largest U.S. company, ahead of General Electric, AT&T, and General Motors.

There are over 21 million veterans in the United States, about 10% of whom are women, and VA provides well-earned services and benefits to many of them. VA operates 144 hospitals and 1,200 outpatient clinics that treat almost seven million veterans annually. To take it one step further, in the last fiscal year VA completed more than 58 million medical appointments and over 25 million community care appointments. VA also has 56 regional offices that are responsible for the distribution of benefits for veterans who have earned them. Around 4.5 million veterans receive disability compensation. About 300,000 veterans and over 200,000 survivors receive pension benefits.

VA also operates and maintains the largest national cemetery system in the United States with 135 national cemeteries. In fiscal year 2017, VA is projected to inter over 130,000 veterans and family members. VA operates the 10th largest life insurance program in the U.S. with over $1.2 trillion in face amount of insurance policies. VA also provides education assistance to over one million students. VA has a home mortgage program with over $2.5 million active loans guaranteed by VA. VA provides vocational rehabilitation and employment benefits to over 140,000 veterans. These numbers are staggering and highlight the size and complexity of VA.

● (1655)

On my first day on the job, I emphasized to my staff that we would always strictly adhere to the following three principles: First, we must ensure that we maintain our independence. Put another way, we make reports to the secretary and Congress, but we do not report to anyone. Second, we must be fully transparent by promptly releasing reports of our work that are not otherwise prohibited from disclosure. Third, we must maintain the highest integrity of our work. This means that each of our reports must meet at least these five standards. They must be accurate, timely, fair, objective, and thorough.

Let me tell you a bit about the structure of our office. We are currently at about 700 staff, with about 200 in Washington, D.C., and 500 in 40 offices around the country. Our fiscal year 2017 appropriation is about $159 million. This is an increase from fiscal year 2016. Even though we're about 700 staff, we're a relatively small office to conduct oversight of an organization that has a budget of $180 billion and includes so many important and complex services. Compared to other inspectors general offices, we are small with respect to both our budget as a percentage of the agency budget and the number of employees compared to number of employees of the agency overall.

We are divided into three directorates. The first and largest is audits and evaluations. They conduct performance and financial audits and other evaluations of VA programs and operations. The next largest of our directorates is investigations, with about 215 staff. Investigations conducts criminal investigations related to VA's programs and operations, as well as administrative investigations of allegations against senior VA officials. Next is our health care inspections, with about 125 staff. Health care inspections conducts inspections of the medical centres and community-based outpatient clinics, performs national reviews of health care issues, and also reviews individual cases.

We speak through our reports and produce about 300 work products a year. This includes the results of our investigations, audits, inspections, and reviews. Our goal is to make our reports of the highest quality.

The OIG provides a healthy return on investment. Over the past five years, we have averaged 475 arrests, 330 convictions, and $3.125 billion in monetary benefits, for a return on investment of $30 for every dollar expended on OIG oversight. This is a strong return and supplements the inestimable value we bring by helping VA improve its health care and benefits services that impact so many lives.

Let me answer some common questions that we have been asked.

How do we see our role? We see our role as helping VA become a more effective organization and ensuring that taxpayer money is spent as appropriated. We do not see it as an adversarial relationship with the department. Although we are independent and must always avoid even the appearance of an impairment to our independence, we meet with VA staff to better understand the programs and operations of the department. It also allows VA staff to get to know us better and learn more about our mission.

How do we get information? We do so in a number of different ways. We have a hotline that gets over 40,000 contacts a year, primarily through phone calls and emails. About 40% of these contacts are from veterans. We review each and every hotline contact we get. We also get numerous requests from members of our Congress. Unfortunately, we are not able to handle each and every matter, and we refer some of these matters to the department for action and follow-up as appropriate. As well, we get tips and other information from VA staff. A number of these are substantiated, so we take these and other tips we receive seriously. We also data mine, to be as proactive as possible. We have a data analytics group based in Austin, Texas, which has access to VA's databases. This allows us to sort and analyze data in numerous ways.

What do we include in our reports? We try to answer at least the following questions in our reports. Why is this report important? If the matter isn't important, then it's not something we should be doing. What happened here? Again, we try to present it in a fair and balanced manner. Why did it happen? This is really important to put the facts in context and to determine whether there are lessons to be learned. Finally, who, if anyone, is responsible for any wrongdoing? This promotes individual accountability.

● (1700)

How do we decide what matters to take? We can take only a small fraction of the potential matters brought to our attention. When deciding whether to take on a matter, we look at a variety of factors, including whether it impacts a large number of veterans, whether there is imminent harm, the impact on taxpayers, whether the conduct is widespread, the public interest, whether we have done something in that area before, whether the issue can be handled by VA or another federal agency, and whether Congress has legislated that we should conduct a certain activity. These are not the only factors but rather some of the more important ones that we consider.

What are our current priorities? We are focused on a number of areas. Among the most significant are the following:

Timely access to quality health care. We have recently issued a number of reports on wait times at VA hospitals, as well as allegations regarding how the quality of care may not have been acceptable, and we have many more reports pending.

Mental health services. VA is a leading provider of mental health services. Suicides of veterans remain tragic and significant in the United States, with recent estimates of 20 veteran suicides a day. We have issued a number of significant reports in this area, and have more pending.

Pain management. There is an opioid crisis in the United States, and we have reported on the use of opioids and other narcotics. Our reporting in this area will continue.

The veterans choice program and other care in the community programs. After the wait time scandal in 2014, Congress appropriated $10 billion for VA to enhance its care in the community. It allows veterans who cannot get an appointment for preauthorized care within 30 days or who live more than 40 miles from a VA facility to get care in the community from a provider who is on an approved VA network. We have issued a few reports on the challenges faced by VA in establishing this program and have more reports to come. The funding for veterans choice was just extended, and Congress will be considering the future of care in the community programs.

Construction. VA has an outdated infrastructure and is in need of remodelled and new facilities. One facility being constructed is for the replacement of the Denver medical centre in Colorado. Congress appropriated $800 million and it was hoped that the facility would have been finished several years ago; however, construction is ongoing. We issued a report last year which showed that the current cost estimates to finish construction are around $1.675 billion, or almost $1 billion above budget. There are a number of other major construction projects set for VA, and we will be watching them closely.

Procurement is another focus area. VA buys billions of dollars' worth of different products, including drugs and prosthetics. We have a number of active investigations related to allegations of fraud and waste of these products and many others.

Information technology. VA has many antiquated IT systems, including its system to prepare its financial statements and schedule appointments. We have issued a number of reports of VA's IT challenges and have a number of other ongoing IT projects.

Benefits fraud. There are numerous instances of benefits fraud committed by veterans, families, and others. We have aggressively investigated and helped criminally prosecute a number of benefit frauds.

I thank you again for inviting me here today, and I hope you have a better understanding of our work. In the time remaining, I'm happy to answer any questions that you may have.

The Chair: Thank you.

We'll begin with Mr. Brassard for six minutes.

Mr. John Brassard: Thank you, sir, for being here today.

We have an Auditor General who oversees all aspects of the federal government in terms of spending, and we have a veterans ombudsman, who looks after veterans issues. We also have a Department of National Defence ombudsman who deals with DND issues. One of the challenges we have is with the reports that are written. You talked about the many reports, sir, that you've done over the years. There's almost an industry that has been created of not doing anything with these reports, some of which have very solid recommendations dealing with, for example, mental health or issues of veterans or forces members transitioning into civilian life.

Do you share that frustration? Do you see that in the United States, that reports are done but nothing gets done?

● (1705)

Mr. Michael Missal: Yes. We've seen examples where some of the same issues seem to come up over and over, so what are we doing about that?

Most of our reports include recommendations. The way our process works is that when we have a draft report with recommendations, we provide it to the department for two reasons. First, we want to make sure that we got it right; that's paramount to what we do. We want to make sure that we got it right. If the department thinks we got it wrong, we'll certainly listen to what they say. It's our report, though, so we stand by it. Second, for recommendations, we want to know if they agree or disagree. Again, they're our recommendations, and even if they disagree with them, we might say that we still want them to do it—

Mr. John Brassard: I'm sorry, but maybe I could ask you this, then. In the process of drafting these reports, what you're saying is that there's a lot of departmental involvement in the drafting to get some feedback, or am I not understanding that correctly?

Mr. Michael Missal: There's no involvement in the initial drafting of the report. We will have a full report, with recommendations, and that is our work, our thinking. Before we publicly issue it, we give the department a copy of the draft of that report and say to them to let us know if they have any comments on it. That's on the text.

Also, on the recommendations, if they concur in the recommendations, we ask them to give us an action plan on how they're going to implement those recommendations, including a timetable, so that we have what we expect them to do and a timetable. We then have something that we can judge them on. We expect all recommendations to be fully implemented within a year. If they are not, we include that in our semi-annual report to Congress and the head of the agency to alert them to the fact that they're open recommendations.

Mr. John Brassard: What type of accountability system is in place if they don't implement any of the recommendations of those reports after that year? Is it simply another report that goes to Congress and it's then up to congressional members to force the issue at that point? Walk me through the process at that point.

Mr. Michael Missal: Sure. There are really two ways in which you have accountability. The first is within the department. The secretary of VA wants to close out all the open recommendations. Remember, these are recommendations that the department is committed to implementing. It reflects on the secretary if they're not implemented. Second, Congress has been very active in looking at the open recommendations. Again, they control the purse, so they have significant leverage over the department to ensure that recommendations are implemented.

Mr. John Brassard: Okay.

On the issue of individual veterans, what are some of the issues that you're hearing about and some of the concerns that individual veterans are having with the veterans administration? The reason I'm asking is that I'm trying to get a sense of whether there are similarities here in Canada. I suspect that there are very similar situations. What are some of the top things that you're hearing about from your veterans?

Mr. Michael Missal: In terms of some of the top things, there's a whole score of issues that we hear about from veterans.

Access to quality health care is a very significant issue. There are about seven million or so veterans who get treatment or a service of some kind at a VA medical facility. They want to make sure that they get in on a timely basis and that they're given the highest quality of care.

We also hear about benefits. Again, you have to apply for benefits. There's a grading that goes on for veterans as to what kinds of benefits they qualify for. We hear from a number of veterans who feel that they're not properly tested or assessed as to the kind of benefit. In addition, if veterans want to appeal the VA's decision on benefits if they disagree with it, it could take up to five years for that appeal to be done, so they're very frustrated by how long the appeal process takes.

There's just a host of things relating to health care and benefits that we hear about.

● (1710)

Mr. John Brassard: Right. Now, on the issue of—

The Chair: Mr. Brassard, you have 10 seconds.

Mr. John Brassard: I have five seconds now.

Thank you, sir, for being here.

The Chair: Mr. Fraser, you're up for six minutes.

Mr. Colin Fraser: Thank you very much, Mr. Chairman.

Mr. Missal, thank you so much for joining us today and sharing your thoughts. It's very much appreciated.

I want to start with one thing that I think is probably common to the veterans departments in Canada and the U.S. That's the complex system of benefits and services provided by each department. I'm wondering if you could comment on what is being done currently in the United States to try to simplify or streamline the process of accessing benefits or services that the members have earned. Could you talk a bit about the complexity issue and how you are focusing on making it simpler?

Mr. Michael Missal: Sure.

VA, as I said, has 56 regional offices that are responsible for administering the benefits that veterans have earned. There were complaints that some of the offices weren't moving as quickly...some were busier than others. What VA has done is to move to a national workload queue, meaning that they're not relying just on the geography of where the veteran is, but rather considering the type of claim it is and which of the veterans regional offices has the capacity to take on that work. The hope there is to streamline that.

In addition, in terms of the complexity, I believe VA is going to try to simplify some of the rules. One of the issues we have found is that the people who work at VBA, the veterans benefits administration, don't fully understand some of the complex rules. I know the secretary has spoken about that, and it certainly comes up as it relates to the wait times to get into a medical centre. There are all these different rules. The secretary has said he'd like to try to simplify the rules, both for access and benefits, so that it's easier to work through the administrative function there.

Mr. Colin Fraser: Do you see a role in working with the Department of Defense on streamlining the process of transitioning veterans towards civilian life, in helping them to understand what benefits and services are available before they are actually released from the military?

Mr. Michael Missal: Yes, I believe there are programs in which that is done. That's VA's responsibility. We have not looked at that area for some time.

Just today, the secretary announced that, with the blessing of Congress, they're going to move to an electronic health care system which is compatible with the Department of Defense, so that a service member's medical records can be transferred to VA when that service member becomes a veteran.

Mr. Colin Fraser: You talked a little about some of the work you do in investigating benefits fraud. In Canada, we have a benefit-of-the-doubt system. The veteran is supposed to be given the benefit of the doubt when approaching Veterans Affairs for services and benefits.

I'm wondering how you balance investigating benefits fraud with ensuring that legitimate claims are processed in a timely manner, especially given that there's an up to five-year waiting period, I understand, for an appeal. It would be nice, I'm sure, to get it right the first time, if possible, in both of our countries.

Can you comment on that, finding those cases where there may be fraud—I assume that's in a limited number of cases—and balancing that with ensuring that we get it right the first time with legitimate claims?

Mr. Michael Missal: We do that balancing all the time.

Unfortunately, we have found a number of instances where veterans, family members, and others have engaged in criminal activity to take advantage of benefits they're not entitled to.

We do spend time investigating that. A number of the cases we have in this area are referred to us by other veterans who do not like to see the system cheated. We work with veterans who provide us with information to ensure that the system is operating as effectively as possible.

We also spend time, in our audits, trying to help VA identify areas where they can make benefits determinations and other decisions more effectively. We have a benefits inspection group, and their job is to go around to the various regional offices that determine benefits, do audits of their processes, and make recommendations as to how they can be more effective.

● (1715)

Mr. Colin Fraser: Excellent.

Thank you very much, sir, for your time today.

Those are my questions.

Mr. Michael Missal: Thank you, Mr. Fraser.

The Chair: Ms. Mathyssen.

Ms. Irene Mathyssen: Thank you, Mr. Chair.

Thank you, Mr. Missal. We appreciate very much your appearing before the committee. I was quite intrigued that you had worked in Toronto for a while and, if there's time, perhaps we could talk about that.

I have a couple of questions.

First, Mr. Reynolds talked about the fact that you have the ability to collect a great deal of data and apply that data. You talked about the fact that there are many female veterans. We're discussing the issue of military sexual trauma, and I have some concerns in regard to how women are identified, men as well, in terms of that kind of trauma, and the tracking and supports. I'm thinking of the clinical help that is given to them.

What's your experience in terms of that? Do women and men readily report? Is there a special service in regard to the tracking and support systems?

Mr. Michael Missal: We do get reports of those issues. We are considering doing a national audit on sexual trauma. We've also done a number of reports relating to women veterans and the kind of treatment they get at the health care facilities at VA. We have done a national audit on that as well. We are very conscious of issues for all veterans, male and female. As I said, we are limited in the number of things we can do, but we consider this an important area that we are going to be exploring further.

Ms. Irene Mathyssen: I also wonder if the U.S. government has considered the option of replacing monthly disability benefits with a lump sum payment. We had a change to our Veterans Charter back in 2005-06, and when service personnel are injured, they can opt for a lump sum. There has been some concern about that. It has its challenges. For example, young individuals receiving a large lump sum don't think ahead to the time when they will be 50 or 60 years old and may need that money for special medical or counselling services, but the money will be gone and the supports will have disappeared.

Have you considered that option, and if so, are there advantages or disadvantages from your perspective?

Mr. Michael Missal: Those kinds of issues relating to the types of benefits that are available to veterans would be determined at first blush by the U.S. Congress, which would determine what the rules are. Then there are times when they delegate to the department the ability to administer other rules as well.

We would get involved once a decision is made to determine whether the program is being run efficiently and effectively, but we typically don't get involved in those kinds of substantive determinations.

Ms. Irene Mathyssen: Okay, thank you.

I was talking about the fact that the reality surrounding a veteran can change over the years. Is the amount of monthly benefit for disability compensation increased or reduced over the years? Do you keep track of the changes in the health of those individuals?

● (1720)

Mr. Michael Missal: That is something the veterans benefits administration would keep track of. They would have all the records of the benefits provided to veterans, as well as whatever tests are done to determine whether or not a veteran is eligible for any kind of benefits. They would have all those records.

Ms. Irene Mathyssen: I assume the testing is fairly rigorous and extensive, just to make sure, as you said, that things are fair and that people are getting the benefits they need without worrying about those who might take advantage of the system.

Mr. Michael Missal: They do have rigorous testing, and for a number of issues it might involve a medical examination as well, depending on the type of benefit being sought.

Ms. Irene Mathyssen: Thank you very much. Those are my questions.

Mr. Michael Missal: Thank you.

The Chair: Mrs. Lockhart, go ahead.

Mrs. Alaina Lockhart (Fundy Royal, Lib.): Thank you, Mr. Chair.

Thank you, Mr. Missal, for joining us today.

My colleague mentioned a bit about transition. We heard from Mr. Reynolds, as well, that the VA has started engaging at the time of enlistment, and those who are separating attend a session with DOD, VA, and other organizations. Is that a result of observations you've made? What have those been?

Mr. Michael Missal: We have not looked at that for some time. It's an area that we are always conscious of. If we receive a number of complaints, if we think it's an area that deserves further attention —obviously, with the secretary's announcement of the IT system that is interoperable with DOD—we would look at those kinds of issues, but sitting here today, I can't recall one we have done recently in that area.

Mrs. Alaina Lockhart: Very good.

Also, one of the things we talk about a lot is peer support. Have you looked at peer support, third party organizations, that sort of thing? Is it a coordinated effort throughout your systems?

Mr. Michael Missal: We work with the veterans service organizations. There are veterans service organizations in the medical facilities as well as in the regional offices. They are there to help veterans make it through the system and to be available for whatever assistance a veteran would want. We talk to them on a regular basis. I personally have met with the leadership of the major VSOs to ensure we're hearing from them about the issues they think are important. We consider them to be a very important source of information.

Mrs. Alaina Lockhart: What would you say are the major challenges, at this point, that you really are delving into in order to provide better service to veterans?

Mr. Michael Missal: There are several things. First, we need to put out our reports in a more timely way. If a report is not timely, it's just not going to have the impact. Second, we want to make sure we get down to the root cause of what really happened. It's very easy to say that this particular issue is a problem, but if we don't go into why it's a problem and how it can be fixed, then I don't believe we're providing the kind of service we should be providing. We're spending a lot of time telling the story of not only what happened, but also why it happened and what can be done to try to ensure it doesn't happen again.

Mrs. Alaina Lockhart: One of the challenges we are working through here in Canada is the use of cannabis as a treatment. Is that something that has come up with you? How is the U.S. dealing with that at this point?

Mr. Michael Missal: That would be a decision of the secretary.

Right now in the United States, under certain state law it's legal, but it's not legal under federal law. Until they change the federal law, the secretary said he didn't think that was an option on the table, but certainly he said that he had seen some studies that were interesting, so they might help.

Mrs. Alaina Lockhart: At this point it's not a treatment option that's offered through VA at all.

● (1725)

Mr. Michael Missal: No, I don't believe so.

Mrs. Alaina Lockhart: Very good.

I want to go back to families. That's an area we focus on quite a bit: what the role of family is, what we expect of them for support, and also how we support them. Could you speak to that a little, as well, in the context of your programs?

Mr. Michael Missal: Sure.

Again, VA would have a number of programs relating either to benefits or services available to families or to how families can be used to support the veterans. It certainly comes up a lot with the mental health aspect, as I said. Veteran suicide, the secretary said, is his number one clinical priority. Certainly the support veterans receive is critically important, particularly those with suicidal ideations Family members can play an important role in helping veterans through some very tough issues.

Mrs. Alaina Lockhart: How is the bank of research for veterans in the U.S. on the topic of suicide ideation?

Mr. Michael Missal: I think it's pretty strong. One project we worked on recently relates to the veterans crisis line, which is a suicide hotline for veterans. It gets over 500,000 contacts a year. We identified areas for improvement, but they have extremely dedicated people working at the VCL on the phones, trying to help veterans. In addition, VA has a number of areas where they're doing research on suicide and related issues.

Mrs. Alaina Lockhart: In terms of that hotline, have you made any moves to modernize it with apps, or anything like that, for online use, too?

Mr. Michael Missal: They do provide online services, as well. They have a texting service that they provide, as well as email. I think they're considering an app. I'm not sure if they have one yet, but I've heard they may be considering it.

Mrs. Alaina Lockhart: Thank you very much.

The Chair: Mr. Eyolfson.

Mr. Doug Eyolfson (Charleswood—St. James—Assiniboia—Headingley, Lib.): Thank you, Mr. Chair.

Thank you, sir, for coming.

You were talking about the kinds of things that you audit and you mentioned the opioid crisis, and you see how there might be problems with that. Among the things you audit, do you audit prescribing patterns among providers, say if you find that there are providers that are giving prescriptions of certain medications that might be causing problems?

Mr. Michael Missal: We could either audit that or we could investigate it. If there's a particular provider that we believe is prescribing things illegally, we have the authority under our criminal authority to open a criminal investigation and to prosecute if appropriate.

Mr. Doug Eyolfson: If the pattern is not illegal, is there a way of tracking if it's just, say, not as clinically indicated as it might be, just departing from practice guidelines?

Mr. Michael Missal: We could do a national health care review on, say, opioid prescriptions. We have the ability to be flexible in what we do and focus on what we consider is the most impactful thing.

Right now we have a number of different projects relating to opioid use. I'll give you an example of one thing we're looking at, which is about 32% of veterans receive care in the community, meaning from a provider outside of the VA medical network. If you're in the VA medical network, they have an opioid safety initiative that ensures that it's done as safely as possible. Once you get out in the community, they're not required to follow that same initiative. We're looking at whether or not there should be additional protection on opioid use prescribed when a veteran goes to see a provider in the community.

Mr. Doug Eyolfson: If providers are finding that there are systemic inefficiencies.... For instance, Ms. Lockhart talked about cannabis and, as you said, federal law right now is not permitting its use, but certain states do. If you had providers saying that they know through their research that their practice could improve by having access to cannabis or something else and they think their ability to provide care is compromised, where up the line could someone make these suggestions for policy changes? Would that be through your office? Through what office would people send suggestions up the line that they can provide better care?

● (1730)

Mr. Michael Missal: For something like that to change a policy of the VA, it would be to go through the VA. If we see something that we think could be something that would make the VA more effective for veterans, we might write a report on it after doing an audit or review, or just some kind of assessment, but the actual policy change would have to be through the VA.

Mr. Doug Eyolfson: Mr. Reynolds was talking about one of the things they have programs for, homeless vets. One of the things that we've noticed not just among vets, but in the homeless population in general, is it's believed a large proportion of the homeless have inadequately treated mental illness. Although Mr. Reynolds mentioned that when someone's about to become homeless they make sure they get the right loans, some people, again, become homeless simply because they're too disorganized, and their mental health has not been adequately addressed. Is there a way of tracking through your department if there are gaps in the system, if you find that some of your homeless vets might actually not be victims of a bad financial situation but more victims of inadequate mental care, and if that could be better addressed?

Mr. Michael Missal: Sure, that would be something the VA should have information on, on homelessness. Trying to reduce homelessness has been a priority for the VA. I believe they have significant information on their programs there.

Mr. Doug Eyolfson: I have no further questions. Thank you very much.

Mr. Michael Missal: Thank you.

The Chair: Ms. Wagantall.

Mrs. Cathay Wagantall: Thank you, Mr. Chair.

Thanks so much for being with us today. You mentioned the responsibilities of your mandate. One of them was investigations in regard to criminal behaviour, false claims, and benefits fraud, that type of thing. You shared very specific stats on the number of arrests, funds that were recouped, and that type of thing. On the flip side of that, is there a comparable level of investigation to determine when veterans are being denied benefits? Your system of eight different silos must make it very complex for veterans. With the long delay of up to five years to get a claim heard, I'm just wondering how they would go about it. Are there any stats on the number of veterans who you feel were unfairly denied, and the amount of funds involved in those kinds of circumstances?

Mr. Michael Missal: We would have different audits of benefits programs. What we typically do in an audit is take a sample, and we do a statistically valid sample, and then from there we will project out what the impact could be. For a particular issue for audits we do, we will be projecting out. Like an example you gave, if we decided to do an audit in the area, it would be of how many veterans were denied a certain kind of benefit improperly.

Mrs. Cathay Wagantall: Okay, thank you.

On a different note, in 2013 the U.S. issued a black box warning on the use of mefloquine as an anti-malaria drug. Very recently an individual case came up with a U.S. veteran who was awarded disability benefits by VA for conditions that looked like PTSD, but that VA attributed to the chronic effects of mefloquine.

Obviously, since 2013 there have been a number of veterans coming forward and trying to determine the impact it had on them, and a number of physicians have been encouraging VA clinics to screen veterans for prior mefloquine exposure.

I am wondering if there is anything being done on that front, as it's an issue with your allies as well around the world right now.

● (1735)

Mr. Michael Missal: I don't believe we have any open projects in this area at the time. We're certainly well aware of the issue. We look at issues on a regular basis to see if we should expend resources there, but as of this time, I don't believe we have any open projects.

Mrs. Cathay Wagantall: Okay, thank you.

In regard to pain management and the opioid crisis, we visited one hospital where they have an outpatient clinic dealing with soldiers who have gone through significant surgery and had to be on the painkillers. They're doing what I think is remarkable work in helping them to get off of them so they aren't dependent. I thought that was a very progressive approach.

Are there recommendations that you guys have put forward in regard to pain management that you could share with us to assist us in making sure that our veterans aren't ending up addicted to something that was initially there to meet a need?

Mr. Michael Missal: We are just finishing up a national review of pain management practices that includes recommendations. Typically our recommendations are going to be focused on what the VA policy or practice is in a particular area and whether they are following that policy or practice. If we think it's not an effective one, then we certainly will mention that, but it's really focusing on what VA is doing in a particular area, and if they are following what they're supposed to be following.

Mrs. Cathay Wagantall: I have one last question. You mentioned your procedures of coming forward with a report, and before it's published, the department has an opportunity to review it and make suggestions as to how they would meet those recommendations. I can see the value of that.

What happens if they say that they don't agree with that recommendation, period?

Mr. Michael Missal: We'll listen to why they don't agree with it. If we still think it's a valid recommendation that we think is appropriate under the circumstance, we will keep it in the report, and we will note that the department does not concur with that recommendation, but it's an open recommendation. We keep it open until they satisfy us that they've met the obligations.

Mrs. Cathay Wagantall: Thank you, Chair.

The Chair: Mr. Bratina.

Mr. Bob Bratina: Thank you. This is a really good session. I appreciate the opportunity.

Sir, one of the headlines associated with your work is, "'Highest levels of chaos' impair D.C. veterans hospital, inspector general finds". You know what I'm referring to.

Mr. Michael Missal: Yes.

Mr. Bob Bratina: In your world—and you've done this kind of work for a long time—what leads to highest levels of chaos? What's the breakdown that ends up where you have to go in?

Mr. Michael Missal: I think it really starts and stops at the top. The saying is that you're a reflection of your leadership.

What I think we're going to find when we finish our work in D.C. is that the tone at the top is still critical, and if you don't have the leadership at the very top of the organization that is committed to ensuring that the facility is operating as it should be, it makes it a very difficult situation.

Mr. Bob Bratina: Is your work proactive as well as reactive, or do you show up and everybody gets worried?

Mr. Michael Missal: Well, we hope they don't get worried. It's that we're here and we're going to do our work. It's a combination of both. For the medical centres, we have an inspection program. We now show up unannounced. We try to inspect every medical centre at least every three years or so. It could be reactive. A whistle-blower could make a complaint that we think has validity, and we'll look into it. We also use data analytics pretty aggressively to try to see what the highest risk areas are, and for areas that we think have high risks, we may initiate an audit, a review, some kind of inspection, without knowing whether or not there's any issue there.

Mr. Bob Bratina: Is it easy for you to determine a true whistle-blower versus a disgruntled individual who's just mad at everybody, and then an investigation begins? Do you go through that process?

Mr. Michael Missal: Yes. We treat with respect everybody who provides us information. We try to listen to what they have to say. Unfortunately, some of what is told to us is not always accurate, and at some point we have to identify that, and given our limited resources, we're not able to go further. We try to communicate that with the person providing us with the information, to ensure that person knows why we've decided not to go forward, so it's fair to that person as well.

● (1740)

Mr. Bob Bratina: How big is the Washington veterans facility? Is it huge or very big?

Mr. Michael Missal: It's one of the larger VA medical centres. I believe it services—my numbers may not be exactly correct—over 100,000 veterans a year.

Mr. Bob Bratina: Is size an issue, too, when cultures grow in institutions?

Mr. Michael Missal: Size can make the culture that much more difficult to change, because the larger an organization, the more difficult it is going to be to change a culture that's been there for a while.

Mr. Bob Bratina: Right. For the investigation process, and you said you're reactive as well as proactive, did you have a learning curve in coming into the veterans world as opposed to previously, or is an investigation pretty much the same thing but just a little different?

Mr. Michael Missal: It's pretty much the same thing to investigate. When I was in the private practice of law, I looked at lots of industries, including the health care industry, and you become an expert on whatever the various topic is. I did have to learn about VA in particular, but that learning curve I thought went very well. I'm learning every day. It's such a massive organization. I don't know if anybody really knows everything at that organization.

Mr. Bob Bratina: That's our situation. That's why it's great to have the witness testimony we're hearing.

The other thing is, whether it's with law firms or other companies that you looked at in the past, there is this heartfelt connection to the veterans themselves, which makes it perhaps more important and vital to get to the solutions.

Mr. Michael Missal: I couldn't agree with you more. Our staff, our folks, are very dedicated and committed to our work, because we realize that the better the job we do, the better the services veterans will receive, and they so richly deserve them.

Mr. Bob Bratina: Well, the public may have an assumption that we in Canada and you in the United States care for our veterans, but we have to make sure, as you do in your investigative process, that we're uncovering the real story to make sure that the services promised are being delivered in a humane and meaningful way. I really appreciate the inspector general's role in all of this. I imagine you have a lot of investigations going on at any one time. Is that fair to say?

Mr. Michael Missal: That's very fair to say, yes.

Mr. Bob Bratina: I won't ask you about any more of them, but—

Mr. Michael Missal: There are hundreds of investigations at any one time.

Mr. Bob Bratina: Right. Well, thank you so much.

Those are my questions, Mr. Chair.

Mr. Michael Missal: It was my pleasure.

The Chair: This ends the round of questioning.

I'd like to thank you, Mr. Missal, on behalf of the committee, for taking time out of your busy schedule today. Thank you for participating in trying to help us with the issues we have. It was a pleasure.

The committee was in Washington a couple of weeks ago. Again, thank you to all the people in your department who hosted us at that time.

We will suspend for about five minutes, and then we'll come back in camera and go into the report.

[*Proceedings continue in camera*]