Written Testimony of
Liz Hempowicz, Policy Counsel
Project On Government Oversight
before the Senate Committee on Veterans' Affairs
on
"Pending Health and Benefits Legislation"
May 17, 2017

Thank you Chairman Isakson and Ranking Member Tester for your continued leadership on whistleblower protections at the Department of Veterans Affairs and for introducing the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017. As the Policy Counsel, I am submitting this written testimony on behalf of the Project On Government Oversight (POGO). Founded in 1981, POGO is a nonpartisan independent watchdog that champions good government reforms. POGO's investigations into corruption, misconduct, and conflicts of interest achieve a more effective, accountable, open, and ethical federal government.

Fear and Retaliation at the Department of Veterans Affairs

None of us would be aware of the extent of the problems at the Department of Veterans Affairs if not for whistleblowers. Over three years ago, whistleblowers came forward to expose that managers at the Phoenix, Arizona, VA facility were falsifying records of extensive wait times in order to get bonuses.[1] Quickly, reports of similar wrongdoing at VA facilities began to pop up in other parts of the country. Although POGO had never investigated the operations of the VA before, we were deeply concerned about what we were seeing in these reports. In 2014, POGO held a joint press conference with Iraq and Afghanistan Veterans of America asking whistleblowers within the VA to share with us their inside perspective in order to help us better understand the issues the Department was facing.

In POGO's 35-year history, we have never received as many submissions from a single agency. In little over a month, nearly 800 current and former VA employees and veterans contacted us. We received credible submissions from 35 states and the District of Columbia.[2] A recurring and

[1] Scott Bronstein, Drew Griffin, and Nelli Black, "Phoenix VA officials put on leave after denial of secret wait list," CNN, May 1, 2014. http://www.cnn.com/2014/05/01/health/veterans-dying-health-care-delays/ (Downloaded July 27, 2015)
[2] Statement for the Record, Project On Government Oversight (POGO), for the House Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations Hearing on "Addressing Continued Whistleblower Retaliation Within VA," April 13, 2015. http://www.pogo.org/our-work/testimony/2015/pogo-provides-statement-for-house-hearing-on-va-whistleblowers.html

fundamental theme became clear: VA employees across the country feared they would face repercussions if they dared to raise a dissenting voice.

Based on what POGO learned from these whistleblowers, we wrote a letter to Acting VA Secretary Sloan Gibson in July 2014, highlighting three specific cases of current or former employees who agreed to share details about their personal experiences of retaliation after they had raised concerns about wrongdoing.[3]

In California, a VA inpatient pharmacy supervisor was placed on administrative leave and ordered not to speak out after raising concerns with his supervisors about "inordinate delays" in delivering medication to patients and "refusal to comply with VHA [Veterans Health Administration] regulations."[4] In one case, he said, a veteran's epidural drip of pain control medication ran dry, and in another case, a veteran developed a high fever after he was administered a chemotherapy drug after its expiration point.

In Pennsylvania, a VA doctor was removed from clinical work and forced to spend his days in an office with nothing to do, he told POGO. This action occurred after he reported to his supervisors that, in medical emergencies, physicians who were supposed to be on call were failing or refusing to report to the hospital. The Office of Special Counsel (OSC) shared his concerns, writing "[w]e have concluded that there is a substantial likelihood that the information that you provided to OSC discloses a substantial and specific danger to public health and safety."[5]

In Appalachia, a VA nurse was intimidated by management and forced out of her job after she raised concerns that patients with serious injuries were being neglected, she told POGO. In one case she was reprimanded for referring a patient to the VA's patient advocate after weeks of being unable to arrange transportation for a medical test to determine if he was in danger of sudden death. In an email exchange with a POGO investigator she said, "Such an upsetting thing for a nurse just to see this blatant neglect occur almost on a daily basis. It was not only overlooked but appeared to be embraced." She also pointed out that there is "a culture of bullying employees….It's just a culture of harassment that goes on if you report wrongdoing."

That culture clearly isn't limited to just one or two VA clinics. Some people, including former employees who are now beyond the reach of VA management, were willing to be interviewed by POGO and to be quoted by name, but others said they contacted us anonymously because they were still employed at the VA and were worried about retaliation. One put it this way: "Management is extremely good at keeping things quiet and employees are very afraid to come forward."

This kind of fear and suppression of whistleblowers who report wrongdoing often culminates in larger problems, as the VA experienced.

---

[3] Letter from Project On Government Oversight to Sloan D. Gibson, then-Acting Secretary of the Department of Veterans Affairs, about Fear and Retaliation in the VA, July 21, 2014. http://www.pogo.org/our-work/letters/2014/pogo-letter-to-va-secretary-about-va-employees-claims.html

[4] Letter from Kelly Robertson, Pharmacy Service Chief at Palo Alto VA Health Care System, to Earl Stuart Kallio, Pharmacy Service, about Direct Order—Restricted Communication, June 20, 2014.

[5] Letter from Karen Gorman, Deputy Chief, Disclosure Unit Office of Special Counsel, to Dr. Thomas Tomasco, about Dr. Tomasco's allegations OSC File No. DI-13-0416, March 21, 2013.

Previous Legislation to Address Problems

Previous laws failed to adequately protect whistleblowers at the VA. Shifting the VA's culture to identify and correct risks to veterans' health and well-being cannot be accomplished without legislation that codifies accountability for those who retaliate against whistleblowers.

Last year, Congress passed legislation aimed at improving whistleblower protections and increasing the ability to hold those who retaliate against whistleblowers accountable. The Military Construction and Veterans Affairs Appropriations bill attempted to remedy the anti-whistleblower culture of the VA and strengthen whistleblower protections, but it wasn't perfect legislation.

POGO and other advocacy organizations raised concerns at the time about the creation of a Central Whistleblower Office (CWO) within the VA.[6] While it is clear that more resources are necessary to address the influx of whistleblower complaints, we believe this office would not be sufficiently independent to investigate whistleblower complaints. The legislation spelled out only that the CWO is not an element of the VA Office of General Counsel, does not report to the General Counsel, does not provide the General Counsel with information regarding whistleblower complains, and does not advice the General Counsel's office.[7] However, POGO's experience with whistleblowers from the VA showed us that more independence was necessary. The reluctance of employees at the VA to come forward to their own Office of the Inspector General (IG) demonstrated a culture of retaliation that would likely not be alleviated by the creation of another office with similar "independence" at the VA. Furthermore, without proper independence, we worried this office could become an internal clearinghouse that would help agency officials identify and retaliate against whistleblowers.

Additionally, the office is tasked with investigating "all whistleblower complaints of the Department" made by VA employees.[8] This created ambiguity regarding whether the drafters intended to maintain the previous standard that VA employees have the option to go to an Inspector General, Member of Congress, or the Office of Special Counsel. By requiring that all investigations be conducted by one office, the language appeared to restrict access to other, more independent offices that had previously been allowed.

Overall, in the instance of the CWO, the benefits of streamlining do not outweigh the risks of priming a whistleblower for retaliation if their disclosure ends up in the wrong ear.

Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017

Last week, Senators Rubio, Tester, Isakson, Nelson, McCain, Shaheen, Moran, and Baldwin introduced a bipartisan bill aimed at reforming the VA's whistleblower procedures and accountability frameworks. The Office of Accountability and Whistleblower Protection (OAWP)

---

[6] Elizabeth Hempowicz, Project On Government Oversight, "Testimony of Liz Hempowicz, Public Policy Associate Project On Government Oversight before the Senate Committee on Veterans' Affairs Legislative Hearing (Health and Benefits)." http://www.pogo.org/our-work/testimony/2015/pogos-liz-hempowicz-whistleblower-protections-va.html; Concerned Groups to Senate: Remove Measure in CR that Poses Risks to VA Whistleblowers, Project On Government Oversight, September 27, 2016. http://www.pogo.org/about/press-room/releases/2016/Senate-Remove-Measure-Posing-Risks-VA-Whistleblowers.html

[7] 38 U.S.C. § 732 (h)(1)

[8] 38 U.S.C. § 732 (h)(2)

created by this legislation to replace the CWO would alleviate many of the concerns that POGO had with the previous office.

The office would be run by a presidentially appointed and Senate-confirmed official who reports directly to the Secretary of the VA, a process that insulates the office from the VA as a whole. This insulation provides the space necessary to conduct unbiased investigations.

Moreover, the legislation defines the mission of the OAWP in a way that addresses the ambiguity problem in the CWO mission: the OAWP accepts whistleblower disclosures, but does not exercise sole jurisdiction over VA whistleblower complaints or investigations. Instead it is empowered to refer complaints to a relevant investigative body, such as the Office of the Medical Inspector or the IG, while maintaining some investigative jurisdiction as appropriate.

In addition to fixing a number of the problems inherent to the CWO, the legislation creates a whistleblower office with built-in accountability functions. The office is tasked with tracking and recording the implementation of findings and recommendations of the IG, the Medical Inspector, OSC, and the Comptroller General. It is also tasked with tracking and aggregating whistleblower disclosures made by VA employees across multiple platforms in order to identify trends and issue reports to the Secretary. This is similar to what POGO did on a smaller scale in 2014.[9] This project helped us identify key areas ripe for reform at the VA, and the VA would benefit from conducting similar analysis regularly.

Finally, the OAWP is required to file an annual report to the relevant Congressional committees about the office's activities. The annual report must include the issues and trends the office identified, analysis of the office's resources, and recommendations for legislative or administrative changes to improve whistleblower protections at the VA.

The statutory authorities provided by Title I of this legislation to act in the best interest of whistleblowers at the VA and to formulate and advance policies that will benefit whistleblowers and veterans alike are a significant improvement over previous attempts to address the issues at the VA.

Recommendations

It is POGO's hope that the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 will ensure that whistleblowers can expose wrongdoing, confident that their disclosures will be independently investigated and that they will not be made targets for retaliation.

Title I of this bill is full of necessary reforms. That said, there are a few changes to the overall bill that should be made before it becomes law, in order to ensure the bill doesn't inadvertently weaken civil service protections for employees at the VA.

Significantly, both sections 201 and 202 of this bill detail the procedures for disciplining Senior Executives and employees at the VA. Both sections allow a window of 7 business days for an employee to respond to a notice of removal. This is unreasonably and unnecessarily short and

[9] Lydia Dennett, "Fear and Retaliation at the VA," Project On Government Oversight, July 21, 2014. http://www.pogo.org/our-work/articles/2014/fear-and-retaliation-at-the-va.html

cannot be considered an adequate time frame to provide fair due process rights to respond to such a notice. Considering how important due process is in the civil service, and that we have seen instances where whistleblowers are targeted when there are weak civil-service protections, this is a substantial point of concern. This time frame must be extended to a minimum of 14 business days. Additionally, the bill reduces the time period in which an employee has to appeal to the Merit Systems Protection Board (MSPB) to 10 business days, which is similarly unreasonable and unnecessarily limits due process rights currently enjoyed by civil service employees.[10] The US Court of Appeals for the Federal Circuit recently struck down similar changes to MSPB access in removal actions.[11] We recommend that section be removed from the bill.

Furthermore, understanding that the intent behind this legislation is to improve whistleblower protections at the VA, POGO encourages you to update the definition of "whistleblower disclosure" in section 101. Your colleagues in the House have recognized that limiting a protected whistleblower disclosure to one that evidences a violation of a provision of law creates an unnecessary loophole and complicates enforcement of whistleblower protections.[12] By expanding the language to include information that evidences violations of rules or regulations as part of a protected whistleblower disclosure, you can help better protect whistleblowers and close this loophole.

Finally, we urge Congress to extend whistleblower protections to contractors and veterans who raise concerns about medical care provided by the VA. POGO's investigation found that both of these groups also fear retaliation, which prevents them from coming forward. In addition, a veteran who is receiving poor care should be able to speak to his or her patient advocate without fear of retaliation, including a reduction in the quality of health care. Veterans should not fear that they will lose access to their medications for blowing the whistle on problems they've experienced at VA hospitals or clinics. Without this reassurance, there is a disincentive to report poor care, allowing it to continue uncorrected.

Conclusion

The VA and Congress must work together to end the culture of fear and retaliation. Whistleblowers who report concerns that affect veteran health must be lauded, not shunned. And the law must protect them. It is POGO's hope that the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 will ensure that whistleblowers can step forward to expose wrongdoing, confident that it will not result in retaliation.

[10] 5 U.S.C. § 7701(e)(1)(A)
[11] *Helman v. DVA*, 2015-3086, 2017 U.S. App. LEXIS 8177 (Fed. Cir. May 9, 2017)
[12] House of Representatives, "Follow the Rules Act" (H.R. 657), introduced January 24, 2017, by Representative Sean Duffy. https://www.congress.gov/bill/115th-congress/house-bill/657/text (Downloaded May 15, 2017) (Amending a protected action taken by civil service employees to "refusing to obey an order that would require the individual to violate a law, rule, or regulation.")