Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. Senate
Committee on Appropriations
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies

"Review of Whistleblower Claims at the Department of Veterans Affairs"

July 30, 2015, 10:30 A.M.

Chairman Kirk, Ranking Member Tester, and Members of the Subcommittee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our work with whistleblowers at the Department of Veterans Affairs (VA). Since April 2014, our office has seen a dramatic increase in the number of whistleblower cases from VA employees. These cases fall into two categories, retaliation complaints and disclosures of misconduct.

In response to retaliation complaints, we have secured relief for dozens of VA whistleblowers, helping courageous employees restore successful careers at the VA. The number of victories for whistleblowers is increasing steadily, with improved cooperation from the VA and our expedited review process for retaliation complaints. In 2015, we will more than double the total number of favorable outcomes for whistleblowers achieved in 2014.

Our work with whistleblowers in disclosure cases has improved the quality of care for veterans throughout the country and promoted accountability. The VA has disciplined or proposed discipline for 40 employees as a result of the wrongdoing identified by whistleblowers in disclosures to OSC. These actions include the termination of employees who failed to properly safeguard patient information and the suspension of four employees who improperly handled and restocked expired prescription drugs.

This statement describes our process for investigating retaliation complaints and reviewing whistleblower disclosures. It provides updated statistical information on case numbers and outcomes, and summarizes recent cases in which OSC secured relief for whistleblowers. Finally, it highlights areas of concern from the investigation and review of hundreds of these claims.

OSC Investigations of Whistleblower Retaliation Complaints

A. Process

OSC investigates allegations of whistleblower retaliation, one of the thirteen "prohibited personnel practices" that federal employees may challenge with our office. After receiving a retaliation complaint, we conduct an investigation to determine whether the employee has been fired, demoted, suspended, or subjected to some other personnel action because the employee blew the whistle. If OSC can demonstrate that a personnel action was retaliatory, we work with the agency to provide relief to the employee. Relief can include reinstatement, back pay, and

other remedies, including monetary damages. OSC also commonly works with the agency involved to implement systemic corrective actions, such as management training on whistleblower protections. Frequently, we resolve cases through alternative dispute resolution, including mediation. If the agency does not agree to provide the requested relief to the employee, either through mediation or based on our investigative findings, we have the authority to initiate formal litigation on behalf of the whistleblower before the Merit Systems Protection Board (MSPB). In egregious cases, we can also petition the MSPB for disciplinary action against a subject official.

B. VA Retaliation Complaints, by the Numbers

Government-wide, OSC is on track to receive over 3,800 prohibited personnel practice complaints in 2015. Over 1,300 of these complaints, or approximately 35%, will be filed by VA employees. In 2014, for the first time, the VA surpassed the Department of Defense in the total number of cases filed with OSC, even though the Defense Department has twice the number of civilian employees as the VA.

We have taken a number of steps to better respond to this tremendous surge in VA complaints. We reallocated a significant percentage of our program staff to work on VA cases. I assigned our deputy special counsel to supervise investigations of VA cases, and we hired an experienced senior counsel to further coordinate our investigations of VA cases. We prioritized the intake and initial review of all VA health and safety related whistleblower complaints and streamlined procedures to handle these cases. And, we established a weekly coordinating meeting on VA complaints with senior staff and case attorneys.

Although we have dedicated more staff and resources to these investigations, the volume of incoming VA complaints remains overwhelming. As I noted in testimony before the House Committee on Veterans' Affairs (HVAC) last year, the number and "severity of these cases underscores the need for substantial, sustained cooperation between the VA and OSC as we work to protect whistleblowers and encourage others to report their concerns." I am pleased to report that we are receiving that cooperation from VA leadership.

Working with the VA's Office of General Counsel (OGC), we implemented an expedited review process for whistleblower retaliation cases. This process allows OSC to present strong cases to the VA at an early stage in the investigative process, saving significant time and resources. To date, we have obtained 22 corrective actions for VA whistleblowers through this process, including a landmark settlement on behalf of Dr. Katherine Mitchell, who testified today, and two other Phoenix VA Medical Center (Phoenix VAMC) employees. The Phoenix VAMC cases were the first to be settled through the expedited program. My April 2015 testimony before HVAC summarized a number of the other cases we resolved in collaboration with the VA through the expedited process. I have attached that statement for reference.

Last week, OSC announced the resolution of three additional VA whistleblower complaints. These cases are summarized here:

Ryan Honl – Mr. Honl was a secretary in the mental health unit at the Tomah VA Medical Center in Tomah, Wisconsin. In addition to other concerns, he disclosed the alleged excessive prescription of opiates to patients. On the same day he made a disclosure to the VA Office of Inspector General, the VA stripped Mr. Honl of his job duties, locked him out of his office, and isolated him from co-workers. Shortly thereafter, he resigned. The VA and Mr. Honl settled his complaint with Mr. Honl receiving several corrective actions, including the removal of negative information from his personnel file and monetary damages.

Joseph Colon Christensen – Mr. Colon is a credentialing support specialist with the VA Caribbean Health System in San Juan, Puerto Rico. Mr. Colon reported concerns relating to patient care at his facility and information about alleged improper conduct by the director of his facility. In September 2014, two days after a newspaper called the facility's director asking for comment on a story about the director's conduct, the facility's chief of staff issued Mr. Colon a notice of proposed removal. In late December, the VA replaced the proposed removal with a three-day suspension and detailed him to a different position. Prior to his disclosures, Mr. Colon had an unblemished disciplinary history at the VA and had received "outstanding" performance reviews. The VA and Mr. Colon settled his retaliation complaint with Mr. Colon receiving several corrective actions, including the repeal of his suspension, a return to his position, and compensatory damages.

Troy Thompson – Mr. Thompson is a food services manager with the Philadelphia VA Medical Center. In 2012, Mr. Thompson reported management inaction on disciplinary issues and several violations of VA sanitation and safety policies, including a fly and pest infestation in facility kitchens. On the same day he made these disclosures to his supervisor, the supervisor detailed Mr. Thompson to the VA's Pathology and Lab Service pending an investigation into him for eating four expired sandwiches worth a total of $5. His new job mostly consisted of janitorial work, including sanitizing the morgue and handling human body parts. Mr. Thompson already had admitted that he ate and gave away the sandwiches instead of disposing of them per VA practice. After the VA investigation concluded he had stolen government property (the sandwiches), he was issued a proposed removal and fined $75. Mr. Thompson spent over two years on the detail and was under the pending removal for most of that time. The VA ultimately took positive steps to address his case by reassigning him to his previous position and rescinding the proposed removal. OSC determined, however, that the VA also owed Mr. Thompson compensatory damages, which the VA has agreed to provide as part of a settlement.

These are important victories for employees who risked their professional lives to improve VA operations and patient care. In addition to cases resolved through the expedited relief program, we are steadily increasing the number of corrective actions in all VA cases. In 2014 and 2015 to date, OSC has secured either full or partial relief 99 times for VA employees who filed whistleblower retaliation complaints, including 66 in fiscal year 2015 alone. These positive outcomes are generated by the OSC-VA expedited settlement process, OSC's normal

investigative process, and OSC's Alternative Dispute Resolution, or mediation, program. In addition, OSC is also currently reviewing the retaliatory conduct of six managers in three locations for possible disciplinary action.

OSC currently has 316 active VA whistleblower retaliation cases in 43 states, the District of Columbia, and Puerto Rico. Approximately 100 of these pending cases allege retaliation for blowing the whistle on a patient health or safety concern. We will continue to update the Committee as we resolve additional cases in the coming months.

Whistleblower Disclosures

A. Process

In addition to protecting employees from retaliation, OSC also provides federal workers a safe channel to disclose violations of law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific threat to public health or safety. Unlike our role in retaliation complaints, OSC does not have investigative authority in disclosure cases. Rather, OSC plays a critical oversight role in agency investigations of alleged misconduct.

After receiving a disclosure from a federal employee, OSC evaluates the information to determine if there is a "substantial likelihood" that wrongdoing exists. If OSC makes a "substantial likelihood" determination, we transmit the information to the head of the appropriate agency. The agency head, or their designee, is required to conduct an investigation and submit a written report on the investigative findings. The whistleblower is given the opportunity to comment on the agency report. After we review the agency report and the whistleblower comments, we transmit them with our analysis to the President and Congress and place the information on our web site.

This process promotes accountability and is transparent. We require agencies to investigate difficult subjects. And, the process empowers whistleblowers, most often the subject matter experts in the issues they have raised, to assess the quality of the agency investigation. In recent years, the OSC disclosure process has prompted significant changes in government operations, including an effort to modernize the pay structure for Border Patrol Agents, an action that saves taxpayers approximately $100 million a year—an amount over four times the size of OSC's annual budget.

At the VA, our work with whistleblowers led to an overhaul of the VA's internal medical oversight office, the Office of the Medical Inspector (OMI), and has prompted positive changes throughout the department. For reference, I have attached my July 2014 testimony before HVAC, which provides a detailed summary of OSC's prior efforts to promote accountability through our disclosure program.

B. VA Disclosure Cases, by the Numbers

Government-wide, OSC will receive nearly 2,000 whistleblower disclosures from federal employees in 2015.[1] At current levels, approximately 750, or 37.5%, of these disclosures will be filed by VA employees.

Through OSC's disclosure channel, VA whistleblowers have identified and set in motion corrective action plans to address significant threats to the health and safety of veterans. For example, numerous whistleblowers at the Jackson, Mississippi VAMC helped to remedy chronic under-staffing in the Primary Care Unit, improper prescriptions of narcotics, and unsanitary medical equipment. A whistleblower at a Brockton, Massachusetts VA community living center exposed extreme shortcomings in the care provided to long-term mental health patients. And, two whistleblowers at a VA clinic in Fort Collins, Colorado, were among the first to identify VA efforts to manipulate data on patient wait times. These efforts all led to positive changes at the facility involved, leaving leaving the hospital, clinic, and living center better able to provide quality care to veterans.

As stated above, I have attached my prior testimony to the Veterans Affairs' Committee, which provides more extensive summaries of these cases and others. The reports are also available in the public file on OSC's website. https://osc.gov/Pages/Resources-PublicFiles.aspx.

These employees' efforts not only improve the care provided to veterans, they also promote accountability and help to deter future misconduct. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct identified by whistleblowers in disclosures to OSC. Some of these actions include:

- Four pharmacy employees were suspended for the improper handling of prescription drugs as identified by a whistleblower in West Palm Beach, Florida.

- Six employees were disciplined for pressuring employees to manipulate scheduling and wait time data in a case brought to light by two whistleblowers in Fort Collins, Colorado and Cheyenne, Wyoming. (One of the six, a high-level employee, retired pending a proposed removal.)

- Two employees were disciplined, including one receiving a notice of proposed removal, for not properly reporting an alleged sexual assault, as disclosed by a whistleblower in Syracuse, New York.

[1] Each year, OSC receives a number of cases that are inadvertently filed by federal employees as disclosures of wrongdoing, and properly should have been filed as retaliation complaints because the employee is seeking to remedy a personnel action. OSC is in the process of modernizing its online complaint filing system to make it more user-friendly and intuitive. With a smarter, more user-friendly interface for federal employees, the new system will greatly diminish the historical problem of wrongly-filed disclosure forms. By diminishing the number of wrongly filed disclosure cases, the new system will provide a more accurate, but lower number of disclosure cases received in FY2016 and beyond. The changes may increase the number of retaliation complaints.

- A manager was disciplined for misrepresenting time spent in counseling sessions with veterans. The VA is currently reviewing the regional leadership's responsibility for lack of oversight on this issue in a case brought to OSC by a whistleblower in Federal Way, Washington.

- A physician received a reprimand and ultimately resigned after a whistleblower in Montgomery, Alabama, exposed that the physician had cut and pasted medical records and vital signs, rather than taking current readings. OSC has requested that the VA review the appropriateness of the level of disciplinary action taken in this case.

- Five employees received disciplinary actions, including two terminations, for failing to safeguard patient information, as disclosed by a whistleblower in Jackson, Mississippi.

- A total of 12 employees in multiple locations have been disciplined for improperly accessing a whistleblower's medical records.

OSC is in the process of reviewing the VA reports generated in response to disclosures made by Drs. Mitchell and Nee, who you heard from today. After our review and the whistleblowers' have the opportunity to comment, we will formally transmit the information to the Veterans Affairs Committees and the President.

I cannot go into detail on the content of these reports at this time. However, I can say that Dr. Mitchell and Dr. Nee exemplify the courage and tenacity that is necessary to overcome obstacles to change in an organization like the VA. While work still needs to be done, their efforts will lead to improved emergency care in Phoenix and improved cardiology care at Hines.

Indeed, we were delighted to present Dr. Mitchell with OSC's "Public Servant of the Year" award at a ceremony last year. At the event, VA Deputy Secretary Sloan Gibson commented on the importance of whistleblowers in prompting change. About Dr. Mitchell, he specifically noted, "[W]hile we still have vast work to do, I believe that it's because of Dr. Katherine Mitchell that access to care in Phoenix is beginning to improve." I can certainly add that it is because of Dr. Lisa Nee that cardiology care is beginning to improve at Hines. I applaud both of these heroes.

Areas of Ongoing Concern

In my April 2015 testimony, I highlighted several ongoing areas of concern in our investigation and review of VA whistleblower cases. As stated, my April 2015 statement is attached here for reference. I want to add detail today on two of the issues I identified in April, accessing employees' medical records and retaliatory investigations. Also, I will discuss our concern about the pace of culture change within the local facilities and regional levels of the VA.

A. Accessing Whistleblowers' Medical Records

An ongoing concern is the accessing of employee medical records in order to discredit whistleblowers. In many instances, VA employees are themselves veterans and receive care at VA hospitals. In several cases, the medical records of whistleblowers have been accessed by those who had no legitimate reason for doing so, in some instances with the apparent motive of using the information contained in those records to discredit the whistleblowers. We have pursued and will continue to pursue relief for these whistleblowers and discipline for those who improperly access medical records. In February of this year, in a referral of a whistleblower disclosure, I notified the VA that it should consider system-wide corrective action to avoid these types of breaches.

We have started to look more closely at this important issue. While we are not experts on record-keeping systems, our review of multiple cases in which an employee alleged improper access of their records leads us to believe that certain systemic changes could deter the retaliatory, accidental, and curiosity-fueled searches of whistleblowers' records.

First, the VA should implement an IT fix to its records-keeping systems to make it more difficult for an employee to access a fellow employee's medical records. The VA should determine the most cost-effective way to both deter improper access to records while still ensuring that those with a legitimate need to access the records can do so easily. Quite simply, it is too easy right now for a mischief-minded employee to enter the medical record system and access information on his or her coworkers. That should not be the case. A better "lock" on the system would potentially eliminate, and certainly reduce, this problem.

Second, a broader problem seems to exist within VistA—the Veterans Health Information Systems and Technology Architecture—or, the VA's Health IT system. VA employees routinely access the VistA system in order to obtain administrative and personnel information for employees. This use of a health information system to obtain both employment and medical information is problematic because it causes unnecessary searches of the medical records system, often to receive demographic information such as an employee's mailing address. In multiple investigations of improper access of medical records, the VA's justification for the searches was to access employee data, not medical information. Even where these searches are justified by VA procedures, there is a clear threat to an employee's privacy when medical records are accessed every time demographic or employment information is needed by HR or a manager. I understand that the VistA system may be undergoing a modernization effort. We believe the VA should address how to better segregate medical records from personnel or administrative information as part of this modernization effort.

B. Retaliatory Investigations

From a whistleblower protection standpoint, there are limitations in OSC's ability to address retaliatory access of medical records and other forms of retaliatory investigations. I should note that the VA has fully cooperated with our investigations and requests for review of improper records searches. However, a policy change may be appropriate to better equip OSC to address this unique form of retaliation.

The whistleblower law allows OSC to seek relief in cases where there has been a concrete personnel action, such as a termination, demotion, suspension, or a decision concerning pay. Congress has not included "an investigation" as a personnel action that we can stop or fix, even if the reason for launching the investigation is retaliation for whistleblowing. There are obviously competing interests at stake. An agency needs to be able to conduct investigations of its employees, and managers should not feel chilled from investigating misconduct because it could lead to a whistleblower complaint. At the same time, current law leaves a gap in coverage for whistleblowers who are subjected to retaliatory investigations, including medical records searches.

It is important to address these more subtle forms of retaliation, which have a negative effect on the whistleblower and their employment, and may chill others from blowing the whistle. However, under the current state of the law, it can be very difficult to challenge these less concrete retaliatory tactics. We will continue to investigate these actions as appropriate, but closing the statutory gap in our enforcement power may ultimately require a legislative fix.

C. Culture Change within the VA

Another ongoing concern is that the cooperation and commitment we are seeing at VA headquarters has not consistently filtered down to the regions. For example, regional counsels do not necessarily have a clear understanding of what constitutes appropriate treatment of whistleblowers. In many cases, the regional counsel is the person who signed off on the very same retaliatory action that OSC challenges, and therefore should not be handling the individual case, or advising managers about their legal responsibilities.

We think that the VA General Counsel's recent efforts to re-orient and sensitize regional counsel through training and other clear directives are extremely helpful and should be continued and expanded. We are particularly pleased that the General Counsel asked OSC staff to meet with VA regional counsels from all over the country this past April, and hope that we can continue such efforts. Also, OSC provided several high-level officials within the VA with in-person "train the trainers" training on whistleblower issues. Those officials can now act as force multipliers to go out and train others throughout the VA.

It is worth noting that no other agency in the federal government, much less one the size of the VA, has taken such a proactive approach to training managers on whistleblower protections. The VA deserves recognition for this important initiative.

Conclusion

We appreciate the Committee's attention to the issues we have raised and your interest in our efforts to protect and promote VA whistleblowers. I thank you for the opportunity to testify, and am happy to answer your questions.

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Special Counsel Carolyn N. Lerner

The Honorable Carolyn N. Lerner heads the United States Office of Special Counsel. Her five-year term began in June 2011. Prior to her appointment as Special Counsel, Ms. Lerner was a partner in the Washington, D.C., civil rights and employment law firm Heller, Huron, Chertkof, Lerner, Simon & Salzman, where she represented individuals in discrimination and employment matters, as well as non-profit organizations on a wide variety of issues. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was a mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights.

Ms. Lerner earned her undergraduate degree from the University of Michigan, where she was selected to be a Harry S. Truman Scholar, and her law degree from New York University (NYU) School of Law, where she was a Root-Tilden-Snow public interest scholar. After law school, she served two years as a law clerk to the Honorable Julian Abele Cook, Jr., Chief U.S. District Court Judge for the Eastern District of Michigan.

Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

"Addressing Continued Whistleblower Retaliation Within the VA"

April 13, 2015, 4:00 P.M.

Chairman Coffman, Ranking Member Kuster, and Members of the Subcommittee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our ongoing work with whistleblowers at the Department of Veterans Affairs (VA).

In July of last year, I spoke to this Committee about OSC's early efforts to respond to the unprecedented increase in whistleblower cases from VA employees. Since that time, and as detailed in the sections below, there has been substantial progress. For example, OSC and the VA implemented an expedited review process for retaliation claims. This process has generated timely and comprehensive relief for many VA whistleblowers. In addition, in response to OSC's findings, the VA overhauled the Office of Medical Inspector (OMI), and has taken steps to better respond to the patient care concerns identified by whistleblowers. Finally, in response to the influx of whistleblower claims, the VA became the first cabinet-level department to complete OSC's "2302(c)" whistleblower certification program. The program ensures that employees and managers are better informed of their rights and responsibilities under the whistleblower law.

Despite this significant progress, the number of new whistleblower cases from VA employees remains overwhelming. These cases include disclosures to OSC of waste, fraud, abuse, and threats to the health and safety of veterans, and also claims of retaliation for reporting such concerns. OSC's monthly intake of VA whistleblower cases remains elevated at a rate nearly 150% higher than historical levels. The percentage of OSC cases filed by VA employees continues to climb. OSC has jurisdiction over the entire federal government, yet in 2015, nearly 40% of our incoming cases will be filed by VA employees. This is up from 20% of OSC cases in 2009, 2010, and 2011.

These numbers provide an important overview of the work OSC is doing. And, while these numbers point to an ongoing problem, it is important to put them in context. The current, elevated number of VA whistleblower cases can be viewed as part of the larger effort to restore accountability at the VA, and do not necessarily mean there is more retaliation than before the scheduling and wait list problems came to light, or that there are more threats to patient health and safety. Instead, these numbers may indicate greater awareness of whistleblower rights and greater employee confidence in the systems designed to protect them.

The current VA leadership has shown a high level of engagement with OSC and a genuine commitment to protecting whistleblowers. As many VA officials and Members of this Committee have repeatedly stated, culture change in an organization the size of the VA is

difficult and will take time. But, if the current number of whistleblower cases is an indication of employees' willingness to speak out, then things are moving in the right direction.

I. Whistleblower Retaliation – Collaboration with the VA to Provide Expedited Relief to VA Employees

My July 2014 statement to the Committee summarized a series of whistleblower retaliation cases. I noted, "The severity of these cases underscores the need for substantial, sustained cooperation between the VA and OSC as we work to protect whistleblowers and encourage others to report their concerns." I further noted that Acting (now Deputy) Secretary Gibson had committed to resolving meritorious whistleblower retaliation cases with OSC on an expedited basis.

Since that time, OSC, working in partnership with the VA's Office of General Counsel (OGC), implemented an expedited review process for whistleblower retaliation cases. This process has generated significant and timely results on behalf of VA employees who were retaliated against for speaking out. To date, we have obtained 15 corrective actions for VA whistleblowers through this process, including landmark settlements on behalf of Phoenix VA Medical Center (VAMC) employees. Summaries of the cases in which the employees consented to the release of their names are included below:

- **Katherine Mitchell, Phoenix VAMC** – Dr. Mitchell blew the whistle on critical understaffing and inadequate triage training in the Phoenix VAMC's emergency room. According to Dr. Mitchell's complaint, Phoenix VAMC leadership engaged in a series of targeted retaliatory acts that included ending her assignment as ER Director. Dr. Mitchell has 16 years of experience at the Phoenix VAMC, and also testified twice before this Committee last year. Among other provisions, Dr. Mitchell's settlement included assignment to a new position that allows her to oversee the quality of patient care.

- **Paula Pedene, Phoenix VAMC** – Ms. Pedene was the chief spokesperson at the Phoenix VAMC, with over two decades of experience. She made numerous disclosures beginning in 2010, including concerns about financial mismanagement by former leadership at the medical center. Many of the allegations were substantiated by a November 2011 VA Office of Inspector General review. Subsequently, according to Ms. Pedene's reprisal complaint, Phoenix VAMC management improperly investigated Pedene on unsubstantiated charges, took away her job duties, and moved her office to the basement library. Among other provisions, Ms. Pedene's settlement includes assignment to a national program specialist position in the Veterans Health Administration, Office of Communications.

- **Damian Reese, Phoenix VAMC** – Mr. Reese is a Phoenix VAMC program analyst. He voiced concerns to Phoenix VAMC management about the amount of time veterans had to wait for primary-care provider appointments and management's efforts to characterize long wait times as a "success" by manipulating the patient records. After making this disclosure, Mr. Reese had his annual performance rating downgraded by a senior official

with knowledge of his email. Mr. Reese agreed to settle his claims with the VA for mutually agreed upon relief.

- **Mark Tello, Saginaw VAMC** – Mr. Tello was a nursing assistant with the VAMC in Saginaw, Michigan. In August 2013, he told his supervisor that management was not properly staffing the VAMC and that this could result in serious patient care lapses. The VAMC then issued a proposed removal, which was later reduced to a five-day suspension that Mr. Tello served in January 2014. The VA again proposed his removal in June 2014. OSC facilitated a settlement where the VA agreed, among other things, to place Mr. Tello in a new position at the VA under different management, to rescind his suspension, and to award him appropriate back pay.

- **Richard Hill, Frederick, MD** – Dr. Hill was a primary care physician at the Fort Detrick, Community Based Outpatient Clinic (CBOC) in Frederick, Maryland, which is part of the Martinsburg, West Virginia VAMC. In March 2014, Dr. Hill made disclosures to VA officials, the VA Office of Inspector General, and others regarding an improper diversion of funds that resulted in harm to patients. Specifically, Dr. Hill expressed serious concerns about the lack of clerical staff assigned to his primary care unit, which he believes led to significant errors in patient care and scheduling problems. In early May 2014, the VA issued Dr. Hill a reprimand. Dr. Hill retired in July 2014. As part of the settlement agreement between Dr. Hill and the VA, the VA has agreed to, among other provisions, expunge Dr. Hill's record of any negative personnel actions.

- **Rachael Hogan, Syracuse VAMC** – Ms. Hogan is a registered nurse (RN) with the VAMC in Syracuse, New York. She disclosed to a superior a patient's rape accusation against a VA employee and, when the superior delayed reporting the accusations to the police, warned the superior about the risks of not timely reporting the accusations. Later, she complained that a nurse fell asleep twice while assigned to watch a suicidal patient and that another superior engaged in sexual harassment, and made a number of other allegations regarding the two superiors. In spring 2014, the two superiors informed Ms. Hogan that they would seek a review board to have her terminated because of her "lack of collegiality" and because she was not a good fit for the unit, and gave her an unsatisfactory proficiency report. The VA agreed to stay the review board for the duration of OSC's investigation. As part of the final settlement, the agency permanently reassigned Ms. Hogan to a RN position under a new chain of command, corrected her performance evaluation, and agreed to cover the costs for an OSC representative to conduct whistleblower protection training at the facility.

- **Charles Johnson**, **Columbia VAMC** – Mr. Johnson, a technologist in the radiology department at the VA Medical Center in Columbia, South Carolina, disclosed that a doctor ordered him to hydrate a patient using a new, unfamiliar method in February 2014. Due to his concerns about the new hydration method, Mr. Johnson consulted with two physicians about the method, neither of whom would verify the method's safety. Mr. Johnson then contacted his union, which suggested he send an email seeking clarification of the method under the VA's "Stop The Line For Patient Safety" policy. In July 2014,

Mr. Johnson was issued a proposed five-day suspension by the same doctor whose hydration method Mr. Johnson had questioned. In October 2014, at OSC's request, the VA agreed to stay Mr. Johnson's suspension. In February 2015, Mr. Johnson and the VA settled his case, under which the VA will, among other things, rescind the proposed suspension and evaluate the hydration method.

- **Phillip Brian Turner, San Antonio, TX** – Mr. Turner is an advanced medical support assistant in a VA Behavioral Health Clinic in San Antonio, Texas. In April 2014, Mr. Turner emailed his supervisor and others about his concerns that the agency did not follow proper scheduling protocols and may have falsified or manipulated patient wait times for appointments. The next day, VA management instructed him to stop emailing about the VA's scheduling practices. Several weeks later, in May 2014, VA management directed Mr. Turner to sign four copies of the VA's media policy, which he refused to do. On May 9, 2014, an article in the San Antonio Express-News—one of the largest newspapers in Texas—quoted a high-level VA official as stating that the agency had conducted an investigation into Mr. Turner's allegations and that Mr. Turner retracted his comments about the improper scheduling practices. Mr. Turner denies making any such retraction. The VA's actions in this case raise important concerns due to the potential chilling effect on other whistleblowers. The case was settled in February 2015 and the VA agreed to several corrective actions.

- **Debora Casados, Denver, CO** – Ms. Casados is a nurse in the VA Eastern Colorado Health Care System. In August 2014, she reported that a coworker sexually assaulted two other VA staff members and made inappropriate sexual comments to her. Human resources told Ms. Casados and the other staff that they were not permitted to discuss the allegations and threatened them with disciplinary action if they did so. In October, human resources removed Ms. Casados from her nursing duties at the clinic and reassigned her to administrative tasks. In January 2015, she was moved again, this time to a windowless basement office to scan documents. In February, her superior denied Ms. Casados leave to care for her terminally ill mother. On April 3, 2015, the VA agreed to OSC's request for an informal stay on behalf of Ms. Casados, returning her to nursing duties at another clinic while OSC investigates her whistleblower reprisal claims to determine if additional corrective action and disciplinary action are appropriate.

Including these cases, in 2014 and 2015 to date, OSC has secured either full or partial relief for over 45 VA employees who have filed whistleblower retaliation complaints. OSC is on track to help nearly twice as many VA employees in 2015 as in 2014. These positive outcomes have been generated by the OSC-VA expedited settlement process, OSC's normal investigative process, and OSC's Alternative Dispute Resolution program. OSC is currently examining about 110 pending claims of whistleblower retaliation at the VA involving patient health and safety, scheduling, and understaffing issues. These pending claims involve VA facilities in 38 states and the District of Columbia. We look forward to updating the Committee as these cases proceed.

II. Whistleblower Disclosures and the Office of Medical Inspector

In my July 2014 testimony, I raised concerns about the VA's longstanding failure to use the information provided by whistleblowers as an early warning system to correct problems and prevent them from recurring. I summarized a series of cases in which the Office of Medical Inspector (OMI) identified deficiencies in patient care, such as chronic understaffing in primary care units, and the inadequate treatment of mental health patients in a community living center. In each case, OMI failed to grasp the severity of the problems, attempted to minimize concerns, and prevented the VA from taking the steps necessary to improve the quality of care for veterans.

In response to our concerns, the VA directed a comprehensive review of all aspects of OMI's operations. Overall, we believe this review has resulted in positive change. A recent whistleblower case is demonstrative.

The case concerns a whistleblower disclosure from a VA employee in Beckley, West Virginia. In response to OSC's referral, OMI conducted an investigation and determined that the Beckley VAMC attempted to meet cost savings goals by requiring mental health providers to prescribe older, cheaper antipsychotic medications to veterans, to alter the current prescriptions for veterans over the objections of their providers, with no clinical review or legitimate clinical need for the substitutions, in violation of VA policies. The investigation additionally found the substituted medications could create medical risks and "may constitute a substantial and specific risk" to the health and safety of impacted veterans. In addition, the OMI investigation found that the formal objections of at least one mental health provider were not documented in the meeting minutes at which the provider raised concerns.

The OMI investigation called for a clinical care review of the condition and medical records of all patients who were impacted, and an assessment of whether there were any adverse patient outcomes as a result of the changed medications. OMI also recommended that, where warranted, discipline be taken against Beckley VAMC leadership and those responsible for approving actions that were not consistent with VA policy, and which could constitute a substantial and specific danger to public health and the safety of veterans.

While the facts of this case are troubling, the OMI response is encouraging. In an organization the size of the VA, problems will occur. Therefore, it is critical that when whistleblowers identify problems, they are addressed swiftly and responsibly. And OMI is an integral component in doing so.

In recent days, we have received additional information from whistleblowers indicating that the OMI recommendations may not have been fully implemented by Beckley VAMC management. Accordingly, we will follow up with the VA to verify that all OMI recommendations in the Beckley investigation, including disciplinary action and necessary changes to the prescription protocol, have been taken.

III. Training Initiatives and Areas of Ongoing Concern

A. OSC's 2302(c) Certification Program

In my July 2014 statement to the Committee, I referenced the VA's commitment to complete OSC's "2302(c)" Certification Program. In October 2014, the VA became the first cabinet-level department to complete OSC's program. The OSC Certification Program allows federal agencies to meet their statutory obligation to inform their workforces about the rights and remedies available to them under the Whistleblower Protection Act, the Whistleblower Protection and Enhancement Act (WPEA), and related civil service laws. The program requires agencies to complete five steps: (1) Place informational posters at agency facilities; (2) Provide information about the whistleblower laws to new employees as part of the orientation process; (3) Provide information to current employees about the whistleblower laws; (4) Train supervisors on their responsibilities under the whistleblower law; and (5) Display a link to OSC's website on the agency's website or intranet.

The most important step in this process is the training provided to supervisors. Ideally, this training is done in person with OSC staff, to provide an opportunity for supervisors to ask questions and engage in a candid back and forth session. However, in an organization the size of the VA, with tens of thousands of supervisors, in-person training is extremely difficult to accomplish. Nevertheless, at the VA's initiative, we are working to develop "train the trainer" sessions, so we can reach as many supervisors as possible in real time. We also anticipate presenting information on the whistleblower law at an upcoming meeting of VA regional counsel.

Based on the claims OSC receives, VA regional counsel will benefit from additional training on whistleblower retaliation. Such training will assist in preventing retaliatory personnel actions from being approved by the legal department at local facilities, and will also help to facilitate resolutions in OSC matters. The commitment we are seeing from VA leadership to correct and eliminate retaliation against whistleblowers has not consistently filtered down to regional counsel. Supplemental training for regional counsel may go a long way to address that issue.

B. Investigation of Whistleblowers

An additional and ongoing area of concern involves situations in which a whistleblower comes forward with an issue of real importance to the VA—for example, a cover-up of patient wait-times, sexual assault or harassment, or over-prescription of opiates—yet instead of focusing on the subject matter of the report, the VA's investigation focuses on the whistleblower. The inquiry becomes: Did the whistleblower violate any regulations in obtaining the evidence of wrongdoing? Has the whistleblower engaged in any other possible wrongdoing that may discredit his or her account?

There are two main problems with this approach. First, by focusing on the individual whistleblower, the systemic problem that has been raised may not receive the attention that it deserves. And second, instead of creating a welcoming environment for whistleblowers to come

forward, it instills fear in potential whistleblowers that by reporting problems, their own actions will come under intense scrutiny.

The VA's focus—not just at headquarters, but throughout the department—should be on solving its systemic problems, and holding those responsible for creating them accountable. While there may be instances in which an individual whistleblower's methods are particularly troublesome and therefore require investigation, such an investigation should be the exception and not the rule, and should only be undertaken after weighing these competing concerns.

C. Accessing Whistleblowers' Medical Records

A final, related issue of ongoing concern is the unlawful accessing of employee medical records in order to discredit whistleblowers. In many instances, VA employees are themselves veterans and receive care at VA hospitals. In several cases, the medical records of whistleblowers have been accessed and information in those records has apparently been used to attempt to discredit the whistleblowers. We will aggressively pursue relief for whistleblowers in these and other cases where the facts and circumstances support corrective action, and we will also work with the VA to incorporate these additional forms of retaliation into our collaborative training programs.

IV. Conclusion

We appreciate this Committee's ongoing attention to the issues we have raised. I thank you for the opportunity to testify, and am happy to answer your questions.

*****

Special Counsel Carolyn N. Lerner

The Honorable Carolyn N. Lerner heads the United States Office of Special Counsel. Her five-year term began in June 2011. Prior to her appointment as Special Counsel, Ms. Lerner was a partner in the Washington, D.C., civil rights and employment law firm Heller, Huron, Chertkof, Lerner, Simon & Salzman, where she represented individuals in discrimination and employment matters, as well as non-profit organizations on a wide variety of issues. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections,* a sexual harassment and retaliation class action.

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was a mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights.

Ms. Lerner earned her undergraduate degree from the University of Michigan, where she was selected to be a Truman Scholar, and her law degree from New York University (NYU) School of Law, where she was a Root-Tilden-Snow public interest scholar. After law school, she served two years as a law clerk to the Honorable Julian Abele Cook, Jr., Chief U.S. District Court Judge for the Eastern District of Michigan.

Testimony of Carolyn Lerner, Special Counsel
and Eric Bachman, Deputy Special Counsel
U.S. Office of Special Counsel

U.S. House of Representatives
Committee on Veterans' Affairs

"VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability"

July 8, 2014, 7:30 P.M.

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our ongoing work with whistleblowers at the Department of Veterans' Affairs (VA). I am joined today by Deputy Special Counsel Eric Bachman, who is supervising OSC's efforts to protect VA employees from retaliation.

I. The Office of Special Counsel

OSC is an independent investigative and prosecutorial federal agency that protects the merit system for over 2.1 million federal employees. We fulfill this good government role with a staff of approximately 120 employees – and the smallest budget of any federal law enforcement agency. Our specific mission areas include enforcement of the Hatch Act, which keeps the federal workplace free of improper partisan politics. OSC also protects the civilian employment rights for returning service members under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Over the last three years, OSC has successfully implemented the USERRA demonstration project this Committee established as part of the Veterans Benefits Act of 2010. With limited resources, we have found innovative ways to resolve USERRA claims and ensure that service members are positioned to succeed upon their return to the civilian federal workforce.

In addition to enforcing the Hatch Act and USERRA, OSC is also uniquely positioned in the federal government to receive whistleblower disclosures and protect whistleblowers from retaliation. We do this in two distinct ways.

First, we provide a safe channel for federal employees to disclose allegations of waste, fraud, abuse, illegality, and/or threats to public health and safety. We receive approximately 1,200 whistleblower disclosures annually. If the disclosure meets the high threshold required for triggering a government investigation, we then refer it to the agency involved. After an OSC referral, the agency is required to investigate and submit a written report to OSC. OSC analyzes the agency's report, receives comments from the whistleblower, and transmits our findings and recommendations to the President and Congress. OSC's work with whistleblowers often identifies trends or areas of concern that require greater scrutiny and/or systemic corrective action. Our testimony today will provide additional detail on OSC's June 23, 2014 letter to the

President and Congress, which made recommendations in response to dozens of whistleblower disclosures from VA employees across the country.

Second, OSC protects federal workers from "prohibited personnel practices," especially retaliation for whistleblowing. OSC receives approximately 3,000 prohibited personnel practice complaints annually, a number that has increased 51% over the last five years. Most of these complaints allege retaliation for whistleblowing or protected activity, such as cooperating with an OSC or Inspector General investigation. In these cases, OSC conducts the investigation and determines if retaliation or another prohibited personnel practice has occurred. After an investigation, OSC has the ability to secure relief on behalf of the employee and to seek disciplinary action against any employee who has engaged in retaliation. Our testimony today will provide the Committee with a summary of OSC's efforts to protect VA employees from retaliation.

Finally, we will discuss a number of encouraging commitments made recently by the VA, in response to our June 23 letter. If implemented, these commitments will go a long way toward ensuring that whistleblowers feel free to step forward, and that their information will be used to improve the quality of care within the VA system.

II. Whistleblower Disclosures

As stated in our June 23, 2014 letter to the President, which is attached to this testimony, "The goal of any effective whistleblower system is to encourage disclosures, identify and examine problem areas, and find effective solutions to correct and prevent identified problems from recurring." Unfortunately, too often the VA has failed to use the information provided by whistleblowers as an early warning system. Instead, in many cases the VA has ignored or attempted to minimize problems, allowing serious issues to fester and grow.

Our June 23 letter raised specific concerns about ten cases in which the VA admitted to serious deficiencies in patient care, yet implausibly denied any impact on veterans' health. As we stated in that communication, "The VA, and particularly the VA's Office of the Medical Inspector (OMI), has consistently used a 'harmless error' defense, where the Department acknowledges problems but claims patient care is unaffected." This approach hides the severity of systemic and longstanding problems, and has prevented the VA from taking the steps necessary to improve quality of care for veterans.

To help illustrate the negative consequences of this approach, we will highlight three cases that were addressed in the June 23 letter.

1. Ft. Collins, CO

In response to a disclosure from a VA employee in Fort Collins, CO, OSC received an OMI report confirming severe scheduling and wait time problems at that facility. The report confirmed multiple violations of VA policies, including the following:

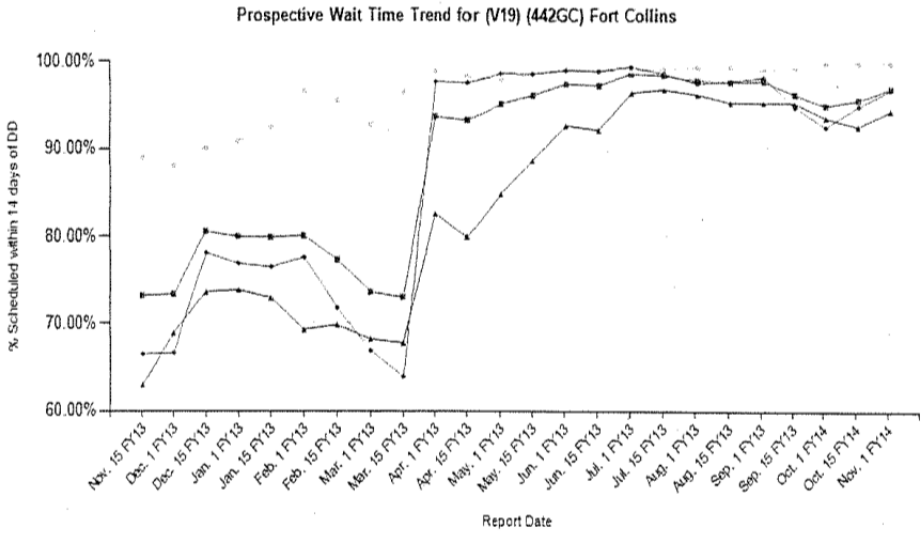
- A shortage of providers caused the facility to frequently cancel appointments for veterans. After cancellations, providers did not conduct required follow-up, resulting in situations where "routine primary care needs were not addressed."

- The facility "blind scheduled" veterans whose appointments were canceled, meaning veterans were not consulted when rescheduling the appointment. If a veteran subsequently called to change the blind-scheduled appointment date, schedulers were instructed to record the appointment as canceled at the patient's request. This had the effect of deleting the initial "desired date" for the appointment, so records would no longer indicate that the initial appointment was actually canceled by the facility, resulting in faulty wait time data.

- At the time of the OMI report, nearly 3,000 veterans were unable to reschedule canceled appointments, and one nurse practitioner alone had a total of 975 patients who were unable to reschedule appointments.

- Staff were instructed to alter wait times to make the waiting periods look shorter. Schedulers were placed on a "bad boy" list if their scheduled appointments were greater than 14 days from the recorded "desired dates" for veterans.

In addition, OSC is currently investigating reprisal allegations by two schedulers who were reportedly removed from their positions at Fort Collins and reassigned to Cheyenne, WY, for not complying with the instructions to "zero out" wait times. After these employees were replaced, the officially recorded wait times for appointments drastically "improved," even though the wait times were actually much longer than the officially recorded data. The chart below, which was provided in the report to OSC, clearly illustrates this phenomenon. After the new schedulers complied with orders to "zero out" wait times, the *officially recorded* percentage of veterans who were "scheduled within 14 days of [their desired date]" spiked to nearly 100%. There is no indication that *actual* wait times decreased.



Despite the detailed findings in their report, OMI concluded, "Due to the lack of specific cases for evaluation, OMI could not substantiate that the failure to properly train staff resulted in a danger to public health and safety." This conclusion is not only unsupportable on its own, it is also inconsistent with reports by other VA components examining similar patient-care issues. For example, the VA Office of Inspector General recently confirmed that delays in access to patient care for 1,700 veterans at the Phoenix Medical Center "negatively impacted the quality of care at the facility."

It is important to note that OSC first referred these allegations to the VA in October 2013, providing the VA with an opportunity to assess and begin to address the systemic scheduling abuses occurring throughout the VA health system. Yet, as discussed, the OMI report, which was issued in February 2014, failed to acknowledge the severity of the identified problems, mischaracterized the concern as a "failure to properly train staff," and then did not consider how the inability to reschedule appointments impacted the health and safety of the 3,000 veterans who could not access care. There is no indication that the VA took any action in response to the deeply troubling facts outlined in the February 2014 report.

2. Brockton, MA

In a second case, a VA psychiatrist disclosed serious concerns about patient neglect in a long-term mental health care facility in Brockton, MA. The OMI report to OSC substantiated allegations about severe threats to the health and safety of veterans, including the following:

- A veteran with a 100 percent service-connected psychiatric condition was a resident of the facility from 2005 to 2013. During that time, he had only one psychiatric note written in his medical chart, in 2012, when he was first examined by the whistleblower, more than seven years after he was admitted. The note addressed treatment recommendations.

- A second veteran was admitted to the facility in 2003, with significant and chronic mental health issues. Yet, his first comprehensive psychiatric evaluation did not occur until 2011, more than eight years after he was admitted, when he was assessed by the whistleblower. No medication assessments or modifications occurred until the 2011 consultation.

Despite these findings, OMI would not acknowledge that the confirmed neglect of residents at the facility had any impact on patient care. Given the lack of accountability demonstrated in the first OMI report, OSC requested a follow-up report. The second report did not depart from the VA's typical "harmless error" approach, concluding: "OMI feels that in some areas [the veterans'] care could have been better but OMI does not feel that their patient's rights were violated." Such statements are a serious disservice to the veterans who received inadequate patient care for years after being admitted to VA facilities.

Moreover, in its initial referral letter to the VA, OSC noted that the whistleblower "believed these instances of patient neglect are an indication of large systemic problems present at the Brockton Campus." When the whistleblower was interviewed by OMI, the whistleblower stated his belief that these were not the only instances of neglect, and recommended that OMI examine

all the patients receiving mental health care in the facility. However, when OMI was onsite, they limited the investigation to the three specific individuals treated by the whistleblower. OMI did not conduct a broader review. Additionally, there is no indication that the VA took action in response to the detailed factual findings in the OMI report, including ordering a broader review of patient neglect at Brockton or in other long-term mental health care facilities.

3. Montgomery, AL

Finally, in Montgomery, AL, an OMI report confirmed a whistleblower's allegations that a pulmonologist copied prior provider notes to represent current readings for veterans, likely resulting in inaccurate recordings of patient health information and in violation of VA rules. Rather than recording current readings, the pulmonologist copied and pasted the patients' earlier recordings from other physicians, including the patients' chief complaint, physical examination findings, vital signs, diagnoses, and plans of care. Despite confirming this misconduct, OMI stated that it could not substantiate whether this activity endangered patient health. The timeline and specific facts indicate a broader lack of accountability and inappropriate responses by the VAMC leadership in Montgomery.

In late 2012, the whistleblower identified six instances in which a staff pulmonologist copied and pasted information from prior patient visits with other physicians. The whistleblower, a surgeon, was first alerted to the possible misconduct by an anesthesiologist during a veteran's preoperative evaluation prior to an operation.

The whistleblower reported these concerns to Alabama VAMC management in October 2012. In response to the whistleblower's report, VAMC management monitored the pulmonologist's medical record documentation practices. After confirming evidence of copying and pasting in medical records, the pulmonologist was placed on a 90-day "Focused Professional Practice Evaluation" (FPPE), or a review of the physician's performance at the VA. Despite additional evidence of improper copying and pasting of medical records *during* the 90-day FPPE, VAMC leadership ended the FPPE, citing satisfactory performance.

Meanwhile, the whistleblower brought his concerns to OSC, citing mismanagement by VAMC leadership in handling his complaint, and a threat to veterans' health and safety caused by the copied recordings.

OSC referred the allegations to the VA in April 2013. OMI initiated an investigation in May 2013. Despite confirming the underlying misconduct, OMI did not substantiate the whistleblower's allegations of mismanagement by VAMC leadership or threats to patient care. However, to its credit, OMI recommended that the Montgomery VAMC review all consults performed by the pulmonologist in 2011 and 2012, and not just the six known to the whistleblower.

Far worse than previously believed, the review determined that the pulmonologist engaged in copying and pasting activity in 1,241 separate patient records.

Despite confirming this widespread abuse, Montgomery VAMC leadership did not change its approach with the pulmonologist, who was again placed on an FPPE. Montgomery VAMC leadership also proposed a reprimand, the lowest level of available discipline.

OSC requested, and has not yet received, information from the VA to determine if the 1,241 instances of copying and pasting resulted in any adverse patient outcomes. Despite the lack of confirmation on this critical issue, Central Alabama VA Director James Talton publicly stated that the pulmonologist is still with the VA because there was no indication that any patient was endangered, adding that the physician's records are checked periodically to make sure no copying is occurring. As VA headquarters completes its review of the patient records, we encourage the VA to also review the specific actions taken by Montgomery VAMC leadership in response to the confirmed misconduct.

Beyond these specific cases, OSC continues to receive a significant number of whistleblower disclosures from employees at VA facilities throughout the country. We currently have over 60 pending cases, all of which allege threats to patient health or safety. OSC has referred 28 of these cases to the VA for investigation. This represents over a quarter of all cases referred by OSC for investigation government-wide. Moving forward, it is critical that VA leadership, including the Office of the Secretary, review all whistleblower reports and proposed corrective actions to ensure that outcomes such as those described above are avoided.

III. Whistleblower Retaliation

1. Overview and scope of the problem

OSC has received scores of complaints from VA employees who say they have been retaliated against for blowing the whistle on improper patient scheduling, understaffing of medical facilities, and other dangers to patient health and safety at VA centers around the country. Based on the scope and breadth of the complaints OSC has received, it is clear that the workplace culture in many VA facilities is hostile to whistleblowers and actively discourages them from coming forward with what is often critical information.

OSC currently has 67 active investigations into retaliation complaints from VA employees. These complaints arise in 28 states and 45 separate facilities. Approximately 30 of these 67 cases have passed the initial review stage in our intake office, the Complaints Examining Unit, and are currently in our Investigation and Prosecution Unit, where they are being further investigated for corrective and disciplinary action. The number of cases increases daily. By way of example, OSC has received approximately 25 new whistleblower retaliation cases from VA employees since June 1, 2014.

2. Actions OSC has taken to investigate and address these cases

In addition to the ongoing investigation of nearly 70 retaliation cases, OSC has taken a number of steps to address and attempt to resolve these widespread complaints of whistleblower reprisal.

- OSC has reallocated staff and resources to investigating VA whistleblower reprisal cases. These cases are the office's highest priority and more than 30 attorneys and investigators are currently assigned to these whistleblower retaliation cases (in addition to all 14 employees in the Disclosure Unit). We have also implemented a priority intake process for VA cases.

- OSC representatives have met personally with VA officials in recent weeks, including Acting Secretary Gibson, Chief of Staff Jose Riojas, White House Deputy Chief of Staff Rob Nabors, attorneys from the Office of General Counsel, and others.

- OSC representatives recently traveled to Phoenix, Arizona to meet with FBI and VA Inspector General agents who are investigating the Phoenix VA cases, and also met with a number of the Phoenix VA whistleblowers.

- In addition to this testimony, OSC continues to brief the House and Senate Committees on Veterans Affairs on an ongoing basis, and provide information to individual Members of Congress who have concerns about disclosures or retaliation claims in their states or districts.

3. Examples of relief obtained

We cannot speak today about the details of ongoing reprisal cases, because doing so would jeopardize the integrity of the investigations and could improperly reveal the confidential identity of certain whistleblowers. However, we would like to mention a few cases where OSC has recently been able to obtain relief for whistleblowers:

An employee in a VA facility in Florida raised concerns about a number of issues, including poor patient care. The highlights of the employee's complaint are as follows:

- The employee had worked for the federal government for over two decades, including over 15 years with the VA. Throughout this lengthy service, the employee received "outstanding" and "excellent" job performance ratings and had never been disciplined.

- However, soon after the employee reported the poor patient care and other issues to the VA OIG in 2013, the VA removed certain of the employee's job duties and conducted a retaliatory investigation of the employee.

- Notably, in 2014, the VA also attempted to suspend the employee but OSC was able to obtain a stay of the suspension pending OSC's investigation of the matter.

- Due to the retaliatory environment, the employee decided to transfer to a VA facility in a different state in order to help protect the employee's job status and retirement benefits.

In a VA facility in New York, an employee complained to a supervisor about a delay in reporting a possible crime in the VA facility, as well as another serious patient care issue. The key points of the employee's complaint are as follows:

- Prior to blowing the whistle on this alleged misconduct, the employee received high job performance ratings as well as a bonus.

- However, soon after reporting the misconduct to a supervisor, this same supervisor informed the employee that an investigation into the employee's job performance would be conducted, which could result in the employee's termination. The basis for the investigation and possible termination was that the employee was "not a good fit for the unit."

- The investigation was set to convene in late June 2014, but OSC was recently able to obtain a stay pending OSC's investigation of the matter.

A VA employee in Hawaii blew the whistle after seeing an elderly patient improperly restrained in a wheelchair, which violated rules prohibiting the use of physical restraints without a doctor's order.

- Almost immediately after this disclosure, the employee was suspended for two weeks and received a letter of counseling.

- OSC investigated the matter and determined the VA had retaliated against the employee. As a result, OSC obtained corrective action for the employee, including a rescission of the suspension, full back pay, and an additional monetary award. At OSC's request, the VA also agreed to suspend the subject official who was responsible for the retaliation.

The severity of these cases underscores the need for substantial, sustained cooperation between the VA and OSC as we work to protect whistleblowers and encourage others to report their concerns.

IV. A New and Better Approach from the VA

While this has been a difficult period for the VA, it is important to note several encouraging signs from VA leadership suggesting a new willingness to listen to whistleblower concerns, act on them appropriately, and ensure that employees are protected for speaking out.

- In a June 13, 2014 statement to all VA employees, Acting Secretary Gibson specifically noted, "Relatively simple issues that front-line staff may be aware of can grow into significantly larger problems if left unresolved." We applaud Acting Secretary Gibson for recognizing the importance of whistleblower disclosures to improving the effectiveness and quality of health care for our veterans and for his commitment to identifying problems early in order to find comprehensive solutions.

- In response to OSC's June 23, 2014 letter to the President and Congress, Acting Secretary Gibson directed a comprehensive review of all aspects of the Office of Medical Inspector's operation. And, in response to OSC's recommendation, he stated his intent to designate an official to assess the conclusions and the proposed corrective actions in OSC reports. We look forward to learning about the results of the OMI review and believe the designated official will help to avoid the same problematic outcomes from prior OSC whistleblower cases.

- In their June 27, 2014 report to the President, Deputy White House Chief of Staff Rob Nabors and Acting VA Secretary Gibson confirmed that a review of VA responses to OSC whistleblower cases is underway, recommended periodic meetings between the Special Counsel and the VA Secretary, and recommended completion of OSC's whistleblower certification program as a necessary step to stop whistleblower retaliation. We look forward to working with the VA on the certification and training process.

- At a July 2014 meeting at OSC, Acting Secretary Gibson committed to resolving meritorious whistleblower retaliation cases with OSC on an expedited basis. We are hopeful this will avoid the need for lengthy investigations and help whistleblowers who have suffered retaliation get back on their feet quickly. In the very near future, we look forward to working out the details of this expedited review process and providing these whistleblowers with the relief and protection they deserve. Doing so will show employees that the VA's stated intolerance for retaliation is backed up by concrete actions. We will keep this Committee fully-informed on significant developments in this area.

V. Conclusion

In conclusion, we want to applaud the courageous VA employees who are speaking out. These problems would not have come to light without the information provided by whistleblowers. Identifying problems is the first step toward fixing them. We look forward to working closely with whistleblowers, the Committee, and VA leadership in the coming months to find solutions.

We would be pleased to answer any questions that the Committee may have.

U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

June 23, 2014

The President
The White House
Washington, D.C. 20500

Re: Continued Deficiencies at Department of Veterans Affairs' Facilities

Dear Mr. President:

I am providing you with the U.S. Office of Special Counsel's (OSC) findings on whistleblower disclosures from employees at the Veterans Affairs Medical Center in Jackson, Mississippi (Jackson VAMC). The Jackson VAMC cases are part of a troubling pattern of responses by the Department of Veterans Affairs (VA) to similar disclosures from whistleblowers at VA medical centers across the country. The recent revelations from Phoenix are the latest and most serious in the years-long pattern of disclosures from VA whistleblowers and their struggle to overcome a culture of non-responsiveness. Too frequently, the VA has failed to use information from whistleblowers to identify and address systemic concerns that impact patient care.

As the VA re-evaluates patient care practices, I recommend that the Department's new leadership also review its process for responding to OSC whistleblower cases. In that regard, I am encouraged by the recent statements from Acting Secretary Sloan Gibson, who recognized the significant contributions whistleblowers make to improving quality of care for veterans. My specific concerns and recommendations are detailed below.

Jackson VAMC

In a letter dated September 17, 2013, I informed you about numerous disclosures regarding patient care at the Jackson VAMC made by Dr. Phyllis Hollenbeck, Dr. Charles Sherwood, and five other whistleblowers at that facility. The VA substantiated these disclosures, which included improper credentialing of providers, inadequate review of radiology images, unlawful prescriptions for narcotics, noncompliant pharmacy equipment used to compound chemotherapy drugs, and unsterile medical equipment. In addition, a persistent patient-care concern involved chronic staffing shortages in the Primary Care Unit. In an attempt to work around this issue, the facility developed "ghost clinics." In these clinics, veterans were scheduled for appointments in clinics with no

assigned provider, resulting in excessive wait times and veterans leaving the facility without receiving treatment.

Despite confirming the problems in each of these (and other) patient-care areas, the VA refused to acknowledge any impact on the health and safety of veterans seeking care at the Jackson VAMC. In my September 17, 2013 letter, I concluded:

> "[T]he Department of Veterans Affairs (VA) has consistently failed to take responsibility for identified problems. Even in cases of substantiated misconduct, including acknowledged violations of state and federal law, the VA routinely suggests that the problems do not affect patient care."

A detailed analysis of Dr. Hollenbeck's and Dr. Sherwood's disclosures regarding patient care at the Jackson VAMC is enclosed with this letter. I have also enclosed a copy of the agency reports and the whistleblowers' comments.

Ongoing Deficiencies in VA Responses to Whistleblower Disclosures

OSC continues to receive a significant number of whistleblower disclosures from employees at VA facilities throughout the country. We currently have over 50 pending cases, all of which allege threats to patient health or safety. I have referred 29 of these cases to the VA for investigation. This represents over a quarter of all cases referred by OSC for investigation government-wide.

I remain concerned about the Department's willingness to acknowledge and address the impact these problems may have on the health and safety of veterans. The VA, and particularly the VA's Office of the Medical Inspector (OMI), has consistently used a "harmless error" defense, where the Department acknowledges problems but claims patient care is unaffected. This approach has prevented the VA from acknowledging the severity of systemic problems and from taking the necessary steps to provide quality care to veterans. As a result, veterans' health and safety has been unnecessarily put at risk. Two recent cases illustrate the negative consequences of this approach.

First, in response to a disclosure from a VA employee in Fort Collins, CO, OSC received an OMI report confirming severe scheduling and wait time problems at that facility. The report confirmed multiple violations of VA policies, including the following:

- A shortage of providers caused the facility to frequently cancel appointments for veterans. After cancellations, providers did not conduct required follow-up, resulting in situations where "routine primary care needs were not addressed."

- The facility "blind scheduled" veterans whose appointments were canceled, meaning veterans were not consulted when rescheduling the appointment. If a veteran subsequently called to change the blind-scheduled appointment date, schedulers were instructed to record the appointment as canceled at the patient's request. This had the effect of deleting the initial "desired date" for the appointment, so records would no longer indicate that the initial appointment was actually canceled by the facility.

- At the time of the OMI report, nearly 3,000 veterans were unable to reschedule canceled appointments, and one nurse practitioner alone had a total of 975 patients who were unable to reschedule appointments.

- Staff were instructed to alter wait times to make the waiting periods look shorter.

- Schedulers were placed on a "bad boy" list if their scheduled appointments were greater than 14 days from the recorded "desired dates" for veterans.

In addition, OSC is currently investigating reprisal allegations by two schedulers who were reportedly removed from their positions at Fort Collins and reassigned to Cheyenne, WY, for not complying with the instructions to "zero out" wait times. After these employees were replaced, the officially recorded wait times for appointments drastically "improved," even though the wait times were actually much longer than the officially recorded data.

Despite these detailed findings, the OMI report concluded, "Due to the lack of specific cases for evaluation, OMI could not substantiate that the failure to properly train staff resulted in a danger to public health and safety." This conclusion is not only unsupportable on its own, but is also inconsistent with reports by other VA components examining similar patient-care issues. For example, the VA Office of Inspector General recently confirmed that delays in access to patient care for 1,700 veterans at the Phoenix Medical Center "negatively impacted the quality of care at the facility."

In a second case, a VA psychiatrist disclosed serious concerns about patient neglect in a long-term mental health care facility in Brockton, MA. The OMI report substantiated allegations about severe threats to the health and safety of veterans, including the following:

- A veteran with a 100 percent service-connected psychiatric condition was a resident of the facility from 2005 to 2013. In that time, he had only one psychiatric note written in his medical chart, in 2012, when he was first examined by the whistleblower, more than seven years after he was admitted. The note addressed treatment recommendations.

- A second veteran was admitted to the facility in 2003, with significant and chronic mental health issues. Yet, his first comprehensive psychiatric evaluation did not occur until 2011, more than eight years after he was admitted, when he was assessed by the whistleblower. No medication assessments or modifications occurred until the 2011 consultation.

Despite these findings, OMI failed to acknowledge that the confirmed neglect of residents at the facility had any impact on patient care. Given the lack of accountability demonstrated in the first OMI report, OSC requested a follow-up report. The second report did not depart from the VA's typical "harmless error" approach, concluding: "OMI feels that in some areas [the veterans'] care could have been better but OMI does not feel that their patient's rights were violated." Such statements are a serious disservice to the veterans who received inadequate patient care for years after being admitted to VA facilities.

Unfortunately, these are not isolated examples. Rather, these cases are part of a troubling pattern of deficient patient care at VA facilities nationwide, and the continued resistance by the VA, and OMI in most cases, to recognize and address the impact on the health and safety of veterans. The following additional examples illustrate this trend:

- In Montgomery, AL, OMI confirmed a whistleblower's allegations that a pulmonologist copied prior provider notes to represent current readings in over 1,200 patient records, likely resulting in inaccurate patient health information being recorded. OMI stated that it could not substantiate whether this activity endangered patient health.

- In Grand Junction, CO, OMI substantiated a whistleblower's concerns that the facility's drinking water had elevated levels of *Legionella* bacteria, and standard maintenance and cleaning procedures required to prevent bacterial growth were not performed. After identifying no "clinical consequences" resulting from the unsafe conditions for veterans, OMI determined there was no substantial and specific danger to public health and safety.

- In Ann Arbor, MI, a whistleblower alleged that employees were practicing unsafe and unsanitary work practices and that untrained employees were improperly handling surgical instruments and supplies. As a result, OMI partially substantiated the allegations and made 12 recommendations. Yet, the whistleblower informed OSC that it was not clear whether the implementation of the corrective actions resulted in better or safer practices in the sterilization and processing division. OMI failed to address the whistleblower's specific continuing concerns in a supplemental report.

- In Buffalo, NY, OMI substantiated a whistleblower's allegation that health care professionals do not always comply with VA sterilization standards for wearing personal protective equipment, and that these workers occasionally failed to place indicator strips in surgical trays and mislabeled sterile instruments. OMI did not believe that the confirmed allegations affected patient safety.

- In Little Rock, AR, OMI substantiated a whistleblower's allegations regarding patient care, including one incident when suction equipment was unavailable when it was needed to treat a veteran who later died. OMI's report found that there was not enough evidence to sustain the allegation that the lack of available equipment caused the patient's death. After reviewing the actions of the medical staff prior to the incident, OMI concluded that the medical care provided to the patient met the standard of care.

- In Harlingen, TX, the VA Deputy Under Secretary for Health confirmed a whistleblower's allegations that the facility did not comply with rules on the credentialing and privileging of surgeons. The VA also found that the facility was not paying fee-basis physicians in a timely manner, resulting in some physicians refusing to care for VA patients. The VA, however, found that there was no substantial and specific danger to public health and safety resulting from these violations.

- In San Juan, PR, the VA's Office of Geriatrics and Extended Care Operations substantiated a whistleblower's allegations that nursing staff neglected elderly residents by failing to assist with essential daily activities, such as bathing, eating, and drinking. OSC sought clarification after the VA's initial report denied that the confirmed conduct constituted a substantial and specific danger to public health. In response, the VA relented and revised the report to state that the substantiated allegations posed significant and serious health issues for the residents.

Next Steps

The goal of any effective whistleblower system is to encourage disclosures, identify and examine problem areas, and find effective solutions to correct and prevent identified problems from recurring. Acting Secretary Gibson recognized as much in a June 13, 2014, statement to all VA employees. He specifically noted, "Relatively simple issues that front-line staff may be aware of can grow into significantly larger problems if left unresolved." I applaud Acting Secretary Gibson for recognizing the importance of whistleblower disclosures to improving the effectiveness and quality of health care for our veterans and for his commitment to identifying problems early in order to find comprehensive solutions.

Moving forward, I recommend that the VA designate a high-level official to assess the conclusions and the proposed corrective actions in OSC reports, including disciplinary actions, and determine if the substantiated concerns indicate broader or systemic problems requiring attention. My staff and I look forward to working closely with VA leadership to ensure that our veterans receive the quality health care services they deserve.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency reports and whistleblowers' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports and the whistleblowers' comments in OSC's public file, which is available online at www.osc.gov.

Respectfully,

Carolyn N. Lerner

Enclosures

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Special Counsel Carolyn N. Lerner

The Honorable Carolyn N. Lerner heads the United States Office of Special Counsel. Her five-year term began in June 2011. Prior to her appointment as Special Counsel, Ms. Lerner was a partner in the Washington, D.C., civil rights and employment law firm Heller, Huron, Chertkof, Lerner, Simon & Salzman, where she represented individuals in discrimination and employment matters, as well as non-profit organizations on a wide variety of issues. While at the firm, she served as the federal court appointed monitor of the consent decree in a sexual harassment and retaliation class action, taught mediation as an adjunct professor at George Washington University Law School, and was a mediator for the United States District Court for the District of Columbia.

Ms. Lerner earned her undergraduate degree from the University of Michigan, where she was selected to be a Truman Scholar, and her law degree from New York University (NYU) School of Law, where she was a Root-Tilden-Snow public interest scholar. After law school, she served two years as a law clerk to the Honorable Julian Abele Cook, Jr., Chief U.S. District Court Judge for the Eastern District of Michigan.

Deputy Special Counsel for Litigation and Legal Affairs Eric Bachman

Eric Bachman joined the Office of Special Counsel in 2014. He served as a special litigation counsel in the Justice Department's Civil Rights Division from 2012 to 2014 and was a senior trial attorney from 2009 to 2012. Before joining the Justice Department, he was in private practice, as an associate and then as a partner, at the Washington, DC office of Wiggins, Childs, Quinn & Pantazis, a civil rights law firm. Mr. Bachman began his legal career as a public defender in Louisville, Kentucky. He received a J.D. from Georgetown University Law Center and a B.A. in History from Middlebury College.