

MILITARY CONSTRUCTION, VETERANS AFFAIRS, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2016

FRIDAY, NOVEMBER 6, 2015

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 1:08 p.m., in Everett McKinley Dirksen Federal Courthouse, court room 1903, 219 South Dearborn Street, Chicago, Illinois, Hon. Mark Kirk (chairman) of the subcommittee, presiding.

Present: Senator Kirk.

A REVIEW OF WHISTLEBLOWER CLAIMS AT THE DEPARTMENT OF VETERANS AFFAIRS

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. We will bring this hearing to order.

We would not have a country without our veterans. The best way to care for our men and women in uniform is to provide for their healthcare after they have finished Active Duty.

I was so disappointed to hear that veterans had been mistreated in Department of Veterans Affairs (VA) hospitals by those charged with providing their care. Dedicated nurses and doctors reporting poor treatment of our vets should be heard and not silenced. Instead, these brave Americans are being victimized for reporting on the culture of corruption that currently exists in the VA.

As chairman of this subcommittee, I want to do all I can to help the professionals who are serving our veterans. We must protect the protectors of our veterans.

I will soon be introducing a VA Patient Protection Act in the Senate, to make sure that abuse and wrongdoing is reported immediately and fixed right away, with the truth-tellers coming forward without fear.

This week, I won a great victory in the Senate for veterans' healthcare when the Senate agreed to move forward on the VA appropriations bill that I wrote with funding for our veterans. In that 93-0 vote, we won the support of every single voting Democrat in the Senate. This was a true bipartisan victory for my bill, which has the highest level ever for funding for our veterans and makes sure that it provides more than \$1 billion more than the President even requested for his budget.

I ask that we go quickly to the President's desk and that he sign it as quickly as possible.

I do want to thank my ranking minority member, Senator Tester of Montana, for working so well with me in a bipartisan manner.

In Illinois, we have several veterans' facilities, like in Marion, Danville, Jesse Brown, and North Chicago. I would argue that Lovell VA is the best in the State because it is half Navy and that my fellow sailors who staff that facility would never mistreat their fellow veterans like some VA bureaucrats have treated our veterans.

I have the most concerns now with the Hines VA, where we know that people are hurting veterans. We will hear stories today from a cardiologist who was stripped of her career for coming forward with stories about how veterans have been mistreated.

I would like to now recognize Dr. Lisa Nee to describe the culture of corruption at the Hines VA.

Dr. Nee, you are recognized.

STATEMENT OF DR. LISA NEE, M.D., FORMER CARDIOLOGIST AT EDWARD HINES, JR. VA HOSPITAL, CHICAGO, ILLINOIS, DEPARTMENT OF VETERANS AFFAIRS

Dr. NEE. Thank you. Chairman Kirk, thank you for the opportunity to testify today regarding the ongoing issues of retaliation against truth-tellers within the Veterans Affairs system. I wish to extend my gratitude to you and your staff for the continued attention to the alarming matter of increasing whistleblower retaliation.

Although there is significant rhetoric from various branches of Government that this type of behavior is detrimental to the care of the veteran, there seems to be no end in sight for those who continue to face retribution for taking the courageous step of coming forward.

A September 2015 report from the Committee on Homeland Security and Governmental Affairs stated the Office of Special Counsel has received 35 percent of its entire retaliation caseload from VA employees. Despite its efforts to prioritize investigations, special counsel Carolyn Lerner testified before Congress in August of this year that the volume of incoming VA complaints remains overwhelming.

This clearly demonstrates the severe dysfunctional culture within the VA that encourages retaliation against the very individual who has exposed harm to the veteran in an attempt to improve the healthcare delivery process.

There are many journeys we all participate in during the course of our lifetime. Some are arduous. Many are attainable. But none has been more agonizing and unfulfilling than the current process of obtaining justice for the men and women who have fought for our freedom.

I realize that not every complex situation in life presents itself with moral clarity. However, this is not one of them. Caring for our veterans should be elementary. There should never be a single instance where a physician must choose between self-preservation and the life of a patient, or suffer an assault to their character in order to obtain accountability for criminal and inhumane acts against patients and fraudulent behavior toward the taxpayer.

The amount of bureaucratic gymnastics coupled with agency corruption can render the strongest individual forlorn and exhausted. Knowing when to lose with grace is an honorable skill and one that requires precise timing. This is not that time.

Armed with veracity for equity, an insatiable appetite for the truth, and a colossal amount of evidence, I am prepared to continue this battle until there is responsibility from leadership and transformative action, which will hold those at fault accountable.

My personal journey began over 4.5 years ago with exposure to the corruption at the Hines VA Medical Center regarding patients who died of cardiac complications while awaiting their cardiac ultrasound to be read. Unfortunately, for them, the tests were hidden in bankers boxes left unread for a year.

The mere questioning of such an egregious act resulted in significant retaliation, which went unabated the entire 2 years I was employed at Hines. But hell hath no fury like a VA administration scorned, and retaliation continued, even after I left VA, by the Office of Inspector General (OIG) and its pervasive culture of disparaging the truth-teller.

Multiple allegations regarding deficiencies in cardiovascular care were made, including but not limited to patients having their chest sawed open for unnecessary procedures, disparity in care based on ethnicity, procedural diagnostic errors resulting in arm, and pervasive billing fraud.

These allegations have resulted in an initial deficient OIG investigation, a subsequent Office of Special Counsel (OSC) investigation, a second contemptible OIG investigation, insistence from the OSC for an authentic and thorough investigation, and culminating with an ongoing Office of Medical Inspector's (OMI's) investigation.

It is a mind-numbing process to not only keep track of the endless agency acronyms but also calculating the amount of wasted taxpayer dollars consumed by these ineffectual inquiries. They are not true investigations, for they lack experienced subject matter experts and have a predetermined conclusion, which maintains the status quo.

The path this case has taken over the last 4 years has been objectively obfuscated and its bureaucratic oscillations can only be the result of stunning deficiencies at all levels of Veterans Health Administration (VHA) leadership. The task has become the exercise within itself. To engage in multiple investigations by varying internal agencies, which have substantiated patient harm as well as criminal activity, and to never mention one single word regarding accountability, one can only conclude this maladjusted behavior is designed to serve the agency itself and not the veterans.

It is the VHA leadership attempting to gain credit for oversight that the agency has failed to provide. Duplicitous—no other word can describe it.

The OMI report from July 2015 substantiated some of my allegations regarding deficiencies in cardiovascular care; deficiencies in echocardiogram processing; failure to disclose deficiencies in care and harm to patients; inflated productivity measures by cardiologists; and evidence that veterans were inappropriately charged copayments for care they never received, otherwise known as billing fraud.

In regard to this billing fraud, the report states, “We found that these actions possibly violate 18 U.S. Code 208, acts affecting a personal financial interest.” The OMI referred this criminal matter to the OIG, who has declined to open an investigation.

Interestingly, the bulk of the report is dedicated to the fraudulent billing practices, including in-depth statistical analysis, diagrammatic explanations, and extensive billing pattern documentation right. This provides a glaring contrast to the lack of investigative fervor and expertise when dealing with patient morbidity and mortality.

However, all this effort is for naught as the end result once again allows the documented criminal activity to go unpunished.

For the agency to demand an OMI investigation yet deny the credibility of criminal findings is administrative misconduct. The OIG must adhere to the quality standards for investigations issued by the Counsel of Inspector General on Integrity and Ethics, and the Attorney General guidelines for OIG with statutory law enforcement authority.

You do not get to be above the law just because you work for the VA. Or do you?

An equally compelling question is, if the OMI substantiated findings and then those are ignored, why do we need any of these investigative arms within the VA? They are redundant and wasteful and should be restructured.

To sum up the totality of all the reports to date is to call them a mismatch between words and deeds, a failed promise to treat and protect the veterans while instead protecting hundreds of useless report generators who will then retire with benefits. The investigators have gone so far out of their way to protect the VHA leadership that it has rendered every investigator impotent and every investigative finding ineffectual.

They are highly skilled at one part of their job: generating a paper trail designed to justify their professional existence. But they have failed at their original mission statement and severely compromised the health of the men and women who have fought for our freedom.

In order for any type of transformative action to begin to take shape and halt systemic corruption, there must be protection for truth-tellers, accountability for those who fail at their duties, and transparency to eliminate both operational deficiencies but also properly analyze collected data.

These are far from novel concepts and are most certainly codified in policy and procedure.

Chairman Kirk’s VA Patient Protection Act will demand accountability for those who retaliate against truth-tellers and empower those who can begin to make a positive impact on the outcomes of patient care. Preventing retaliation in the current defective culture of the VA requires deterrence, which should be timely, formidable, and indelible.

This bill would properly punish VA supervisors who have been found to take retaliatory actions against whistleblowers. There can be no saving of an agency as large as the VA if the employees operate from a constant position of fear rather than conviction and collaboration.

An additional step toward agency accountability which should be addressed by Congress is extending legislative authority to the OSC in two arenas: one, allow the agency to embark on a criminal investigation or partner with the Department of Justice, if the preponderance of evidence suggests illegal activity; and two, grant the OSC the necessary authority to determine the corrective action and punishment once the allegations are substantiated.

They currently have independent authority to determine if conduct constitutes a violation of law, rule, gross mismanagement, and a substantial and specific danger to public health. If they can determine the crime, they should be allowed to determine the punishment.

Many people have asked me why I continue to fight for the veterans even though I have left the VA. "What can you do?" they ask. I want the American public to contemplate that question for a moment and then consider an alternative perspective and perceive it as, "What should I do?" With that, the only acceptable response would be to strive for social justice and search for the truth, which brings us to the truth—a glorious, unadulterated supreme reality holding the ultimate meaning of values of existence corroborated by evidence. It does not change over time, and it never has to rely on anyone else's interpretation.

As a Nation, we can achieve this goal for the genuine protectors of truth, our veterans. Thank you.

[The statement follows:]

PREPARED STATEMENT OF DR. LISA M. NEE

Chairman Kirk, thank you for the opportunity to testify today regarding the ongoing issues of retaliation against truth tellers within the Veterans Affairs (VA) system. I wish to extend my gratitude to you and your staff for the continued attention to the alarming matter of increasing whistleblower retaliation. Although there is significant rhetoric from various branches of government that this type of behavior is detrimental to the care of the veteran, there seems to be no end in sight for those who continue to face retribution for taking the courageous step of coming forward. A September 2015 report from the Committee on Homeland Security and Governmental Affairs stated the Office of Special Counsel (OSC) has received 35 percent of its entire retaliation caseload from VA employees. Despite its efforts to prioritize investigations, Special Counsel Carolyn Lerner testified before Congress in August of this year that the volume of incoming VA complaints remains overwhelming. This clearly demonstrates the severe, dysfunctional culture within the VA that encourages retaliation against the very individuals who expose harm to the veteran and attempt to improve the healthcare delivery process.

There are many journeys we all participate in during the course of our lifetime. Some are arduous, many are attainable, but none has been more agonizing and unfulfilling than the current process of obtaining justice for the men and women who have fought for our freedom. I realize that not every complex situation in life presents itself with moral clarity, however this is not one of them. There should never be a single instance where a physician must choose between self-preservation and the life of a patient. Or suffer an assault to their character in order to obtain accountability for criminal and inhumane acts against patients and fraudulent behavior towards the taxpayer. The amount of bureaucratic gymnastics coupled with agency corruption can render the strongest individual forlorn and exhausted. Knowing when to lose with grace in an honorable skill and one that requires precise timing—this is not that time. Armed with voracity for equity, an insatiable appetite for the truth and a colossal amount of evidence, I am prepared to continue this battle until there is responsibility from leadership and transformative action which will hold those at fault accountable.

My personal journey began over 4½ years ago with exposure to the corruption at Hines regarding patients who died of cardiac complications while awaiting their cardiac ultrasound to be read. Unfortunately for them the tests were hidden in bankers boxes and left unread for a year. The mere questioning of such an egregious act re-

sulted in significant retaliation, which went unabated the entire 2 years I was employed at Hines VA Medical Center. But hell hath no fury like a VA Administration scorned, and the retaliation continued even after I resigned, with the Office of Inspector General (OIG) and its pervasive culture of disparaging the truth teller. Multiple allegations regarding deficiencies in cardiovascular care were made including, but not limited to: patients having their chest sawed open for unnecessary procedures, disparities in care based on ethnicity, procedural diagnostic errors and billing fraud. These allegations have resulted in an initial deficient OIG investigation, a subsequent OSC investigation, a second contemptible OIG investigation, insistence from the OSC for an authentic and thorough investigation, and culminating with an ongoing Office of Medical Inspector's (OMI) investigation. It is a mind-numbing process to not only keep track of the endless acronyms but also calculating the amount of taxpayer dollars this course of action has taken.

The path this case has taken over the last 4 years has been objectively obfuscated, and its bureaucratic oscillations can only be the result of stunning deficiencies at all levels of the Veterans Health Administration (VHA) leadership. The task has become the exercise within itself. To engage in multiple investigations by varying internal agencies which have substantiated patient harm as well as criminal activity, and to never mention one, single word regarding accountability, one can only conclude this dysfunctional behavior is designed to serve the agency itself, and not the veterans. It is the VHA leadership attempting to gain credit for oversight that the agency has failed to provide. Duplicitous. No other word describes it.

The OMI report from July 2015 substantiated my allegations regarding deficiencies in cardiovascular care, deficiencies in echocardiogram processing, failure to disclose deficiencies in care and harm to patients, inflated productivity measures by cardiologists, and evidence that veterans were inappropriately charged copayments for care they did not receive, otherwise known as billing fraud. In regards to the billing fraud, the report states, "We found that these actions possibly violate 18 U.S. Code 208—Acts affecting a personal financial interest". The OMI referred this criminal matter to the OIG who has declined to open a criminal investigation.

Interestingly the bulk of the report is dedicated to the fraudulent billing practices, including in depth statistical analysis, diagrammatic explanations and extensive billing pattern documentation. This provides a glaring contrast to the lack of investigative fervor and expertise when dealing with patient morbidity and mortality. However all this effort is for naught as the end result once again allows the documented criminal activity to go unpunished. For the agency to demand an OMI investigation yet deny the credibility of criminal findings is administrative misconduct. The OIG must adhere to the Quality Standards for Investigations issued by the Council of Inspectors General on Integrity and Efficiency (CIGIE) and the Attorney General Guidelines for OIG with Statutory Law Enforcement Authority. You don't get to be above the law just because you work for the VHA. Or do you? An equally compelling question is, if the OMI substantiated findings are ignored, why do we need any of these investigative arms within the VA?

To sum up the totality of all the reports to date is to call them a mismatch between words and deeds. A failed promise to treat and protect the veterans, while instead protecting hundreds of useless report generators who will then retire with benefits. The investigators have gone so far out of their way to protect the VHA leadership that it has rendered every investigator impotent and every investigative finding ineffectual. They are highly skilled at one part of their job, generating a paper trail designed to justify their professional existence. But they have failed at their original mission statement and severely compromised the healthcare of the men and women who have fought for our freedom.

In order for any type of transformative action to begin to take shape and halt systemic corruption, there must be protection for truth tellers, accountability for those who fail at their duties and transparency to illuminate both operational deficiencies but also properly analyze collected data. These are far from novel concepts and are most certainly codified in policy and procedure. Chairman Kirk's VA Patient Protection Act will demand accountability for those who retaliate against truth tellers and empower those who can begin to make a positive impact on the outcomes of patient care. Preventing retaliation in the current dysfunctional culture of the VA requires deterrents, which should be timely, formidable and indelible. This bill would properly punish VA supervisors who have been found to take retaliatory actions against whistleblowers. There can be no saving of an agency as large as the VHA if the employees operate from a constant position of fear, rather than transparency and collaboration.

An additional step towards agency accountability that can be addressed by Congress is extending legislative authority to the OSC in two arenas:

—Allow the agency to embark on a criminal investigation or partner with the Department of Justice if the preponderance of evidence suggests illegal activity and

—Grant the OSC the necessary authority to determine the corrective action and punishment once the allegations are substantiated.

They have independent authority to determine if conduct constitutes a violation of law, rule, gross mismanagement and a substantial and specific danger to public health. If they can determine the crime, they should be allowed to determine the punishment.

Many people have asked me why I continue to fight for the veterans even though I have left the VA. “What can you do?” I want the American public to contemplate that question for a moment and then consider an alternative perspective, and perceive it as “What should I do?”—the only acceptable response would be to strive for the truth.

Which brings us to the truth. A glorious, unadulterated supreme reality, holding the ultimate meaning and value of existence, corroborated by evidence. It does not change over time, as it never has to rely on anybody else’s interpretation.

UNREAD ECHOCARDIOGRAMS

Senator KIRK. Thank you, Dr. Nee.

So to summarize, the thing that you found when you went to work for Hines, as a cardiologist, you found boxes and boxes of echocardiograms. For someone having an echocardiogram, that means they have some signs of heart disease.

And if I can summarize, when you looked through these boxes and boxes of echocardiograms, you had found some of the veterans had passed already?

Dr. NEE. That is true. Looking up their names to initiate a report, the system tells you if someone has expired or not.

Senator KIRK. And when you said that, hey, we should follow up with these patients because they have heart disease, what did the VA at Hines say?

Dr. NEE. Hines wanted me to be readily aware that they already knew that the boxes were there and that it was my job to be quiet and continue to read.

That is nothing even remotely close to what you would experience in the private sector. A risk management team would have been involved. There would have been accountability. Patients would have been notified. Patients would have been offered additional testing in an urgent manner.

Senator KIRK. In a normal civilian hospital, if the hospital did not read the echocardiogram and the patient died, would that be grounds for a malpractice lawsuit?

Dr. NEE. Absolutely. Absolutely.

Senator KIRK. So many of these veterans had no idea that they had severe medical heart issues because the VA never even bothered to read the echocardiogram?

Dr. NEE. That is correct. And you are taking advantage of a population in two manners. You are taking advantage because they have no choice for their healthcare, so they are presenting to you and expecting you to react in a responsible manner. And now they are not even being notified that there may be something wrong or harm may come to them because of this delay.

Senator KIRK. Could you estimate for the subcommittee how many patients’ echocardiograms were in those boxes that were never read?

Dr. NEE. There were hundreds, so my best estimation would be——

Senator KIRK. So they were doing echocardiograms and not even looking at them?

Dr. NEE. Correct.

It was just another box to check. The test was ordered. We will do it. Put it in the box. Do not worry about it.

RETALIATION TO WHISTLEBLOWERS

Senator KIRK. You were also confirmed by the Office of Medical Inspector, who said this was an improper thing. What was the follow-up when the Office of Medical Inspector said that you were right in calling out this problem?

Dr. NEE. Well, the problem with all these agencies is even if you can get the allegation substantiated, the report then goes back to the agency itself. So Hines VA received the report from the OMI before I ever knew about it. And unfortunately, the people who came forward to testify to the OMI were retaliated against.

So not only are you not holding people accountable, you are placing a chilling effect on the entire institution that people should never come forward because nothing will change and they will be harmed along with the patient.

Senator KIRK. Before when you testified before my subcommittee, you described this retaliation mechanism that they have against physicians where they would try to pull your Statewide credentials, so you would not be able to practice as a cardiologist.

Dr. NEE. Well, I think what they do to you is, your first 2 years as a physician, you are probationary. So even if you recognize problems and/or the retaliation is so bad you want to leave, if you leave before that 2 years, they will alter your H.R. record, and it will be listed that you were fired, which pretty much puts an end to your career. So you have to stay the 2 years, regardless of what is going on, to make sure that your record is clean.

Senator KIRK. So if you report a problem like you reported, they will put in your H.R. record that you were fired?

Dr. NEE. Correct.

Senator KIRK. And you will lose accreditation to practice medicine in another hospital?

Dr. NEE. It would look very suspicious to anyone else hiring, why you were fired from the Veterans Administration.

Senator KIRK. Let us go to our next witness, Germaine Clarno. Let me call Germaine Clarno to the table.

Germaine is the president of Local 781 of the American Federation of Government Employees, the union that represents the workers at Hines.

Germaine, if you could continue your statement.

**STATEMENT OF GERMAINE CLARNO, LCSW, PRESIDENT, AFGE LOCAL
781, EDWARD HINES, JR. VA HOSPITAL, CHICAGO, ILLINOIS, DE-
PARTMENT OF VETERANS AFFAIRS**

Ms. CLARNO. Thank you. Senator Kirk, I want to thank you for the opportunity to provide my testimony to discuss the culture of continued fear and retaliation at the Edward Hines Jr. Hospital.

I also want to personally thank you for your support. If it wasn't for your involvement, I don't know if I would have the strength to withstand the constant retaliation I continue to experience.

You have also shown me that it is possible for a Republican and a Democrat, who is also a union leader, that we can work together. So thank you.

I am a social worker and local president of the American Federation of Government Employees (AFGE), and a very proud whistleblower and truth-teller. I have worked at Edward Hines Jr. Hospital in Illinois for 6 years, 2 years after receiving a master's in social work.

Social work is a second career, and it was important to me that I work with veterans, so I was elated with the opportunity to work at the VA. It has been an honor and a privilege to serve our Nation's veterans in the capacity of a mental health provider.

I worked alongside amazing, dedicated employees that shared the same passion for helping our veterans heal from the invisible wounds of war.

Unfortunately, I experienced early in my career the toxic culture of fear. Asking a simple question or a suggestion can result in career sabotage. I witnessed good-intentioned, professional employees be retaliated against for simply wanting to raise issues that interfered with quality care for our veterans.

After 3 years working in mental health, I had experienced and witnessed deplorable treatment of employees that dared to speak up against fraud, waste, and abuse. My dedication to our veterans convinced me to explore means to improve the culture at Hines. The root cause was mistreatment of frontline employees that did not have a voice or an advocate.

I then became chief steward of Local 781 at Hines. With determination and the union contract, I optimistically marched onward with an honored mission to change the culture at Hines. The master agreement, our union contract, states in our preamble the department and the union agree that a constructive and cooperative working relationship between labor and management is essential to achieving the department's mission and to ensuring a quality work environment for all employees. This agreement is not honored by the leadership at Hines.

They spend more time finding loopholes of the contract and ways not to comply with this simple agreement, which is also an element of Secretary McDonald's Blueprint for Excellence. He states, "The VA will become an organization where employees are comfortable raising issues and concerns. Only then can we truly thrive and innovate." This plan for change was published a year ago, and employees are still afraid more than ever.

During my time as a union representative, I have seen firsthand the obstacles for employees to perform at the highest level due to

an environment that is not conducive to enhancing employee morale or efficiency.

In the fall of 2012, after exhausting all avenues with our chain of command, Dr. Lisa Nee came to me, as other employees have, with overwhelming evidence of wrongdoing by leadership at Hines.

The severe retaliation that Dr. Nee experienced as a result of her disclosure is not unique. Retaliation at Hines is a systematic campaign of interpersonal destruction that jeopardizes employees' health, careers, and the jobs they once loved.

These forms of retaliation are a nonphysical form of violence. But because it is violence and it is abusive, emotional harm often is the result.

It has been over a year since I disclosed wrongdoing at Hines in regard to the wait list, scheduling manipulation, and excessive wait time for veterans requesting individual therapy for post-traumatic stress disorder (PTSD) on the CBS Evening News. The very next day after my disclosure, the Hines leadership had a meeting without my knowledge in the chapel of the hospital with approximately 300 of my coworkers from Mental Health.

That day, 300 employees were taken away from their work areas and were not serving veterans. The purpose of this meeting was to discredit my claims and turn my coworkers against me.

The same day, I received emails and voicemails from my supervisor ordering me to contact and report to the Criminal Division of the OIG on Hines' campus.

What was more outrageous is the leadership's attempt to discredit a veteran who was also in this news story by sharing information from his medical chart, blaming him for the delays by saying that he canceled appointments and was a no-show. Veterans are not immune to the retaliation at Hines.

I wish I could report that things have improved at Hines but the sad truth is, it has not. Just the past couple weeks, employees have been severely retaliated against.

One of these employees is Jasmine Ramakrishna. Jasmine has given me permission to tell her story today. Jasmine is a dental hygienist at Hines. Like most of our frontline employees, she is dedicated to serving veterans. She has reported wrongdoing on issues in the dental clinic to include unnecessary procedures for the purpose of increasing productivity, and issues with assessments and coding procedures.

As a result of her raising concerns, she is currently being retaliated against. Jasmine has always been rated outstanding on her performance appraisal, but when she received her performance appraisal a few weeks ago, her rating was lowered.

Jasmine and I met with her supervisor to discuss her rating, and he responded that she violated the VA Code of Conduct. Jasmine has never been counseled or informed of any wrongdoing. But in this meeting, he referenced a folder that contained information that he said he has on her and is refusing to share with the employee.

As you can imagine, this is devastating for this employee. This is an example of a supervisor using his power to make false allegations and violate the law to harass and intimidate an employee.

The union has filed grievances, and he is refusing to respond. As a result, the union has filed two separate unfair labor practices with the Federal Labor Relations Authority against the agency.

The same supervisor, the chief of the dental clinic, is also harassing another employee, a dentist. The supervisor is asking coworkers to do surveillance on him. After a meeting I had with the supervisor to notify him that asking coworkers to surveillance other employees is not appropriate and it is illegal, he called the police on me and made false reports that I was aggressive and threatening him.

This event took place just this past Monday. Ironically, Senator Kirk, one of your staff members was in my office when the police came and witnessed the harassment.

That same day, I notified Hines leadership of this disgraceful conduct, and I have not received a reply.

Another form of retaliation is to ignore the complaint or justify the supervisor's behavior.

My concern is for our veterans. Employees are being intimidated and retaliated against for speaking up for quality care. The Nation's veterans pay that price. In order to retain the best and brightest healthcare providers to serve the needs of our Nation's heroes, we must rid our workplace of the toxic retaliatory practices engaged by this management. Thank you.

[The statement follows:]

PREPARED STATEMENT OF GERMAINE M. CLARNO

Senator Kirk, thank you for the opportunity to provide my testimony to discuss the culture of continued fear and retaliation at Edward Hines, Jr Hospital.

I also want to personally thank you for your support. If it wasn't for your involvement I don't know if I would have had the strength to withstand the constant retaliation I continue to experience. You have also shown me that it is possible for a republican and democrat, who is also a union leader that we can work together.

I am a social worker and local president of the American Federation of Government Employees (AFGE). I have worked at Edward Hines, Jr. Hospital in Illinois for 6 years, 2 years after receiving a masters in social work. Social work is a second career, it was important to me that I work with veterans so I was elated with the opportunity to work at the VA. It has been an honor and privilege to serve our Nation's veterans in the capacity of a mental health provider. I have worked alongside amazing dedicated employees that share the same passion for helping our veterans heal from the invisible wounds of war.

Unfortunately, I experienced early in my career the toxic culture of fear. Asking a simple question or suggestion can result in career sabotage. I witnessed good intentioned professional employees be retaliated against for simply wanting to raise issues that interfered with quality healthcare for our veterans. After 3 years working in mental health, I had experienced and witnessed deplorable treatment of employees that dared to speak up against fraud, waste and abuse. My dedication to our veterans convinced me to explore means to improve the culture at Hines. The root cause was mistreatment of frontline employees that did not have a voice or an advocate. I then became a chief steward for Local 781 at Hines, with determination and the union contract, I optimistically marched onward with an honored mission to change the culture at Hines.

The Master Agreement (our union contract) states in our preamble "The Department and the Union agree that a constructive and cooperative working relationship between labor and management is essential to achieving the Department's mission and to ensuring a quality work environment for all employees".

This agreement is not honored by the leadership at Hines. They spend more time finding loop holes of the contract and ways not to comply with this simple agreement, which is also an element of Secretary McDonald's "Blue Print for Excellence." He states "VA will become an organization where employees are comfortable raising issues and concerns. Only then, can we truly thrive and innovate". This plan for change was published a year ago and employees are still afraid, more than ever.

During my time as a union representative I have seen firsthand the obstacles for employees to perform at the highest level due to an environment that is not conducive to enhancing employee morale and efficiency. In the fall of 2012, after exhausting all avenues within her chain of command, Dr. Lisa Nee came to me, as other employees have with overwhelming evidence of wrongdoing by the leadership at Hines.

The severe retaliation that Dr. Nee experienced as the result of her disclosure is not unique. Retaliation at Hines is a systematic campaign of interpersonal destruction that jeopardizes employee's health, careers, and the jobs they once loved. These forms of retaliation is a non-physical form of violence, but because it is violence and abusive, emotional harm often is the result.

It's been over a year since I first disclosed wrong doing at Hines in regards to waitlist, scheduling manipulation and excessive wait time for veterans requesting individual therapy for PTSD on CBS evening news. The very next day of my disclosure the Hines leadership had a meeting without my knowledge, in the chapel, with approximately 300 of my coworkers from mental health. That day 300 employees were taken away from their work areas and were not serving veterans. The purpose of the meeting was to discredit my claims and turn my co-workers against me. That same day I received emails and voicemails from my supervisor ordering me to report to the criminal division of the OIG on Hines Campus.

What was more outrageous is that leadership attempted to discredit a veteran that also was in this news story by sharing information from his medical chart. Blaming him for the delays by saying that he cancelled appointments or was a no show. Veterans aren't immune to retaliation at Hines.

I wish I could report that things have improved at Hines but the sad truth is it has not. Just in the past couple of weeks employees have been severely retaliated against. One of these employees is Jasmine Ramakrishna. Jasmine gave me permission to tell her story today. Jasmine is a Dental Hygienist at Hines, like most of our front line employees she is dedicated to serving veterans. She has reported wrongdoing on issues in the dental clinic to include unnecessary procedures (for the purpose of increasing productivity) and issues with assessments and coding procedures. As a result of her raising concerns, she is currently being retaliated against. Jasmine has always been rated outstanding on her performance appraisals but when she received her performance appraisal a few weeks ago her rating was lowered. Jasmine and I met with her supervisor to discuss her rating and he responded that she has violated the VA Code of Conduct. Jasmine has never been counseled or informed of any wrongdoing but in this meeting he referenced a folder that contained information that he "has on her" and is refusing to share with the employee. As you can imagine this is devastating for this employee. This is example of a supervisor using his power to make false allegations and violate the law to harass and intimidate an employee. The union has filed grievances and he is refusing to respond. As a result, the union has filed two separate Unfair Labor Practices with the Federal Labor Relations Authority against the agency.

This same supervisor, the Chief of the Dental clinic is also harassing another employee, a dentist. This supervisor is asking co-workers to surveillance him. After a meeting I had with this supervisor to notify him that asking co-workers to surveillance other employees is not appropriate and is illegal, he called the police and made a false report that I was aggressive and threatening him. This event took place just this past Monday. Ironically, one of Senator Kirk's staff members was in my office when the police arrived and witnessed the harassment. That same day I notified Hines leadership of this disgraceful conduct and I have not received a reply. Another form of retaliation is to ignore the complaint or justify the supervisor's behavior.

My concern is for our veterans. When employees are being intimidated and retaliated against for speaking up for quality care, the Nation's veterans pay the price. In order to retain the best and brightest healthcare providers, to service the needs of our Nation's heroes, we must rid our workplace of the toxic, retaliatory practices engaged in by management.

PROTECTING THE PROTECTORS

Senator KIRK. Germaine, let me just follow up. That is pretty brazen. Senate staff is in with you, and they are sending in the police to harass you. That is a pretty brazen feeling that nobody can touch them.

Ms. CLARNO. Right.

Senator KIRK. In your case, as president of the union, let me ask you how many union members do you have at 781?

Ms. CLARNO. We represent approximately 1,000 bargaining unit members. I represent the professionals at the hospital.

Senator KIRK. So you have 1,000 people taking care of our veterans at Hines.

Ms. CLARNO. Yes.

Senator KIRK. In your job of protecting the protectors, I would think you are particularly vulnerable to retaliation. Given the fact that this is a Democratic administration that is very pro-union, do you feel any benefit by being a union leader, that you are simply carrying out your duties that you were elected to do to care for union members?

Ms. CLARNO. I do, and it is because of the union I belong to. That is the reason that I took on these roles, because I thought I could proceed, bring up issues of fraud, waste, and abuse and illegal actions, and be able to—

HINES VAMC WAIT LIST

Senator KIRK. Germaine, let me get into our work together. I have been able to get you to meet with the Secretary of Veterans Affairs Robert McDonald. Since you have met with Robert McDonald and the White House Deputy Chief of Staff Robert Nabors, has the wait list problem improved at Hines at all?

Ms. CLARNO. Well, the VA is very good at, when they get caught doing one thing, they create another way to manipulate. So they are not doing the same tactics, because they got busted. But now what they are doing is they are overbooking and double-booking.

I just talked to a scheduler yesterday who came to me and said she has veterans coming into the clinic, four veterans scheduled for one appointment, say 9 o'clock in the morning, three veterans for 10, 11. So what happens is, the experience of the veteran is that they wait all day to see a provider.

So that is now the gaming system that they are doing. So now they can say we are meeting the benchmark of 30 days, and we are getting the veteran an appointment. But the appointment is to come and spend the day at Hines. If they do not get seen, and most of them do not, they are sent home and then it is on them. They canceled the appointment.

Dr. NEE. And those no-shows are counted against them.

Senator KIRK. Even though the veteran is there in the hospital, it is listed as an appointment canceled by a patient.

Ms. CLARNO. Right.

PERFORMANCE AWARDS

Senator KIRK. You have gone through extensively the bonus program, which I have looked into, in which the Hines VA paid over \$16 million in bonuses to employees there. And you have told me that to get these bonuses, they have been falsifying work, claiming to have done work that they did not actually do. Can you describe the bonus system, how it works, and the culture of corruption at Hines?

Ms. CLARNO. Well, all employees in their performance appraisal, whether you are a physician, a chief of staff, a director, a social

worker, a pharmacist, we all have critical elements, standard elements. One of them is access to care. That is a critical element that they look at. It is the first element that they look at.

So you are being rated on access to care. So that translates into getting veterans appointments, not access to real care, but to just get them an appointment on the books.

Senator KIRK. Germaine, as a social worker, I would think that you are pretty much on the frontline of making sure that veteran suicide is as low as possible. In your case, I think that frontline job is to make sure a veteran never makes that tragic decision to end his own life.

Ms. CLARNO. Absolutely.

MENTAL HEALTH TREATMENT

Senator KIRK. If people are manipulating the wait times, then somebody in crisis could make that decision and you could have avoided it. I want to make sure people understand just how important your work is at the VA.

Ms. CLARNO. Absolutely. And I think that, in mental health, one of the issues that I disclosed was in mental health and veterans accessing individual treatment for PTSD.

They are placed in groups, and I consider them holding pens, so that they are waiting for individual appointments. If I was to seek a therapist in the private sector, and I was having thoughts and nightmares and having the effects of PTSD, I could get in to see someone within 24 hours.

Senator KIRK. Did any of your veterans commit suicide while in one of your holding pens when they could not see you?

Ms. CLARNO. No, not that I am aware of. But they should not have to suffer.

Senator KIRK. Right.

Ms. CLARNO. They are barely holding onto life. Their family no longer knows who they are. With PTSD and traumatic brain injury (TBI), there are anger issues. They have a hard time focusing. They are losing their job. Domestic violence is a big piece, because they do not know how to handle civilian life. And they are suffering.

It is our job and responsibility when a veteran, first of all, has the courage to come and say, "I need help," that is not always an easy thing for our soldiers. Immediately, they should be taken in to see an individual therapist for crisis.

Senator KIRK. If an individual veteran says, "Hey, I am thinking about committing suicide," is there a way to make sure that you see him right away?

Ms. CLARNO. In Hines, I have to be honest, we do a good job of that, because of the frontline employees, because we care. I know social workers that will sit in the waiting room for hours with a veteran because they have exhibited some signs of suicide ideation and they do not want to leave them alone. So they will sit there and wait and wait and wait long hours until they are seen.

Senator KIRK. I would like to now hear the testimony of Lydia Dennett from the Project on Government Oversight, who has flown in from Washington, an investigator.

Lydia, you are recognized by the subcommittee.

STATEMENT OF LYDIA DENNETT, INVESTIGATOR, PROJECT ON GOVERNMENT OVERSIGHT

Ms. DENNETT. Chairman Kirk, thank you for inviting me to testify today, as well as for your leadership and ongoing interest in this issue.

My name is Lydia Dennett, and I am an investigator at the Project on Government Oversight (POGO), a nonpartisan, independent watchdog that champions good government reforms. I personally have been working on issues at the Department of Veterans Affairs since the allegations at Phoenix first came to light. I have been the point of contact at POGO for hundreds of whistleblowers who shared their stories with us.

If it were not for whistleblowers, none of us would be aware of the extent of problems at the VA. The bravery of Doctors Mitchell and Foote from Phoenix caused an avalanche of reports from whistleblowers at VA facilities across the country.

Last year, 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 our 34-year history, POGO has 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 multiple credible submissions from 35 States and the District of Columbia, and a recurring and fundamental theme became clear. VA employees across the country feared they would face repercussions if they dared to raise a dissenting voice, but they came forward anyway.

I want to emphasize this means there were extraordinary numbers of people who work inside the VA system who care so much about the mission of the department that they were willing to put their lives at risk to come forward in order to fix it. Some were willing to be interviewed by POGO and to be quoted by name, but others said they contacted us anonymously because they are still employed at the VA and are worried about retaliation.

For example, from right here in Illinois at the Hines Hospital, we received several allegations of scheduling manipulations. These whistleblowers described VA staff members improperly canceling and rescheduling veteran appointments, as well as fake waiting lists hiding the fact that some vets were waiting 4 or more months for an appointment.

The majority of the current or former Hines employees decided to remain anonymous out of fear of retaliation. One stated, "I can't reveal my name as I fear retribution from my supervisors and other staff members. I need my job and would surely lose it for telling you any of this."

VA whistleblowers are supposed to be able to turn to the VA's Office of Inspector General, but many have come to doubt the VA Inspector General's willingness to protect them or to hold wrongdoers accountable. These fears appear to be well-founded.

We believe the VA Inspector General has been an example of oversight at its worst. Last year, in the midst of our investigation, the VA Inspector General issued a subpoena to POGO demanding all records we received from current or former VA employees. Of course, POGO refused to comply with the subpoena. However, it

was understandably cause for concern for many of the whistleblowers who had come to us and caused a chilling effect.

It was only thanks to your interest and support, Chairman Kirk, that the new Acting Inspector General dropped the subpoena against POGO 3 months ago.

In comparison, the Office of Special Counsel has been working to investigate claims of retaliation and get favorable actions for many of the VA whistleblowers who have come forward. In 2014 and 2015 alone, the OSC has achieved favorable actions for 116 VA whistleblowers. Last year, the VA surpassed the Defense Department in the number of cases filed with the OSC for the first time, even though the Defense Department has twice the number of civilian employees as the VA.

We commend the OSC's good work and commitment to helping VA whistleblowers. But merely addressing isolated incidents is not enough. The cultural shift that is required inside the VA cannot be accomplished without legislation that codifies accountability for those who retaliate against whistleblowers.

POGO is extremely pleased to note that this has been included in your Veteran Patient Protection Act, as it has been missing in other pending VA legislation. This bill would punish VA supervisors who have been found to take retaliatory actions against whistleblowers first with a 12-day unpaid suspension, and if a second offense is committed, the removal of the supervisor.

Additionally, we are glad to see that how supervisors handle whistleblower complaints will be included as criteria for their annual review and that bonuses will not be awarded to those who have retaliated against whistleblowers.

It is POGO's hope that this legislation will ensure that whistleblowers can expose wrongdoing confident that it will not result in retaliation. Your bill, Chairman Kirk, gives teeth for protecting VA employees. But Congress should also extend whistleblower protections to contract employees and veterans who raise concerns about medical care provided by the VA.

We have heard countless stories from veterans who fear reporting problems to their doctors or even patient advocates because they worry their medications will be stopped or they will not be able to get another appointment for months.

Additionally, we urge the Senate to vote and, if found to be qualified, confirm the President's recent nomination for a permanent VA Inspector General as soon as possible.

POGO also recommends that VA Secretary McDonald make a tangible and meaningful gesture to support those whistleblowers who have been trying to fix the VA from the inside. Secretary McDonald should personally meet with whistleblowers and elevate their status from villain to hero.

The Government has failed in its sacred responsibility to care for our veterans. It is our collective duty to help the whistleblowers who have taken the risks to fix this broken agency and improve care for our veterans across the country.

[The statement follows:]

PREPARED STATEMENT OF LYDIA DENNETT

Chairman Kirk, thank you for inviting me to testify today, as well as for your leadership and ongoing interest in the care of our veterans. I am Lydia Dennett, an investigator at 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

I want to first point out that if it were not for whistleblowers, none of us would be aware of the extent of the problems at the Department of Veterans Affairs. Early last year, whistleblowers came forward to expose that managers at the Phoenix, Arizona, VA facility were falsifying records of extensive wait times in order to get personal bonuses.¹ Quickly, news 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 Department of Veterans Affairs before, we were deeply concerned about what we were seeing in these reports. In an unusual move for us, 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 our 34-year history, POGO has 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 fundamental theme became clear: VA employees across the country feared they would face repercussions if they dared to raise a dissenting voice. But they came forward anyway—the sheer number was overwhelming. I want to emphasize this important point: this means there were extraordinary numbers of people who work inside the VA system who care so much about the mission of the Department that they were still willing to risk their livelihood to come forward in order to fix it.

Based on what POGO learned from these whistleblowers, we wrote a letter to Acting VA Secretary Sloan Gibson in July last year, highlighting three specific cases of current or former employees who agreed to share details about their personal experiences of retaliation.³

From right here in Illinois, at the Hines VA Medical Center, we received several allegations of scheduling manipulations. These whistleblowers described VA staff members improperly canceling and rescheduling veteran appointments, as well as fake waiting lists hiding the fact that some vets were waiting four or more months for an appointment. The majority of the current or former Hines employees decided to remain anonymous out of fear of retaliation. One stated, “I can’t reveal my name as I fear retribution from my supervisors and other staff members. . . . I need my job, and would surely lose it for telling you any of this.”

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 former 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 alleged 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

¹Scott 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).

²Statement 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>.

³Letter 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>.

⁴Letter 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.

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 former 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. “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 said. 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,” she said.

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 are still employed at the VA and are 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 has been experiencing.

VA employees who have concerns about management or fear retaliation are supposed to be able to turn to the VA’s Office of Inspector General (OIG). But whistleblowers had come to doubt the VA Inspector General’s willingness to protect them or to hold wrongdoers accountable.

OVERSIGHT AT ITS WORST

These fears appear to be well-founded. In May 2014, the VA Inspector General’s office issued an administrative subpoena to POGO that was little more than an invasive fishing expedition for whistleblowers who had come to us in confidence. The Inspector General demanded “All records that POGO has received from current or former employees of the Department of Veterans Affairs, and other individuals or entities.”⁶ Though POGO refused to comply with the subpoena, such an action was cause for concern for many of the whistleblowers who had shared information with us. We believe this extraordinary step created an understandable chilling effect, and the number of VA whistleblowers coming to POGO slowed to a trickle in the following months.

In June of this year, the VA Inspector General’s office attacked POGO again. In an unusual step, the VA OIG submitted a statement to the Senate Homeland Security and Governmental Affairs Committee raising concerns about POGO’s investigation into the VA.⁷ However, the OIG could provide almost no relevant or specific evidence to support its own claims or rebut POGO’s arguments. The very next day the VA OIG sent a white paper to all HSGAC members as well as 22 other Members of Congress publicly attacking victims and whistleblowers at the VA Medical Center in Tomah, Wisconsin.⁸

Less than a month later, Acting Inspector General Richard Griffin suddenly stepped down from his position. We were pleased to see that the new Acting Inspector General, Linda Halliday, released two statements detailing steps she plans to take to improve the Inspector General’s whistleblower protection program, including seeking certification by the Office of Special Counsel.⁹

Furthermore, at the request of Chairman Kirk, Acting Inspector General Halliday dropped the subpoena against POGO. We greatly appreciate Chairman Kirk’s con-

⁵Letter 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.

⁶Letter from Richard Griffin, then-Acting Inspector General, Department of Veterans Affairs, to Project On Government Oversight, regarding subpoena to POGO, May 30, 2014.

⁷Department of Veterans Affairs, Office of Inspector General, statement regarding the Senate Homeland Security and Governmental Affairs Committee’s hearing, “Watchdogs Needed: Top Government Oversight Investigators Left Unfilled for Years,” submitted on June 25, 2015, p. 3. http://www.pogoarchives.org/m/va_oversight/va_oig_statement_for_record_20150603.pdf.

⁸Department of Veterans Affairs, Office of Inspector General, “OIG Releases White Paper on Evidence Supporting Administrative Closure of 2014 Tomah, WI, VA Medical Center Inspection on Opioid Prescription Practice,” June 4, 2014. (Downloaded July 22, 2015).

⁹Linda Halliday, Department of Veterans Affairs, Office of Inspector General, “Deputy Inspector General Announces Steps to Strengthen Whistleblower Protection Training for OIG Employees,” July 10, 2015. <http://www.va.gov/oig/pubs/press-releases/VAOIG-WhistleblowerProtectionsPressRelease.pdf> (Downloaded July 22, 2015); Linda Halliday, Department of Veterans Affairs, Office of Inspector General, “Deputy Inspector General Announces Steps to Strengthen OIG Whistleblower Protection Ombudsman Program,” <http://www.va.gov/oig/pubs/press-releases/VAOIG-%20Ombudsmen-%2007-15-15.pdf> (Downloaded July 22, 2015).

tinued support and applaud his commitment fixing these issues at the VA, perhaps best evidenced by the VA Patient Protection Act he introduced just this week.

VA PATIENT PROTECTION ACT

The cultural shift that is required inside the Department of Veterans Affairs cannot be accomplished without legislation that codifies accountability for those who retaliate against whistleblowers. This important piece has been missing in other pending VA legislation but is one of the strongest aspects of Chairman Kirk's VA Patient Protection Act.

This bill would punish VA supervisors who have been found to take retaliatory actions against whistleblowers, first with a 12-day unpaid suspension, and if a second offense is committed, the removal of the supervisor. Additionally we are glad to see that how supervisors handle whistleblower complaints will be included as criteria for their annual review, and that bonuses will not be awarded to those who have retaliated against whistleblowers.

Preventing retaliation is also key to fixing the culture at the VA. We are pleased to see that The VA Patient Protection Act requires annual training for all VA employees on prohibited personnel actions, which includes retaliating against whistleblowers as a prohibited action. Further, VA employees will receive an explanation of all the methods they can use to report wrongdoing. This bill would also create a new formal process for VA whistleblowers to file complaints within the VA, to be handled by a new Central Whistleblower Office, separate from the VA's General Counsel Office. This office will be required to report to Congress the number of complaints filed and how the Secretary addressed those complaints.

It is POGO's hope that this legislation will ensure that whistleblowers can step forward to expose wrongdoing, confident that it will not result in retaliation.

RECOMMENDATIONS

In POGO's 2014 letter, we recommended concrete steps incoming VA Secretary McDonald could take in order to demonstrate an agency-wide commitment to changing the VA's culture of fear, bullying, and retaliation. Neither then-Acting Secretary Sloan Gibson nor Secretary McDonald responded to our multiple requests for a meeting.

POGO also recommended that Secretary McDonald make a tangible and meaningful gesture to support those whistleblowers who have been trying to fix the VA from the inside. Once the OSC has identified meritorious cases, Secretary McDonald should personally meet with those whistleblowers and elevate their status from villain to hero. These employees should be publicly celebrated for their courage, and should receive positive recognition in their personnel files, including possibly receiving the types of personal bonuses that managers who had been falsifying records received in the past. This should not be an isolated event done in response to recent criticisms but an ongoing effort. Whistleblowing must be encouraged and celebrated or wrongdoing will continue.

Although then-Acting Secretary Gibson did attend an OSC event honoring VA whistleblowers, such high-profile recognition of whistleblowers needs to take place at the VA facilities themselves. For the culture at the VA to change, we believe this is a simple but meaningful step.

Additionally, the VA still does not have a permanent Inspector General in place. That position has been vacant for over 670 days—over a year and a half.¹⁰ Our own investigations have found that the absence of permanent and competent leadership can have a serious impact on the effectiveness of an Inspector General office.¹¹ Acting Inspector Generals do not undergo the same kind of extensive vetting process required of permanent Inspector Generals, and as a consequence usually lack the credibility of a permanent Inspector General. Acting Inspector Generals also often seek appointment to the permanent position, which can compromise their independence by giving them an incentive to curry favor with the White House and the leadership of their agency.¹² Perhaps most worrisome, given the significant challenges facing the VA Inspector General, a 2009 Southern California Law study found that vacancies in top agency positions promote agency inaction, create confusion among

¹⁰Project On Government Oversight, "Where Are All the Watchdogs?" <http://www.pogo.org/tools-and-data/ig-watchdogs/go-igi-20120208-where-are-all-the-watchdogs-inspector-general-vacancies1.html>.

¹¹Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs? Addressing Inspector General Vacancies," May 10, 2012. (Hereinafter Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs?")

¹²Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs?"

career employees, make an agency less likely to handle controversial issues, result in fewer enforcement actions by regulatory agencies, and decrease public trust in government.¹³ POGO urges the Senate to vet and, if qualified, confirm President Obama's nomination for a permanent VA Inspector General as soon as possible.

On the other hand, the OSC has been working to investigate claims of retaliation and get favorable actions for many of the VA whistleblowers who have come forward. In 2014 and 2015 alone, the OSC has achieved favorable actions for 116 VA whistleblowers. But the OSC still has nearly 100 pending VA reprisal cases for disclosing concerns about patient care or safety, among the highest of any government agency, according to Special Counsel Carolyn Lerner.¹⁴ POGO recommends that Congress consider appropriating additional funds to this agency to help with the increased workload.

But it's not just the OSC, VA Secretary, or Inspector General who can work to fix this problem. Congress should enact legislation, like Chairman Kirk's VA Patient Protection Act, to increase protections for VA whistleblowers and hold their retaliators accountable.

POGO also urges 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. Contractors are only currently protected under a pilot program, but need permanent statutory protections. 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 healthcare. Without this reassurance, there is a disincentive to report poor care, allowing it to continue uncorrected.

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.

The Government has failed in its sacred responsibility to care for our veterans. It is our collective duty to help the whistleblowers who have taken risks to fix this broken agency.

VA RETALIATION COMPLAINTS

Senator KIRK. Let me follow up, Lydia, to sum up, as I understand it, POGO got about 800 whistleblowers who contacted it about problems in the VA. The Inspector General demanded you hand over the names of all those whistleblowers.

In your view, what would have happened if you had given the Inspector General the names of all those whistleblowers?

Ms. DENNETT. We believe that they would have been retaliated against. We have heard from several whistleblowers who did not contact the Inspector General anonymously and the Inspector General went back to their hospitals and revealed their names, and they were subsequently retaliated against by their supervisors.

Senator KIRK. So since the hearing that we had with the Acting Inspector General, they have now backed down on that subpoena and you have not provided those names. So we could say that those 800 whistleblowers are all protected, and the Inspector General does not even know who they are.

Ms. DENNETT. Yes, correct.

Senator KIRK. Let me pull up a board that we have made, showing the rising number of retaliation complaints at the Department of Veterans Affairs, rising from about 291 to 712. It is a pretty alarming rising there.

¹³ Anne Joseph O'Connell, "Vacant Offices: Delays in Staffing Top Agency Positions," *Southern California Law Review*, Vol. 82, 2009.

¹⁴ Testimony of Carolyn Lerner, Special Counsel U.S. Office of Special Counsel on "Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers," September 22, 2015. <http://www.hsgac.senate.gov/hearings/improving-va-accountability-examining-first-hand-accounts-of-department-of-veterans-affairs-whistleblowers> (Downloaded November 2, 2015).

Lydia, could you comment on that?

Ms. DENNETT. Yes. It is not surprising based on what we have been hearing ever since the doctors in Phoenix came forward in 2014. I think that gave some confidence to other employees there that they could also come forward, or should come forward to report the kinds of problems at Phoenix and other kinds from all over the country.

Senator KIRK. Germaine, I would just say, normally, you would not expect people who work at Hines VA would get a highway sign. You guys have been responsible for this sign that says, "VA is lying and veterans are dying." What led you to get the sign to be put up?

Ms. CLARNO. It really came from VA employees who wanted to help the cause, but were too afraid to come forward in any other way. So this came from an idea from a VA employee. And I contacted Ron Nestler, who is a veteran who has a Facebook page. We collected funds. It is not an inexpensive thing to do, to put a billboard up in Chicago. But we collected money and the Facebook group also contributed to helping.

Senator KIRK. So how many folks do you have on Facebook with you after this sign went up?

Ms. CLARNO. Part of not only being a local president, a social worker, after I made my disclosure on CBS Evening News, I got calls from all around the country from whistleblowers. I started a Facebook page—

Senator KIRK. Germaine, I wanted to get into that. You have talked to a number of employees around the country who are also in your union, and they have described the same kind of retaliation. You suspect there is a retaliation memo, and that they all get retaliation of the same kind. Can you describe the disturbing similarities that you have seen?

Ms. CLARNO. Sure. We often joke that there must be a manual on how to retaliate against whistleblowers, because it is the same. They will start with the harassment and intimidation, and it will just proceed from there to such a point that there are whistleblowers around the country that have been hospitalized in psychiatric wards for suicide ideation, for depression. It is shocking.

The sacrifices that truth-tellers make to protect our veterans is very alarming, and the numbers are very high.

Senator KIRK. I want to present one last board where we have seen that the Department of Justice has decided to prosecute a number of people at the VA for poor medical care. At places like Florida and Ohio and Tennessee, we have seen people prosecuted for poor care.

Lisa, could you comment on that, this lack of prosecution that we have seen?

Dr. NEE. Well, it is glaringly obvious. Health and Human Services has partnered with the Department of Justice to go after physicians who commit fraud, so they can recover the funds. It is clear that the exact same law that is used by them for prosecuting people is ignored in Hines.

Many physicians at Hines have committed these exact acts word for word. Not only are they not prosecuted, the Hines VA is allowed to then investigate itself to make any corrective action, which is ludicrous. You would never allow a criminal to investigate them—

selves and then come back to you with their plan of action to not do that again.

It is a very scary thought, I think, for good physicians and for any patient.

Senator KIRK. All right, I will start to wrap up. Let me finish with a closing statement.

It is totally demoralizing for us to hear all of this about our own VA taking care of the best of the best, the men and women of the greatest generation that saves civilization who get terrible treatment like this.

We need to focus on legislation to protect the protectors and to make sure that medical professionals like the ones we heard from are able to report mistreatment of a veteran and ensure high quality for that veteran.

CONCLUSION OF HEARINGS

Senator KIRK. I will close this hearing. We are adjourned.

[Whereupon, at 1:53 p.m., Friday, November 6, the hearings were concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]