STATEMENT OF
HANSEL CORDEIRO, ACTING ASSISTANT SECRETARY
ACCOUNTABILITY AND WHISTLEBLOWER PROTECTION AT THE
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE COMMITTEE ON VETERANS' AFFAIRS

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Chairman Pappas, Ranking Member Mann and Members of the Subcommittee, thank you for providing me the opportunity to testify at this hearing on whistleblower rights and protections at the Department of Veterans Affairs (VA). Whistleblower rights and protections are a cornerstone of improved accountability in VA. VA's Office of Accountability and Whistleblower Protection (OAWP) provides whistleblowers and other individuals who want to promote change and improvements in VA a channel to safely raise concerns of wrongdoing.

OAWP diligently protects whistleblowers and other individuals who have the courage to speak truth to power. When an individual alleges retaliation after raising concerns about wrongdoing at VA, whether to OAWP or any other individual, OAWP investigates these allegations. OAWP also investigates allegations of VA senior leader misconduct and poor performance. Senior leaders include political appointees, VA senior executives, VA facility directors, associate directors, chiefs of staff and nurse executives.

OAWP works closely with other oversight entities, including VA's Office of Inspector General (OIG) and the U.S. Office of Special Counsel (OSC) to mitigate any duplication of investigative efforts. OAWP worked closely with these offices to develop a chart that explains where individuals can file complaints and what types of allegations each office investigates. The chart is available on OAWP's website at www.va.gov/accountability.

Because OAWP is not a component of any VA administration or staff office, and the Assistant Secretary for Accountability and Whistleblower Protection reports directly to the Secretary of Veterans Affairs, OAWP is able to investigate these allegations in a fair and unbiased manner. If OAWP substantiates allegations, it makes recommendations to VA for disciplinary action against the wrongdoer and corrective action for the whistleblower.

Our last Congressional report in June 2020 highlighted some of the efforts underway to improve OAWP. This testimony highlights some of the results of those efforts, including the following:

- OAWP issued more than 99 recommendations as a result of its investigations between April 2020 and April 2021.

- OAWP directly investigated more than 400 cases between April 2020 and April 2021.
- As required by law, OAWP referred for investigation to VA administrations and staff offices and maintained oversight of more than 500 cases between April 2020 and April 2021.
- OAWP implemented a compliance audit program to test VA's compliance with recommendations made by external oversight entities.
- Due to OAWP's improvements, OIG closed the last of 17 OAWP-related recommendations from its October 2019 report, number 18-04968-249.
- OAWP resolved all 572 backlogged cases dating back to 2017 and 2018, which were initially identified in late 2019.

WHISTLEBLOWER DISCLOSURES AND COMPLAINTS

OAWP receives a wide variety of allegations ranging from policy violations to issues that directly impact Veteran care and benefits. OAWP provides a safe and confidential channel for VA employees, many of whom are Veterans themselves, and applicants for VA employment to disclose their concerns. OAWP also provides a safe and confidential channel for Veterans, former VA employees, and other individuals to disclose allegations of senior leader misconduct and/or poor performance and allegations of whistleblower retaliation. By providing a safe and confidential channel to raise concerns, individuals are more likely to raise concerns when they observe them. OAWP's timeliness in handling these disclosures and its efficient investigative process helps to mitigate harm that could result if deficiencies in VA care and services are not identified by whistleblowers and remain unaddressed by VA.

Examples of significant whistleblower disclosures include the following:

- OAWP received a whistleblower disclosure about a VA primary care physician who provided direct patient care after traveling both internationally and within the United States without quarantining or wearing a mask. The whistleblower disclosure was substantiated and resulted in corrective action and review of daily employee screening requirements at the facility to ensure compliance with COVID-19 safety measures. The whistleblower disclosure and corrective actions potentially mitigated the transmission of COVID-19 to Veterans and other individuals who would have been treated by or in proximity to the physician.

- OAWP received a whistleblower disclosure that a VA supervisor was unprofessional regarding deceased Veteran patients and grossly mismanaged a cardiology follow-up call list of over 1,000 Veteran patients. The list included multiple errors and most of the Veterans on the list were beyond the clinically indicated 28-day limit. The whistleblower disclosure was substantiated and resulted in action against the supervisor and remedial actions for the impacted Veterans.

IMPROVING COMMUNICATION

OAWP has significantly improved the way it communicates with whistleblowers and complainants. In September 2020, OAWP implemented a web-based disclosure and complainant portal. The portal enables whistleblowers and complainants to submit whistleblower disclosures, allegations of whistleblower retaliation, and allegations of senior leader misconduct and/or poor performance, using any web-enabled device such as a tablet or smartphone. Once a disclosure or complaint is received through the portal, it is immediately assigned to an OAWP Intake and Referral Analyst for review. More than 40% of the whistleblower disclosures and complaints received by OAWP now come through the portal.

In addition to the web-based disclosure and complainant portal, OAWP has a toll-free telephone hotline for whistleblowers and complainants to report matters to our office. The telephone hotline is monitored each business day, and in most circumstances, whistleblowers and complainants are contacted within one to two business days after making their submission to OAWP. Over 10% of the contacts received by OAWP are from Veterans and their families, caregivers and survivors who reach out to OAWP for more information about VA benefits or health care (e.g., attempting to make healthcare appointments). OAWP performs a warm handoff to the respective VA administration or the Veterans Experience Office so that these individuals are connected to the correct VA office in a timely manner.

FAIR AND UNBIASED INVESTIGATIONS

OAWP has substantially improved its investigative processes to ensure that its investigations are fair and unbiased. OAWP investigators perform their work using standard operating procedures that were developed based on Quality Standards for Investigations issued by the Council of the Inspectors General on Integrity and Efficiency. Over the last year and a half, OAWP hired seasoned investigators with years of experience in Federal administrative investigations. Many OAWP investigators have worked with Federal Inspectors General to investigate allegations of senior leader wrongdoing and have experience investigating whistleblower retaliation complaints. Prior to being assigned casework, new OAWP investigators complete a week-long comprehensive training course focused specifically on OAWP investigations. After completing training, new investigators are linked with OAWP peer investigators for several months to ensure that they are conducting investigations in accordance with OAWP's standard operating procedures.

OAWP investigative teams allow supervisors to coach and mentor employees and address deficiencies in work-product throughout the investigative process. Supervisors review investigative plans and perform regular case reviews with investigators. A multilayered supervisory review of reports of investigation ensures investigative sufficiency and accuracy in OAWP reports of investigation.

Consistent quality across our investigative processes is critical to ensuring that OAWP investigations are fair and unbiased. OAWP's Quality Division performs quality assurance reviews of OAWP's investigative processes. The Quality Division reviews closed OAWP matters and cases to assess their conformity to law, policy and standard operating procedures. If deficiencies are identified, the Quality Division notifies the respective division and the Executive Director for Investigation, identifies the root causes for the deficiencies, and recommends solutions. The work of the Quality Division enables OAWP to identify gaps early in the intake, referral and investigation processes to provide opportunities for improvement. The improvement in OAWP's investigations was recognized by OIG when it closed all OAWP-related recommendations from its October 2019 report.

PROTECTING WHISTLEBLOWERS

VA must consistently provide a safe environment in which its employees feel comfortable and confident in making disclosures about wrongdoing. Individuals should never be in a position in which they must choose between their conscience and their career.

OAWP receives and investigates allegations of whistleblower retaliation. If OAWP substantiates allegations, it may recommend disciplinary action against the wrongdoer and corrective action for the whistleblower. Since April 2020, OAWP issued 29 disciplinary recommendations for VA supervisors because of whistleblower retaliation and made over 16 non-disciplinary recommendations, such as corrective action for whistleblowers. Over a similar length of time, OSC negotiated 27 disciplinary actions for whistleblower retaliation and other prohibited personnel practices across the entire Federal government. *See* OSC's Annual Report to Congress for Fiscal Year 2019. Examples of significant OAWP whistleblower retaliation cases are as follows:

- Two VA medical center (VAMC) employees made whistleblower disclosures regarding multiple violations of VA policy at their facility, including maintaining an unauthorized waitlist. The employees worked at VA for a significant period of time and did not have any prior discipline. Both employees had their removals proposed by the VAMC Director. One employee subsequently retired and the other employee transferred to a different VAMC. OAWP's investigation determined the evidence relied upon for the proposed removal actions was either unsupported, weak, or so minor in nature that removal would have been clearly unwarranted. Similarly situated employees, who were not whistleblowers, were not disciplined at all for similar actions. OAWP recommended that the VAMC Director be disciplined for whistleblower retaliation in the range of a 12-day suspension to removal. This is consistent with the penalty prescribed under 38 U.S.C. § 731 for whistleblower retaliation. OAWP also recommended corrective action for the whistleblowers.

- A VAMC supervisory employee made whistleblower disclosures about staffing shortages and equipment failures to the VAMC Director. Subsequently, the OIG performed a health care inspection at the VAMC. The employee's supervisors

assumed that the OIG performed the inspection because the employee raised similar concerns to the OIG. The employee's supervisors later downgraded the employee's performance evaluation, detailed the employee to another unit, and reassigned the employee. OAWP's investigation found that the timing of the personnel actions established a causal connection between the personnel actions and the employee's whistleblower disclosures. OAWP also found several statements of animus made by the employee's supervisors, including that "[m]anagers do not behave the way you are filing against the [C]hief [of Staff]. Do you know how to handle problems rather than escalate situations, how to use the proper chain of command?" OAWP recommended the employee's supervisors be disciplined in the range of a 12-day suspension to removal. This is consistent with the penalty prescribed under 38 U.S.C. § 731 for whistleblower retaliation. OAWP recommended that VA consider recouping the awards and bonuses of one of the employee's supervisors who resigned from VA under 38 U.S.C. § 721. OAWP recommended corrective action for the whistleblower.

Under 38 U.S.C. § 714(e), VA may not discipline employees while they have allegations under investigation in OAWP or are seeking corrective action from OSC. OAWP works closely with VA officials to place disciplinary actions proposed against VA employees under 38 U.S.C. § 714 "on hold" until OAWP completes its investigation. Or, in cases where the employee has a pending complaint with OSC, OAWP works closely with OSC to place the matter "on hold" until OSC has completed its investigation or allows the disciplinary action to proceed. OAWP receives, reviews, and responds to questions from individuals about the 38 U.S.C. § 714(e) hold process. OAWP tracks all 38 U.S.C. § 714(e) holds and works with OSC to manage and release 38 U.S.C. § 714(e) holds.

Educating and training VA employees and other individuals about whistleblower rights and protections is a critical part of establishing an environment where employees understand their rights and are encouraged to raise concerns, and where instances of retaliation for raising those concerns is minimized. Under 38 U.S.C. § 733, VA must provide its employees with biennial whistleblower rights and protections training. OAWP developed this training and has trained more than 353,000 VA employees. OAWP also developed a supervisory module that addresses some common questions about whistleblower rights and protections and includes best-practices to encourage employees to raise concerns. More than 34,000 supervisors have taken this training module.

OAWP is developing a program to provide customized education to VA employees on whistleblower rights and protections. The education program will allow VA facilities and labor partners to request whistleblower rights and protections courses, presented by OAWP, for their employees and members. These courses will address ways to safely make whistleblower disclosures and what protections are available to individuals who raise concerns.

IMPROVING SENIOR LEADER ACCOUNTABILITY

Accountability begins at the top. OAWP receives and investigates allegations of VA senior leader misconduct and poor performance. If OAWP substantiates allegations, it may recommend disciplinary action against the senior leader. If a senior leader has left VA or retired, OAWP may recommend non-disciplinary action, for example, that VA consider the recoupment of awards and bonuses paid to the senior leader under 38 U.S.C. § 721. Since April 2020, OAWP issued 40 disciplinary recommendations for senior leader misconduct and/or poor performance and 14 non-disciplinary recommendations. Examples of significant OAWP senior leader cases include the following:

- A VA executive was alleged to have been in an inappropriate personal relationship with a subordinate employee. The executive also made inappropriate comments to the employee. During the course of the investigation, OAWP determined that the executive's testimony lacked candor regarding his personal relationship with the subordinate employee. OAWP recommended the executive's removal from VA.

- A senior leader at a VAMC was alleged to have failed to provide subordinate employees with their performance standards and their performance ratings, as required by VA policy and Merit System Principles. The OAWP investigation revealed that the senior leader failed to provide performance standards and/or performance ratings for multiple employees over multiple rating periods. OAWP recommended that the senior leader be demoted or removed for his engagement in this misconduct.

IMPROVING ORGANIZATIONAL ACCOUNTABILITY

Improving accountability at VA involves two key areas: personnel accountability, through investigations and education, and organizational accountability. Organizational accountability ensures that systemic deficiencies are identified and do not reoccur.

To improve organizational accountability at VA, OAWP records, tracks, reviews and confirms the implementation of recommendations from audits and investigations carried out by OIG, VA's Office of the Medical Inspector (OMI), OSC and the U.S. Government Accountability Office (GAO). OAWP routinely identifies systemic issues through its review of the findings and recommendations contained in these oversight entity reports. OAWP also determines VA's priority areas that are in need of improvement and conducts compliance audits to confirm the implementation of select closed recommendations in these areas to ensure VA administrations and staff offices continue to adhere to them.

Over the last year, OAWP has performed several compliance audits. These audits cover a variety of topics, including VA's implementation of select closed OIG and GAO credentialing and privileging recommendations and whether the Veterans Health Administration's Regional Procurement Offices are complying with regulations and

policies when closing contracts. More information about the results of these audits will be shared by OAWP in its June Congressional report.

TRANSFORMING OAWP'S WORKPLACE CULTURE

OAWP has 105 employees residing and working in 28 states. Most OAWP staff work remotely. Today, OAWP is more inclusive and diverse than in the past. OAWP also better reflects the Veteran population that it serves. Currently, 54% of OAWP employees are Veterans whereas 32% of OAWP employees were Veterans in 2018. In addition to increasing the number of Veterans on our staff, we have doubled our racial and gender diversity in supervisory and leadership positions since 2018. Improving our diversity and making OAWP an inclusive, equitable and accessible environment for our staff ensures that we approach challenges holistically to promote and improve accountability within VA for all individuals.

OAWP has taken a concerted approach to transform its workplace culture by focusing on improving transparency, communication, and organizational diversity. OAWP has partnered with frontline staff, the backbone of the organization, to identify barriers and provide solutions, which have improved transparency, communication, and organizational diversity through various employee led initiatives over this past year. OAWP was recognized as the Most Improved Organization within VA Central Office in the annual All Employee Survey, as we increased our Best Place to Work score by 21 points from 2019. The Best Place to Work index reflects general employee satisfaction. It is VA's best overall organizational health metric and is used to compare VA to other Federal agencies.

ENGAGING WITH STAKEHOLDERS

Stakeholder feedback is critical to assessing OAWP's progress in improving accountability within VA. Over the last year, OAWP leadership met with more than thirty stakeholders, including Members of Congress and their staff, Veteran Service Organizations (VSO), labor partners, and whistleblower advocacy groups. We solicited input from these individuals and groups and will continue to seek input as we improve. We also continue to work closely with Congressional staff on legislative proposals to improve whistleblower rights and protections within VA.

CONCLUSION

Secretary McDonough and I recognize the importance of whistleblower rights and protections. Whistleblowers and others with the courage to speak the truth continue to have a positive impact on the care of Veterans, including playing a critical role in mitigating the impact of the Coronavirus Disease 2019 pandemic. As we approach the fourth anniversary of the establishment of OAWP, we look forward to working with Congress, VSOs, labor partners, whistleblower, good-government advocacy groups, and the Veteran community to strengthen whistleblower rights and protections at VA and to continue to promote and improve accountability within VA.