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Statement of:
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Before the
Committee on Veterans' Affairs
U.S. House of Representatives
on
The Implementation of the VA Accountability and Whistleblower Protection Act of 2017

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Chairman Roe and Ranking Member Walz:

Whistleblowers of America (WoA) is grateful that this Committee recognized the need to review the Department of Veterans Affairs (VA) ability to appropriately implement the legislation passed last year on Accountability and Whistleblower Protection. WoA has monitored and tracked the Office of Accountability and Whistleblower Protection (OAWP) activities as it has had implications for so many of our peers.

Background and Data:
Incorporated in 2017, WoA has provided peer support to 246 whistleblowers with 157 contacts coming from across VA. They represent a gamut of VA employees nationwide, including healthcare providers, executives, contracting officers, and disability claims adjudicators. Many are veterans themselves, veterans' family members or are veteran/patients. They are employees who came to work every day expecting to do their jobs. They expected policies and procedures to be in place to guide them and their co-workers. They expected fair treatment and a positive work environment. They expected orientation, training, supervision and career development. They expected to be held accountable for their professional ethics and conduct and to follow standards, such as those outlined by The Joint Commission or the FAR.[1] They expected to be able to voice their concerns, especially when they saw harm to veterans. They expected to engage in continuous process improvements. Their expectations were met with disappointment and an adversarial experience that caused irreparable damage to them economically, physically, mentally, and socially.

They have reported contracting waste, fraud and abuse, substandards of care, scheduling irregularities, prescription/formulary mismanagement, medical errors, wrongful deaths/suicides, inaccurate reporting in homeless veteran numbers, privacy violations, lost files or equipment, and the lack of appropriate policies or procedures to ensure patient safety or benefits. In most

[1] Federal Acquisition Regulation

cases, they saw something unethical or concerning and made a disclosure through their chain of command as they were taught to do. Repeatedly, WoA has listened as VA employees recount that they did not think of themselves as whistleblowers, which also means that they did not know how to protect themselves. They thought they were following ethical standards and identified wrongdoing or simply questioned policies and procedures that were confusing or contradictory to veteran care. They were often unprepared for the retaliation, discrimination, harassment, bullying, and a hostile work environment that ensued. They have become all too familiar with the 14 Prohibited Personnel Practices outlined in 5 United States Code, Section 2302. They have been the victims of gaslighting, mobbing, marginalizing, devaluing, shunning, blackballing, double-binding, counter-accusing and violence. They describe being stalked, cyber-bullied, intimidated, threatened and physically assaulted. These toxic tactics are well documented in the mental health literature as related to depression, anxiety, posttraumatic stress disorder (PTSD) and suicide among whistleblowers. The law does not recognize the damages done by this level of emotional distress, nor does it hold perpetrators of harassment or retaliation accountable.

VA alone represents approximately 40% of cases being adjudicated by OSC with a 31% increase in 2017. [2] VA had amongst the lowest scores on the Federal Employee Viewpoints Survey (FEVS) in 2017. It was 17th of the 18 largest federal agencies.[3] On July 3, 2018, VA announced it would drop its participation in FEVS in favor of its own survey.[4] It is unlikely that VA will be able to effectively execute an independent viewpoint assessment, without comparator data from other agencies, without Office of Personnel Management (OPM) as a 3rd party evaluator, and without compromising personal information. WoA fears that this is a move to further identify whistleblowers and target them. We urge Congress to further review this plan and discuss it with OPM; the administrators of FEVS. On Glassdoor, VA has a 3.4 rating (out of 5), with pros mostly attributed to federal benefits and cons related to the difficult work environment.[5] If VA is not an organization of choice, then the implications in being able to recruit and retain the best staff is impaired. Lack of quality staffing will continue to destabilize VA.

Costs of Whistleblowing:

Whistleblowers on average spend three to five years and thousands of dollars of their family money or retirement savings with cases before the Office of Inspector General (OIG), Office of Special Counsel (OSC), the Equal Employment Opportunity Commission (EEOC) and/or the Merit System Protection Board (MSPB). If an employee is covered by professional insurance and able to fully litigate their claim, their costs are often $200,000-$300,000 (limits of the policy) plus out of pocket costs. However, most VA employees end up pro se when they have spent $10,00 of their life savings and can no longer afford an attorney. Often overlooked are the costs of annual leave for legal and medical consultation and responses to litigation, while the federal official identified in misconduct is allowed unlimited time and legal support to target the employee or respond to whistleblower activity at the taxpayer expense.

[2] https://osc.gov/Resources/OSC_Lerner_Testimony_VA_Whistleblowers_04.13.15%20FINAL.pdf

[3] https://federalnewsradio.com/your-job/2018/06/va-drops-the-fevs-in-favor-of-its-own-employee-engagement-survey/

[4] https://federalnewsradio.com/your-job/2018/06/va-drops-the-fevs-in-favor-of-its-own-employee-engagement-survey/

[5] https://www.glassdoor.com/Reviews/department-of-veterans-affairs-reviews-SRCH_KE0,30.htm

Even when cases are substantiated in favor of the whistleblower, the VA employee may have already been demoted, detailed, discharged of duties, or terminated and bankrupt. Professionally, they are compromised. If they are a credentialed provider, they lose their profession and, in some cases, the ability to work ever again because VA has reported them to their licensing board or to the National Practitioner Data Base (NPDB)[6] without having to prove proper investigation. For example, in the Memorandum of Understanding (MOU) between VA and NPDB, any report the agency submits to NPDB, must be documented in the physician's file, and becomes a permanent record. The MOU is governed by Chevron Deference; i.e.: NPDB assumes any report they receive from VA is accurate and valid. Congress should address the fact that there is no mechanism in place to question if VA is, or is not, providing accurate and valid information to the NPDB and the elements that constitute that investigation. There should be a mechanism to retract and remove such reports when whistleblower retaliation is substantiated. NPDB does allow a physician to submit a statement to refute the VA's submission. However, it is limited to one-page and does not allow enough latitude to extensively and in detail provide written evidence to disprove the VA's report. The VA is aware of the destructive effect a malevolent statement can have on a physician's, (nurse's, social worker's, etc.) career and the agency frequently uses that leverage to threaten whistleblowers into submission. WoA has reviewed several of these threatening letters. The loss of their profession also means that providers lose their homes, families, and future. So, the consequences of whistleblowing are very real and life-altering for healthcare providers reporting substandard care.

In the meantime, VA officials responsible for the wrongdoing and the subsequent retaliation move along in their careers unscathed and protected by fellow VA leaders. Millions of taxpayer dollars are footing the bill for employee wrongdoing, poor performance, and the legal and investigative fees of targeting whistleblowers. Promotions and bonuses are corruptly awarded to entice those who aide and assist VA leaders in the removal of a whistleblower. Congress should ask the Government Accountability Office to document the amount of taxpayer dollars VA uses in cases related to retaliation, harassment, and discrimination.

Lack of Government Accountability or Whistleblower Protection:

The first component of the 2017 law was designed to enhance accountability. According to the OAWP, it "Serves to improve the performance and accountability of VA senior executives and employees through thorough, timely, and unbiased investigation of all allegations and concerns."[7] However, according to its May 31, 2018 report, of the 1,171 accountability actions taken (demotions, suspensions, removals), 1 was listed as against a senior official.[8] This list is barely a report. It does nothing to explain why those actions were taken nor does it identify violations of law (i.e.: FAR, Anti-Deficiency Act) or misdemeanor for felonious convictions. It does not give any data on its timeliness or how it ensures an unbiased investigation. In its second report regarding whistleblowers, 2,161 employees[9] made complaints, but OWAP found that half were not whistleblowers. This data point is concerning because it either means that employees

[6] A web-based repository of reports containing information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. Established by Congress in 1986, it is a workforce tool that prevents practitioners from moving state to state without disclosure or discovery of previous damaging performance.

[7] https://www.va.gov/accountability/

[8] https://www.va.gov/accountability/Accountability_Report_062618_1.pdf

[9] https://www.va.gov/accountability/Whistleblower-Disclosures-Summary_070518_1.pdf

are not being educated in accordance with the NO FEAR Act or whistleblowers are being unjustly denied. There is also a lack of data on how they are being assisted. The OAWP needs to open the aperture on how it is defining its whistleblower terms and capturing retaliation (in its many forms) and be able to account for the assistance provided. It should denote how many of the adverse actions they took involved any whistleblowers and who among them were veterans. (Veterans have reported to WoA retaliation related to asking for reasonable accommodations and use of Family Medical Leave Act time due to their service connected disabilities.)

When a whistleblower contacts the OAWP, they are assigned a case manager who asks them to fill out the VA Form 10177. Whistleblowers wait several months and are then given "boilerplate" answers. They are told that they will hear back, but never do. One whistleblower shared his email exchange with OAWP from April to July 2018. He contacted his case manager over 30 times asking for a case update because he was still on a detail. She repeatedly asks him for case information and responds multiple times with, "*Your disclosure has been reviewed. Any applicable findings have been addressed appropriately and your case is now closed,*" (he gets that response 9 times) "*I am unable to provide more information due to privacy,*" (he gets that response 5 times) and finally she tells him, "*Your OAWP case will remain on hold pending the OSC investigation. If OSC does not complete its review, OAWP will re-open the case."* If this is in fact true, then OAWP is a complete waste of government resources and Congress should consider abolishing it and transferring those funds to OSC so that they can complete their binding unbiased reviews in a timely fashion.

Complaints that go to the OAWP are redirected back to the same leadership chain that disclosures were made against, so there is no real neutral party involved in the investigation. Whistleblower confirm that sometimes there is some form of an internal review, usually an Administrative Investigation Board (AIB). VA has a Directive and Handbook (0700) on AIB, it does notate that they are never binding. It describes AIB as an "information gathering process". It does not specify the level of training for employees delegated the responsibility as collateral duty. These investigators usually do not hold the proper job series or certification to conduct an investigation. Additionally, whistleblowers categorize it as biased because it is often conducted by a person who reports to the same supervisor or up the same chain of command. OAWP staff are allegedly a mix of Human Resource specialists, investigators, mediators/arbitrators and decision makers. Congress should ask VA for its staffing portfolio and qualifications for employees assigned to OAWP and for those asked to "investigate" complaints at all levels or serve on AIBs. Congress should require OAWP to report on how long it takes them to adjudicate a complaint and how it ensures impartiality. It should also require them to document the nature of the complaint and which of the 14 Prohibited Personnel Practices were violated.

Furthermore, even the term "investigation" has legal ramifications that the VA misuses. Whistleblowers report that they were told the "investigation" was merely an "evaluation" or a "fact-finding" which means it was nonbinding but may still result in legal action against the whistleblower. When employees are asked to cooperate with these investigations, they are not necessarily advised about potential charges that could be brought against them, nor are they advised about their due process rights or entitlement to legal representation, which are violations of the NO FEAR Act, and certainly there is no ability to utilize the same resources that the government mobilizes. And since most whistleblowers are not legally savvy about governing

statutes, not aware of protocols for collecting evidence, not informed on options for assistance, not always covered by a union, and do not have the same unlimited taxpayer resources as the government for adjudicating these cases, they are immediately at a disadvantage in the process. This imbalance of power should not only be seen as unjust by the Committee, but as inhumane because of the extreme burden it places on employees. At the least, Congress should require any formal or informal investigation, evaluation or fact-finding provide employees with their NO FEAR Act rights prior to any interview. It should ask GAO to review all of VA's policies, MOUs, and procedures for these formal and informal investigations, the results that they generated, and the level of evidence required prior to reporting a provider to their licensing board and/or the NPDB. And, if the submission is found to be fraudulent, how are providers reinstated and recompensed.

Under the law[10], federal agencies are required to have a policy on Alternative Dispute Resolutions (ADR). According to the OPM, an ADR should involve a neutral, impartial individual as a mediator/arbitrator, but as noted that is not usually the case at VA facilities. Additionally, the ADR Act calls upon the Federal Mediation and Conciliation Service (FMCS) to help other federal agencies resolve disputes. The FMCS provides a wide variety of professional services such as mediation, designing and building capacity for effective conflict management systems, and developing tools for interagency/public-private cooperation and collaboration. Although FMCS reports VA as one of its customers, there is no visible data as to how often VA uses its services and no outcomes of that support are reported. Congress should ascertain more information about VAs use of FMCS services and outcomes. This may be a more viable option than allowing VA to investigate or mediate itself. Congress should also obtain information as to how FMCS develops tools for public/private partnerships so that those independent entities could be enlisted more often to evaluate, mediate and facilitate a whistleblower resolution. Furthermore, if this authority is removed from OAWP, those funds should be transferred to FMCS for expansion of public/private partnerships.

Since the 2017 law passed, VA has not engaged in meaningful arbitration or mediation. Several whistleblowers have entered arbitration with VA in good faith (and accruing legal fees) only to have VA delay discussions and abruptly withdraw from arbitration unless the whistleblower agrees to resign. Settlements have also been limited since VA changed the policy (issued by Secretary Shulkin) that amounts above $5,000 must be approved by an Undersecretary. Congress should ask the GAO to assess the trends and cost expenditures for all parties related to arbitration, mediation, and MSPB judgements.

OIG Recommendation Enhancements:

Overall, WoA has concerns that there is also a lack of accountability for follow up on OIG reports. The fact remains that OIG can only make recommendations to VA senior leaders. Those recommendations are nonbinding. Only the OSC can mandate any corrective action. Congress should require an annual roll up of all VA OIG findings and recommendations. Those recommendations should be tracked, and outcomes documented. Since there are no mandates to implement an OIG recommendation, this would allow Congress to more readily intervene. Otherwise, OIG reports can literally, "sit on the shelf" for decades. Because of this lack of urgency, the recommendations themselves tend to be nebulous and inconsequential.

[10] Administrative Dispute Resolution Act of 1996 (ADR Act)

In one case reviewed by WoA, a whistleblower reported inappropriate conduct, corruption, and fraud by Veterans Benefits Administration (VBA) leadership to over 10 VA officials. The whistleblower was almost immediately put under investigation, but never further interviewed. Not a single VBA leader has been held accountable for any of the waste, fraud and abuse or subsequent retaliation related to the OIG report #16-04555-138, "*Alleged Contracting and Appropriation Irregularities at the Office of Transition, Employment and Economic Impact*"[11] that was disclosed by the whistleblower. Released on May 2, 2018, it documented that Transition, Employment and Economic Impact Office committed statutory violations of $11.7 million to CALIBRE for printing, dashboards, and other information technology. This may be an Anti-Deficiency Act violation, so the OIG recommended that the Office remedy this unauthorized commitment (does not say how) and that they should obtain appropriate funding and accounting in the future. So, what happens to almost $12 million? Does CALIBRE have to reimburse the government? Who at the VBA is accountable for that misspending?

The whistleblower who initially disclosed this wrongdoing went to the OAWP for assistance but got no response. However, after this Committee held a VBA hearing in March, WoA published a press release on April 11, 2018 regarding the VBA testimony and the OIG report that resulted in an email on June 14, 2018, from Nicole Craven, OAWP Administrative Investigator requesting information about the whistleblowers who shared information with us. Ms. Craven stated that she was "directed" by her leadership to reach out to WoA. This behavior further validates for WoA its survey results previously reported to this Committee. In that survey of 23 VA whistleblowers of which 13 said that they contacted the OAWP for assistance and got no real response or felt it resulted in further targeting and retaliation.[12]

Therefore, WoA concludes that VA managers guilty of wrongdoing or the retaliation are not held accountable – rarely are they even identified by the OIG. Most of the time, the OIG recommendation is for "further training." There should be serious penalties for retaliation (fines, demotions, loss of retired pay, etc) to discourage the tactics related to it. Congress should create a fund that requires those identified as engaging in wrongdoing and retaliation to contribute fines. This fund could be used to offset those costs for a public/private partnership that pays for the independent consultants or attorneys (as described by the FMCS) chosen by the whistleblower and reduce the burden on the taxpayer.

In conclusion, WoA finds that OAWP does not meet the standards outlined by this Committee. It has been an extension of retaliation, harassment, and bias. This Committee would be hard-pressed to find employees that would trust or have faith in VA Central Office to oversee their ability to seek justice. WoA advocates for a real overhaul of the whistleblower protection process and calls upon Congress to create new authorities for VA to transfer funds to OSC and FMCS for more independent, unbiased and neutral parties and public/private partnerships that can truly adjudicate wrongdoing, conduct root cause analyses, and improve care to veterans.

[11] https://www.va.gov/oig/pubs/VAOIG-16-04555-138.pdf

[12] https://whistleblowersofamerica.org/f/woa-survey-on-va-in-the-news (Several more responded after the story was published.)