

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

THURSDAY, JULY 30, 2015

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

The subcommittee met at 10:38 a.m. in room SD-124, Dirksen Senate Office Building, Hon. Mark Kirk (chairman) of the subcommittee, presiding.

Present: Senators Kirk, Collins, Boozman, Capito, Cassidy, Reed, Udall, and Baldwin.

**A REVIEW OF WHISTLEBLOWER CLAIMS AT THE
DEPARTMENT OF VETERANS AFFAIRS**

OPENING STATEMENT OF SENATOR MARK KIRK

Senator KIRK. Well, thank you all for being here.

The American people rightly expect our veterans to receive the best healthcare in America, but the system that is designed to provide it is failing. The reason why we know about these failures is because of the people we are going to hear from, like Dr. Katherine Mitchell.

Dr. Mitchell is going to tell us about the failures of people who have been entrusted with the duty to give that care. She broke the story on the Department of Veterans Affairs (VA) scandal that ended up in the resignation of the secretary. We quickly realized that the Veterans Affairs corruption problem was not unique. Instead, the corruption was actually rampant.

Germaine Carno, a social worker and union president, stood up to say that the corrupt bonus schemes that brought down the Phoenix VA was at the Hines VA in my home State.

Dr. Lisa Nee also uncovered boxes and boxes of unread echocardiograms leading her to discover dozens of unnecessary surgeries on our veterans.

The truth about corruption in VA hospitals was not easy to reveal for Katherine Mitchell, Germaine Carno, and Dr. Lisa Nee. They have been through hell to give mistreated veterans a voice because the system built to protect whistleblowers to fight corruption has failed them. The VA system is funded by this committee. We are here to ensure that those who wore the uniform get the care that they deserve.

Linda Halliday, the new Acting Inspector General of the VA and Carolyn Lerner of the Office of Special Counsel are here today. Together, they will tell us why the system is failing our veterans.

Let me turn it over to Senator Collins for an opener.

STATEMENT OF SENATOR SUSAN M. COLLINS

Senator COLLINS. Thank you very much, Mr. Chairman.

I would note that today is National Whistleblowers Day. So it is particularly appropriate that you have called this very important and timely hearing regarding the oversight performed by the VA's Office of Inspector General (OIG) and the responsibility that we have to protect the invaluable contributions of whistleblowers. It is deeply disturbing that the administration continues to drag its feet on filling the Inspector General position at the VA; vacant now for more than 18 months despite the crisis that exists within that agency.

Inspectors General are directly responsible for rooting out fraud, waste, and abuse, and effecting cultural change within an organization. The President's nomination of an Inspector General is long overdue. I urge the administration to act quickly to fill this vacancy and to appoint a well-qualified, independent Inspector General who can guarantee transparency, responsiveness, and accountability.

As the former ranking member of the Senate Committee on Homeland Security and Governmental Affairs, I focus significant attention on strengthening whistleblower protections. In fact, my staff pointed out that when President Obama signed a bill that I wrote with former Senator Akaka, we had a signing ceremony on November 27, 2012, to sign the Whistleblower Protection Enhancement Act into law, and it is on the Special Counsel's homepage. That law recognizes the crucial role that whistleblowers play in helping to expose mismanagement and threats to public health and safety.

As the chairman has indicated, whistleblower disclosures made by courageous individuals, such as Dr. Mitchell and Dr. Nee, have shed light on issues that directly affect the health and well-being of our Nation's veterans. Their disclosures have saved taxpayer dollars and, more important, human lives and they deserve our utmost respect and gratitude for coming forward. I know it isn't easy.

The Department of Veterans Affairs faces many challenges that demand our attention including barriers to access to care and a backlog in disability claims. Another pressing challenge, however, is restoring the trust and confidence that has been impaired as a direct result of abusive and retaliatory practices which came to light after the Phoenix wait list scandal. We must ensure that VA employees who speak out will be protected. This is not only the law but also our moral obligation.

Again, Mr. Chairman, thank you so much for holding this important hearing and for your leadership as a veteran, yourself. Thank you.

Senator UDALL. Mr. Chairman, could I do a short opening, please?

Senator KIRK. Go ahead.

STATEMENT OF SENATOR TOM UDALL

Senator UDALL. Thank you, Mr. Chairman. And very appropriate for you to hold this hearing on Whistleblower's Day as Senator Collins has noted.

What happened last summer at the VA was a betrayal of our veterans. My State of New Mexico is under the same regional office as the Phoenix office and the events over the past year eroded the trust they have in the VA. We made a solemn promise. Our vets put their lives on the line for our freedom and we must ensure that the recent scheduling scandal is never repeated.

However, we must note that it was because of whistleblowers who blew the lid on the systemic problems at the VA that we were able to work together in Congress to address those issues. My office has worked along side VA staff and veterans in New Mexico to refer complaints to the Inspector General. But this process is eroded when whistleblowers are silenced. When that happens, Congress and veterans we serve are not served well.

Because of whistleblowers, like Dr. Mitchell and Dr. Nee, Congress was able to take action. With the Veterans' Access Choice and Accountability Act, Congress sent a strong message that VA employees who manipulated scheduling or other data will be held accountable. New management in New Mexico and at the national level, along with new policies, have helped to put the VA back on course. But there is still more to do. So long as mismanagement and reprisals continue, we must continue to do more.

We have a duty to ensure that our veterans get the best possible care when whistleblowers expose problems, that those problems are fixed. And I—it has been a pleasure to work with Secretary McDonald and meeting with him. And I have had the opportunity to work through some of these systemic problems and I believe that he has helped restore a culture of transparency and accountability. And I look forward to him coming before the committee again.

Thank you, Mr. Chairman. I really appreciate it.

Senator KIRK. Thank you very much.

Let us hear from Dr. Katherine Mitchell.

Let me briefly introduce you, Dr. Mitchell.

You trained, originally, as a nurse in the ER. So you know ER procedures pretty well. And you are the person that broke the story on the Phoenix VA. Let me hear your testimony.

STATEMENT OF DR. KATHERINE L. MITCHELL, M.D., MEDICAL DIRECTOR, IRAQ AND AFGHANISTAN POST-DEPLOYMENT CENTER, VETERANS AFFAIRS HEALTH CARE SYSTEM, PHOENIX, ARIZONA, DEPARTMENT OF VETERANS AFFAIRS

Dr. MITCHELL. First of all, I am Dr. Katherine Mitchell. I actually trained as a hospital ward nurse at the Phoenix VA. I want to thank the Committee members for inviting me to testify today. As a VA whistleblower, I have had exposure to the VA Inspector General process as outlined in my written testimony. My experiences highlight the important failures within the VA Inspector General system.

Before I describe those experiences, I want to make your committee aware of two important items. First of all, the routine process for handling the VA Office of Inspector General (OIG) hotline

complaints often enables the facilities to investigate themselves without any oversight. This process exposes the whistleblower to retaliation because the hotline complaint is sent back to the same people who may be retaliating against them or who ignore the problem in the first place. It is also self serving to facility administrators at all levels who have an invested interest in suppressing negative information from the facility.

The second item is that OIG hotline reports damaging to the VA are consistently suppressed. In fact, it is not clear to me if any OIG hotline reports are released. Therefore, in my exhibits I have included an alarming 2014 hotline report on the St. Cloud VA that talks about fear or reprisal, substantiate inappropriate behavior by senior administrators, and discuss other really serious issues.

This information was available by Freedom of Information Act (FOIA) request by a person who was involved in the investigation. However, the average person would not know the report existed because a list of hotline reports is not published anywhere to my knowledge.

On a personal basis, the Inspector General failed to protect my confidentiality as a whistleblower and inadequately investigated life-threatening patient care issues. In 2013, I submitted a lengthy complaint through my Senator's office requesting that my name be kept confidential. The report dealt with potentially life-threatening issues including scheduling delays, faulty police equipment, and inadequate response to suicide trends by the facilities.

As part of the complaint, I submitted limited patient information on suicide victims to support my allegations for any oversight investigation. Within days after my receipt of the complaint was acknowledged in Washington, the retaliation began. I was pulled out of clinic. I was put on administrative leave for a month. I was quizzed about the suicide names that I had turned into the Senator's office. Eventually, I was investigated for many months. I would receive a written counseling for violating patient privacy rights for providing those suicide names even though it is clearly not a violation to provide information to a Senator's office in support of an oversight investigation.

The only way the Phoenix administration would have had names of the suicide victims is if the Inspector General leaked that information. More importantly in leaking my name, however, and the retaliation that ensued, is the fact that there was no real Inspector General investigation and no Inspector General report that I can determine. I absolutely was never interviewed by anyone regarding any of the issues that I brought up in my Inspector General complaint. The only report that my Senator's office could find was a short narrative that the VA—wherein the VA had concluded that all my allegations were false including the ones on the improper scheduling practices. This is ironic because Phoenix would become the epicenter for the scheduling scandal.

The VA response was full of so many blatant lies it could have been contradicted by available facts and multiple individuals within the facility if the team had bothered to ask.

The second incident of note involves the Inspector General gross failure to conduct a legitimate evaluation of evidence involving patient deaths. The report was whitewashed. The Inspector General

investigators reviewed the cases of the Phoenix VA patients on the waitlist that was brought to the attention of the Nation by Dr. Sam Foote. The report stated that the Inspector General was “unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans.”

However, under oath in a House Committee, the Acting Inspector General would eventually admit that delays “contributed to deaths.” That fact was conveniently left out of the originally Inspector General report and withheld from the Nation. On my review of cases, based on the information in the Inspector General report, I saw where the Inspector General failed miserably to see the obvious causal effects between delayed or improper care and veteran death.

For example, one of the patients had a massive heart attack presumably when he suffered a lethal heart rhythm. He had been waiting months for the implantable device that treats the lethal heart rhythm immediately and would have prevented death. The Inspector General stated that the device “might have forestalled death.”

Of course it would have. It is the only medically acceptable treatment for that type of lethal heart rhythm and he would have only waited 24 to 48 hours in a private community.

Lack of appropriate psychiatric admission for a mentally unstable patient with multiple suicide risk factors enabled his death from suicide within 24 hours from the point of last VA mental health contact. The Inspector General merely stated that inpatient psychiatric admission “would have been a more appropriate management plan.”

It was the only management plan. It has medical malpractice not to admit this patient who was unstable.

In addition, in that same Inspector General report, the team states it was unable to substantiate bullying behavior at the Phoenix VA. I told them a bullying behavior. Frankly, they never asked me to describe anybody else that had bullying behavior.

Frankly, the malignant culture is so pervasive at the Phoenix VA, in all levels of administration, that there are only two reasons why an Inspector General team would fail to substantiate bullying behavior. The first is that it deliberately chose not to look for the behaviors or, the second, it has such poor investigative training skills that it literally could not investigate its way out of a paper bag.

There are many more details in my written testimony.

Thank you very much for your time.

[The statement follows:]

PREPARED STATEMENT OF DR. KATHERINE L. MITCHELL, M.D.

INTRODUCTION

My name is Dr. Katherine Mitchell. I am an internist who is fellowship trained in geriatrics. I have over 17 years of experience within the Veterans Healthcare Administration (VHA). Since September 2014 I have been assigned to the Veterans Integrated Service Network (VISN) 18 in Gilbert, Arizona as the Specialty Care Medicine lead. Prior to this time I was the medical director of the Phoenix VA Post-Deployment Clinic for 1.5 years. I was also a Phoenix VA Emergency Department (ED) physician for a total of 9.5 years including 6 years as the ED medical co-director/

director. My background also includes 5 years serving as a Phoenix VA hospital nurse.

Throughout my career at the Phoenix VA Medical Center (VAMC) I heard anecdotal comments from staff that the VA Office of Inspector General (OIG) did not conduct objective investigations and rarely, if ever, accurately reported on the serious safety and patient care problems present within the Phoenix VAMC. I was told that confidentiality was never preserved because the IG investigators would leak the names of staff discretely reporting concerns to the VA OIG Hotline. Through the hospital grapevine, I had been informed OIG investigations were closely monitored by Phoenix VA administrators who would penalize staff for answering questions honestly. I was warned by trusted co-workers that initiating an OIG investigation was equivalent to risking job loss.

Subsequent events over the last 2 years have convinced me that every anecdotal comment about the OIG was true. I would learn that the OIG does not maintain whistleblower confidentiality, allows VA facilities to investigate themselves, does not conduct thorough investigations, and white-washes its reports. Within the body of this written testimony I will describe the events that have led me to these conclusions.

SECTION I: OIG FAILURE TO MAINTAIN MY CONFIDENTIALITY OR CONDUCT ADEQUATE INVESTIGATION INTO MY OIG COMPLAINT

After years of trying unsuccessfully to have Phoenix VA administrators adequately address the deep patient safety and staffing issues within the Phoenix VA ED, I was ethically compelled to go outside the usual chain of command to protect the welfare of Phoenix VA ED patients. I decided to submit a confidential OIG complaint through my Senator's office. I hoped such a congressional avenue could ensure my complaint would be investigated quickly and thoroughly.

I could not file an anonymous OIG complaint because my assistance with the OIG investigation would be key to ensuring that the depth and breadth of the Phoenix ED safety issues would be uncovered. Because I knew from personal experience that the Phoenix VA administrators were extremely retaliatory, I hoped my name would not be revealed by the investigators. Filing a complaint would easily compel the Phoenix VA administration to make my working conditions so unbearable that resignation would be the only viable option. I did not want to lose the only career I've ever cared about—working for veterans within the VA system.

When I decided to file, I knew I was risking my career if my name was released. Therefore, I organized my complaint so it would address as many patient care and safety issues as possible. I hoped this would increase the likelihood that my OIG complaint would result in significant positive changes within the Phoenix VA. I went to my fellow Phoenix VA employees with whom I had developed a trusted relationship and asked them to provide me with information regarding the most serious issues within the VA facility. The problems must be easily proven and be urgent enough that the issues could not wait for resolution by the normally ponderous VA process of change. It was equally important the information could not be traced back by management to my "sources". I wanted to be the only target if my name was not kept in confidence by the OIG investigators. As the result of the information collected as well as my first-hand knowledge of facility issues and overt backlash, I wrote a lengthy complaint detailing the various problems.

When I presented my written OIG complaint to staff at my Senator's office, the seriousness of the VA situation was evident to even those staff who had no healthcare background. I was informed by the Senator's office that the most serious safety issues listed in my complaint would be forwarded with a request for an expedited OIG investigation to address the issues and maintain the confidentiality of my name. Some of the issues in my complaint included disturbing system issues involving suicides, statistical manipulation of the wait list, failure to prioritize appointments according to national VA policy, improper distribution of complex patients, inadequate/malfunctioning police equipment including radio system, and pending waste of VA funds because of gross inadequacies of the blueprints for the proposed Phoenix VA ED construction project.

I supplemented my complaint with a document outlining inadequate response by the facility to increasing number of veteran suicides. I included the first name and last initial of some veterans who committed suicide in order to substantiate my allegations. Those names had been obtained in the process of a work-related project on suicides that I was conducting and of which Phoenix VA medicine chain of command was aware. Those names would only be identifiable to the investigators if they pulled a list of suicide victims during the timeframe named in the document. Release of patient information to a Congressman within the context of arranging an

OIG oversight investigation on those patient cases is not a violation of the Health Insurance Portability and Accountability Act (HIPAA).

I was informed by the Senator's office that a truncated version of my complaint would be forwarded to the OIG including my supplemental documents. The letter acknowledging VA receipt of my complaint was time/date stamped September 12, 2013. Shortly thereafter I was hauled into my supervisor's office. I was informed I was being placed immediately on administrative leave for undisclosed alleged misconduct.

After being on administrative leave at home for approximately a month, I was allowed to return to work. Upon my return, management informed me that I was being investigated for accessing the charts of the suicide victims and violating an unspecified privacy policy. While my supervisor didn't state I was being punished for reporting information to my Senator's office, the only way that information could have come to the attention of Phoenix VA management was if the OIG had leaked my name to the Phoenix VA administration.

I would eventually receive a written counseling allegedly for working outside the scope of my duties as well as purportedly violating a patient privacy policy which the Phoenix VA Human Resource Service declined to specify.

I waited for the OIG report into my allegations but none came. I saw no changes implemented as the result of my OIG complaint. In February 2014 my Senator's office was able to verify the OIG had been involved in an investigation of my complaint. However, the extent of OIG involvement could not be determined.

I have never seen the official OIG report on my 2013 complaint and believe one does not exist. My Senator's office made attempts to locate the report for me without success. The only follow-up on the investigation the office could locate was contained in a short email containing a portion of the VHA response to my complaint. (Exhibit A) The email indicates that the "results of the preliminary fact finding investigations, as well as subsequent investigation and actions" did not substantiate the concerns I reported through my Senator's office.

That email did not give answers to the troubling concerns I had raised in that truncated OIG complaint. In regards to the suicide trends and inadequate facility response to those trends, it merely stated "root cause analyses were conducted" by the facility during the timeframe in question. It also stated there were plans to staff the suicide team in 2014.

The email failed to address the issues I knew to be true through my work with the Suicide Prevention Team and other committees. It never mentioned that the facility was ignoring the trends in suicide which were associated with inadequate pain management. It failed to highlight the fact that the Suicide Prevention Team was grossly understaffed and near-buckling under the weight of the required case management. It did not reveal that Phoenix VA administration had already informed the Suicide Prevention Team that one staff member would be moved into an unrelated area because of budget limitations/staffing shortages in the ambulatory care clinics. (This planned reduction in Suicide Prevention Team members was to be done even though the head of the team stated they would not be able to adequately manage high risk suicidal patients if the team was reduced.) The email neglected to note that the Suicide Prevention Team had no ancillary support so the team was stretched extremely thin trying to juggle administrative issues, manage cases, and handle the calls sent to the team from the VA Suicide Crisis Line. (PLEASE NOTE: Only after the Phoenix VA scandal erupted would the Phoenix senior leadership scrap plans to transfer a social worker off the team and instead actually hire desperately needed staff members.)

That email response also stated the Phoenix VA Healthcare System leadership "confirmed the Electronic Wait List is being used where indicated." No mention was made of my complaints regarding wait list manipulation and failure to adequately schedule veterans according to priority category. It would take until 2014 before the true depth of the Phoenix wait list manipulation would be exposed. (Eventually the wait list manipulation and associated patient deaths would lead to the OIG to reluctantly admit in a House Committee hearing that the wait lists delays contributed to veteran death.)

That email response also stated there were "no findings related to equipment" deficiencies in the police department. At that time, I knew with complete certainty that five police bullet proof vests were expired. I also knew the outdated VA police radio system had many dead zones within the building including within the highest risk areas for violence—the Emergency Department and the outpatient mental health clinic. Those dead zones meant officers would have to use a landline to request police back-up. In addition, the officers' radios had so much static at baseline that it was extremely hard for them to communicate in areas where they could get reception. (PLEASE NOTE: Although it was an extremely slow process, the officer

police radio system has since been updated to correct these deficiencies and the vests have been replaced.)

Although the exact extent of the OIG investigation could not be determined, it was clear to me that the OIG investigation was grossly inadequate. If the investigator(s) would have scratched more than just the surface, deep issues would have been uncovered. The OIG would have had the opportunity to uncover the wait list manipulation in September 2013 and prevent the significant morbidity and mortality occurring when veterans were left to languish on unauthorized wait lists. The OIG could have intervened earlier to improve needed services for veterans who were at high risk for suicide. The OIG could have also uncovered gaps in facility security related to inadequate police equipment.

SECTION II: FOUR EXAMPLES OF OIG REPORT DEFICIENCIES

Example #1: OIG Report: Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System—8/26/2014

- Issues: a. When evaluating patient deaths on the wait list, the OIG failed to use sound medical judgement in determining if there was an association between delayed patient care and patient death. The report was phrased so that it appeared there was no association between patient deaths and waiting on the “secret” wait list. The acting Inspector General would later admit under oath that those patient care delays contributed to patient deaths.
- b. The OIG failed to adequately investigate the presence of mid-upper level management bullying and harassment within the Phoenix VA Medical Center.

As per my September 2014 written and oral testimony to the House Committee on Veterans Affairs, there were significant deficiencies in medical judgement of OIG investigators. (Exhibit D) In my opinion, based only on the information provided in its 8/26/2014 report, the OIG failed to recognize obvious associations between delays in care and patient deaths and/or loss of quality of life before death.

In its final report summary the OIG wrote “We were unable to assert that the absence of timely quality care caused the deaths of these veterans”. However, in that September 2014 congressional hearing, eventually the OIG acting Inspector General reluctantly admitted that the patient care delays were contributing factors in several patient deaths. Failure to provide this information in the 8/26/14 OIG report effectively obscured the tremendous negative impact that the Phoenix “secret” wait list had on the lives of the veterans who died before they could get an appointment.

Specifically, as described in my previous testimony last year, there were 4 cases in which a causal relationship was clearly evident between delayed and/or improper care & veteran death, excluding veterans for which cause of death was not listed. Those cases are described as follows:

—1. Case 29

This patient had a severe cardiomyopathy which is a disease of the heart muscle that progressively impairs the heart’s ability to pump blood and to maintain a normal heart rhythm.

A patient with severe cardiomyopathy is at high risk for having his heart suddenly stop beating without any warning as the results of a life-threatening heart rhythm known as ventricular fibrillation (“v-fib”). The treatment to avoid sudden death from v-fib/cardiomyopathy is permanently inserting a medical device known as an ICD “implantable cardiac defibrillator”. Immediate defibrillation (giving the heart an electrical shock) has the best chance to restart the heart and prevent death or complications from prolonged v-fib such as brain damage or permanent heart muscle damage.

Per community medical standards, an ICD should be implanted quickly in patients diagnosed with severe cardiomyopathy. Unfortunately, this veteran waited at least 4+ months after the original cardiac consultation without having ICD placement scheduled. (Exact wait time could not be determined because OIG did not give dates in its report.)

Delayed scheduling of an ICD implant allowed the veteran to have an episode of prolonged v-fib which resulted in severe damage to the brain/body from which the veteran could not recover. Life support was withdrawn 3 days after he collapsed and was found to be in v-fib.

Although OIG concluded “ICD placement might have forestalled that death”, the investigators didn’t draw any direct connection between delayed access to specialty care procedure and the veteran’s death.

My Conclusion: The veteran died from complications of prolonged v-fib because he didn’t have access to appropriate/timely specialty care for ICD placement that would have immediately treated v-fib.

—2. Case 36

This veteran with multiple medical problems had both depression and a history of chronic pain that was not well controlled. When his pain significantly worsened, he made statements to various VA healthcare providers indicating his pain was severe that he was feeling like “it might make him suicidal” and that he “could cry [because of pain]”. However, the veteran denied having any overt suicidal thoughts. The OIG did not give any indication that the PCP provider responded to this veteran’s message(s) regarding the worsening pain control.

When the veteran did present in person to the walk-in PCP clinic to get treatment for the pain, the veteran apparently was only referred to mental health to address the side effect of pain (depression) and did not get medical interventions to relieve the pain. The same day, the patient called the National Suicide Prevention Hotline to complain of “severe and chronic pain unresponsive to treatment” and complained that his PCP was not responding to his requests for contact. A consult was placed to the suicide prevention coordinator but the consult was closed, presumably because the veteran indicated the issue was related only to severe/unrelenting pain and denied having suicidal thoughts. Within one week the veteran committed suicide without ever having any medical intervention to control his unrelenting, severe pain.

As per the OIG, this patient should have been identified as having a high risk for suicide because of underlying depression. However, even if this had been done, it is clear that the impetus for the suicidal thoughts was unremitting, severe pain which was never addressed by the PCP.

The OIG did not draw a connection between the lack of PCP response/treatment of acutely worsening unrelenting pain and the veteran’s subsequent suicide.

My Conclusion: The veteran did not receive appropriate/timely care for his unrelenting, severe pain that served as the impetus for his suicidal thoughts and ultimate suicide.

—3. Case 39

This homeless veteran had a history of PTSD, 3 suicide attempts requiring hospitalization in the prior 2 years, and schizoaffective disorder which is a serious psychiatric diagnosis predisposing him to irrational thoughts, paranoia, and hallucinations.

At the time of presentation to the ER, this patient was having intense emotional stressors as evidenced by the comment that he “hates life and it is so stressful that he doesn’t want to be in it”. He also reportedly felt suicidal because he could not afford to stay at his motel. While inability to pay for a motel is normally not a reason for suicidal thoughts, this veteran was predisposed to irrational thoughts based on his psychiatric diagnosis and could have easily felt overwhelmed at the thought of living on the streets again.

Despite his psychiatric history and intense current social stressors, the veteran inexplicably was rated as having a low risk for suicide. Since the veteran was not appropriately admitted to an inpatient unit where his risk of completing suicide would have been almost zero, the veteran found himself again in an unstable environment. He committed suicide the next day.

Recognizing the veteran’s risk factors for suicide and acute psychiatric instability, the OIG wrote psychiatric admission “. . . would have been a more appropriate management plan” for this patient with a history of “multiple suicide attempts, psychosis, homelessness”. However the OIG failed to draw a connection between inappropriate discharge from the ER and this unstable veteran’s suicide the next day.

My Conclusion: Lack of appropriate psychiatric admission for a patient with multiple risk factors for suicide enabled a death from suicide within 24 hours from point of last VA mental health/ER contact.

—4. Case 40 (almost certainly a suicide based on context)

This veteran had a history of suicidal thoughts, 7 former psychiatric hospitalizations for mental health instability, and a history of hurting himself. He had been admitted to the Phoenix VA inpatient psychiatry unit because of suicidal thoughts, thoughts of harming his brother, and self-reported difficulty controlling his rage.

Although the veteran denied suicidal/homicidal thoughts on the day of discharge, his behavior/demeanor on the inpatient ward and at the family conference indicated the veteran was not yet stabilized psychiatrically on medication.

The veteran was discharged home presumably by his insistence. Neither the family nor the VA inpatient psychiatry staff tried to block this discharge by requesting the Court grant permission to keep this patient involuntarily until his meds could be stabilized. Two days later, the veteran was found dead from a “possible overdose on medication” which, in this context, is consistent with suicide. Even if this was an accidental overdose, the veteran’s psychiatric presentation indicated very poor impulse control that often predisposes an individual to make irrational decisions such as overuse of medication.

The OIG wrote it “would have been prudent” to continue the inpatient hospitalization (either voluntary or involuntary) for this veteran. Failure to prudently continue inpatient psychiatric care resulted in discharge of a veteran to an unmonitored outpatient setting wherein the veteran died from a suspected overdose 2 days later. If the veteran would have remained on the inpatient psychiatric unit, his risk of accidental/intentional death would have been almost nonexistent.

The OIG did not draw a connection between lack of “prudent” continued psychiatric inpatient care and the death of this unstable veteran from suicide 2 days later.

My Conclusion: Premature discharge from a psychiatric ward for a patient with multiple risk factors for suicide enabled a death from suicide within 48 hours from point of last VA mental health contact.

In addition to the previously described cases there were 3 other cases in which a causal link was strongly suspected but could not be proven based on information given in the final OIG report. There were multiple instances of deficits in patient care that reasonably would have contributed to loss of quality of life and/or inadequate follow-up. The specifics of those details can be found in Exhibit D.

In its 5/28/2014 interim report, the OIG stated “Lastly, while conducting our work at the Phoenix HCS our on-site OIG staff and OIG Hotline receive numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility. We are assessing the validity of these complaints and if true, the impact to the facility’s senior leadership’s ability to make effective improvements to patients’ access to care.” By making these statements, the OIG announced its intention on investigating these serious allegations further.

Unfortunately, in its final report, the investigators inexplicably failed to substantiate bullying behavior within the Phoenix VA Medical Center. This was shocking to me. As an employee within that facility for a total of 16+ years, I can unequivocally assert that bullying behavior and other harassment by mid to upper level managers permeated Medicine, Nursing, Environmental Management Service, and the Health Administrative Service at that facility for many years. Not only had I encountered bullying behavior in 4 of those services, my co-workers from each of those areas had spoken to me of extensive harassment at the hands of management. Although I described some of the harassment to OIG investigators, I was never asked to elucidate nor asked if I could refer the investigators to other staff who could substantiate bullying/harassment by mid to upper level management. If I had been asked, I would have gladly referred the team to staff who have been willing to discuss such behaviors.

Example #2: OIG Interim Report—Review of VHA’s Patient Wait Times, Scheduling Practices and Alleged Patient Deaths at the Phoenix Health Care System—5/28/2014

Issue: The phrasing/reporting in the Interim OIG report allowed the VA to effectively obscure the fact that the scheduling system at the Phoenix VA was lagging behind 477 days.

The investigative team failed to include pertinent details on the NEAR list which could have disclosed exactly how long the waits had been for Phoenix VA veterans. Without explaining its statistical sampling method in its interim report the OIG investigators wrote “. . . our review found these 226 veterans waited on average 115 days for their primary care appointment, and an estimated 84 percent waited more than 14 days. Most of the wait time discrepancies occurred because of delays between the veteran’s requested appointment date and the date the appointment was created . . .”

A review of an actual redacted NEAR report from Phoenix VAMC reveals there was much more information about lengthy delays that would have been damaging to the VA if released. (Exhibit B) A significant number of patients waited greater than 115 days. There were 16 pages in the Phoenix downtown clinics NEAR list with 56 names per page through page 15. The wait times slowly trended downward from 477 days. A wait time of 115 days was not found until near the bottom of page 9. Therefore, although the number of days spent waiting for Phoenix VA downtown clinic appointments ranged 0–477 days, approximately 496 veterans on the list waited more than “average” 115 days that were reported by the OIG team.

In addition, the investigators should have known it was meaningless to even list an average number of days waiting because the “average” was an artificial statistical value. According to the way in which the electronic wait list was improperly managed, only those waiting the longest would have the first opportunity for appointments. This was because patients were scheduled according to the order in which they were placed on the unofficial wait list. In truth, the entire scheduling system was backed up 477 days which reflected the longest number of days a veteran had been waiting for an appointment. As per Exhibit B, the veteran who had waited 115 days would not be scheduled until the 496 patients ahead of him were scheduled. Barring any deliberate intervention by staff, the veteran listed on page 16 would not be scheduled until all patients on the 15 pages ahead of him were scheduled. Instead of reporting the average wait time, the OIG team should have revealed the true number of days the scheduling system was backed-up—477 days.

For objective/impartial disclosure of pertinent information including accurate wait times, the OIG should have presented data reflecting more details of the NEAR list. At a time when the country was clamoring for an accurate depiction of the problems at the Phoenix VA, there was no reason to withhold such information.

Example #3: OIG Hotline Case #2014–00459–HL–0044 regarding St. Cloud VA Health Care System

Issue: The OIG is still suppressing at least one Hotline Report that is critical of the VA.

Last year I received a copy of the OIG Hotline Case #2014–00459–0044 that substantiated significant problems at the St. Cloud VA Health Care System including “disrespectful manner by [the facility’s] senior management” and “fear of reprisal” among primary care employees. (Exhibit C) Multiple other serious issues were identified including patient panel sizes at 150 percent over VA recommended limits. That report was not found on the VA OIG website when I specifically searched for it last year.

Recently, with the stated goal of transparency, the OIG released over 140 reports on its website. That OIG Hotline case does not appear when I searched the website again. It remains unclear to me if the absence of this damning hotline report is a unique situation or if additional/all OIG Hotline reports have not been released. I am concerned because such OIG Hotline reports are directly relevant to the oversight and monitoring of the VHA.

Example #4: OIG Report—Health Care Inspection Alleged Quality Control Issues in Supply Processing & Distribution Carl T. Hayden VA Medical Center Phoenix, Arizona—7/13/07

Issue: The OIG failed to consider/investigate the possibility that potentially contaminated surgical instruments may have placed veterans at risk for contracting HIV, Hepatitis B, or Hepatitis C during surgery.

In its 2007 investigation, the OIG team reported “We substantiated that SPD had ongoing problems including contaminated instruments, damp wrappers, and torn or

discolored instrument wrappers, resulting in 20 orthopedic surgery cancellations from August 11, 2006, through April 30, 2007. Because OR nurses were vigilant in checking instrument wrappers during the SPD construction project, surgeries were cancelled when problems were identified. Staff never used contaminated instruments during any surgical procedure. Infection control data did not show any increase in surgical infections from August 2006 through April 2007.”

However this statement did not reflect an adequate understanding of the problem scope nor potential implications of the deficiencies in SPD processing. In the body of its report, the OIG team noted repeated failures of SPD processing of surgical instruments over a prolonged period of time. SPD processing including sterilization removes both visibly soiled contaminants and microscopic contaminants. Although the nurses rejected visibly contaminated instruments, they could not monitor for microscopically contaminated surgical instruments. Therefore, it would have been impossible for the OIG team to state with any certainty that “Staff never used contaminated instruments during any surgical procedure” because only visibly soiled instruments can be detected by the human eye. Viruses such as HIV, Hepatitis B, and Hepatitis C could be transmitted via microscopically contaminated instruments.

The investigators stated there was no spike in surgical infections. However, they likely were referring only to bacterial infections because those are only type of post-operative infections for which Infection Control staff routinely monitor. There is no evidence in the report that the OIG considered the possibility of viral infection transmission. During the timeframe of impaired SPD sterilization processes, every instrument processed was potentially inadequately sterilized after being used in the operating room. For this reason, the OIG should have recommended screening all post-operative surgical patients for HIV or hepatitis infections. Each one of those patients would have been at risk for receiving viral transmission if the instruments used were microscopically contaminated with debris from patients with HIV, Hepatitis B, or Hepatitis C.

SECTION III: GENERAL OIG HOTLINE PROCESS EXPOSES WHISTLEBLOWERS TO RETALIATION

Through my current position in VISN 18, I have become peripherally aware of how OIG Hotline complaints are routinely handled. The OIG screens Hotline complaints based on criteria which are unknown to me. The OIG forwards the complaint electronically to the VISN office supervising the pertinent facility as well as copies the VA Medical Review Service onto the email. The VISN office screens the complaint and sends the complaint either to the facility for self investigation, keeps the complaint for the VISN to investigate, or refers the complaint to another entity for investigation.

If the facility is allowed to self-investigate, the facility senior management then arranges its own investigation and forwards the results of its investigation to the VISN office. VISN office staff review the complaint response in depth for completeness and accuracy. Inaccurate or incomplete responses are sent back to the facility for revision. When the final report is approved by the VISN, the office then sends the complaint back to the OIG and copies the VA Medical Review Service onto the email. The OIG then determines if further action is needed.

To ensure accuracy and impartiality of each investigation and protect whistleblowers, individual VA facilities should not be allowed to investigate themselves or have access to whistleblower names. Because inadequacies in facility performance can affect annual reviews and bonuses, facility-level senior executives have financial and professional incentives to suppress any negative information that might be revealed in an investigation. When OIG hotline complaints are turned over to facility management, there is an opportunity for unscrupulous supervisors to retaliate against the VA employees who either reported the OIG hotline complaint or are involved in the investigation.

Senator KIRK. Thank you, Dr. Mitchell.
Dr. Nee.

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

Dr. NEE. Thank you, Mr. Chairman and members of the Committee, for this unique opportunity.

Senator KIRK. If you could explain——

Dr. NEE. I am sorry.

Senator KIRK [continuing]. Those files that are sitting next to you. Those, as I understand, are hundreds of unread echocardiograms from patients that were through the cardiology department at Hines; as I understand it.

Dr. NEE. These represent the amount that would have been hidden in banker's boxes. And this would be the size of the banker's boxes.

Senator KIRK. How many banker's boxes were there of unread echocardiograms in your view?

Dr. NEE. That was difficult to calculate because the technicians would bring them one by one and when I asked them where they were hidden they said they couldn't tell because they would get in large trouble and probably be fired. So my personal guesstimation, for me, would be somewhere between five to ten.

Senator KIRK. Ten boxes of unread echocardiograms?

Dr. NEE. Correct.

Senator KIRK. That would be over a thousand people?

Dr. NEE. Correct.

Senator KIRK. Yeah.

Dr. NEE. Thank you for this unique opportunity to address ongoing issues regarding retaliation against truth-tellers in the Veterans Affairs system. In preparation for this hearing, I have reviewed countless hours of both written and verbal testimony by those who have attempted to illuminate the pervasive dysfunction within the VA system and subsequent retaliation that all have endured.

Despite significant attention from both Congress as well as the media, there has been no meaningful progress towards increasing transparency during investigations, implementing accountability for documented wrongdoing, or improvement in overall healthcare delivery. It is therefore my belief to make the most of your time and effort, I shall focus on the glaring incongruities between the malignant processes of the VA and the OIG and how most other healthcare organizations must behave under Federal law.

My experience in the private sector as a nurse and a physician encompasses over 20 years of direct patient care at various institutions. I have never encountered such overt disinterest in quality patient care, deliberately organized retribution towards exceptional employees, and blatant disregard for universal guidelines until I encountered leadership at Hines VA in Illinois.

Exposure to the corruption at Hines began almost immediately as the reality of a year-long backlog of unread heart ultrasounds were brought to my attention by the technicians. The studies, hundreds, possibly thousands of them, were stored in banker's boxes and I was expected to interpret them and not ask any questions. My shock turned to horror as I realized many of the veterans had already died from or suffered cardiac complications after the study was performed but prior to it being interpreted. After reporting this

to many supervisors along the chain of command, the nauseating reality that leadership was not only aware but also complicit with the cover-up quickly sank in.

A VA Inspector General report from April 2014 substantiated the significant backlog. However, no one was ever held accountable and no patients were ever informed. In the real world, this type of malpractice and fraud would result in serious repercussions for the physician as well as the healthcare agency, and monetary damages to the patient and/or family. But this is the Veterans' Affairs; a taxpayer-funded agency which is allowed to ignore the law and behave with brazen impunity.

The next stop in the journey of astonishing comparisons will focus on the Veterans' Office of Inspector General; the oversight agency with a penchant for accelerating retaliation against the truth-teller while failing the veterans by either ignoring the initial complaint or engaging in a cover-up. I have been on the receiving end of retaliation from both the leadership at Hines as well as the Inspector General, including defamatory remarks made to the public regarding my integrity. But more troubling is a distinct pattern to almost every truth-teller experience. It begins with the Inspector General first destroying complainant anonymity then personally disparaging the reputation, and finally colluding with the agency to engage in various methods of calculated retaliation.

As a contrast, the Inspector General at the U.S. Department of Health and Human Services works with truth-tellers and has partnered with the Department of Justice to arrest and convict individuals for healthcare waste, fraud, and abuse. To date, it has recovered \$1.6 billion in taxpayer funds. To this point, the previously mentioned Hines Inspector General report from 2014 substantiated my allegations that patients indeed received unnecessary coronary artery stents and coronary artery bypass surgery. However, once again, no one was ever held accountable and patients were never notified.

The current Department of Justice Web site lists numerous cases where cardiologists in the private sector have been indicted for these exact same charges and sentenced to Federal prison and their employers fined as they were made aware of this malfeasance but failed to act. The press release states "The Department of Justice will not tolerate those who abuse Federal healthcare programs and put the beneficiaries of these programs at risk." In order for anyone to justify this double standard one must conclude that the men and women who sacrifice their lives for our country do not carry the same value as patients in the private sector.

Calculus is a marvelous discipline. You begin with the answer and you work backwards. This is the VA OIG's approach to dealing with allegations and patient malpractice. They need to get to a certain answer to protect the status quo and it matters little whether there is a cogent analysis to justify the outcome. Unfortunately, this is inherently corrosive and ultimately a deficient approach to maintaining the integrity of a healthcare delivery system. Please do not confuse this issue with claims of lack of resources or sophomoric accounting practices. It is operational breakdown, organized cover-up, and absence of accountability. Plain and simple.

The time is now for veterans and taxpayers to demand transformative action and for Congress to respond in a bipartisan manner.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF DR. LISA NEE, M.D.

Thank you Mr. Chairman, and members of the subcommittee, for this unique opportunity to address ongoing issues regarding retaliation against truth tellers in the Veterans Affairs system. In preparation for this hearing, I have reviewed countless hours of both written and verbal testimony by those who have attempted to illuminate the pervasive dysfunction within the VA system, and the subsequent retaliation they all have endured. Despite significant attention from both Congress as well as the media, there has been no meaningful progress towards increasing transparency during investigations, implementing accountability for documented wrongdoing, or improvement in overall healthcare delivery. It is therefore my belief that to make the most of your time and effort, I shall focus on the glaring incongruities between the malignant processes of the VA and how most other healthcare organizations behave under Federal law.

My experience in the private sector as a nurse and a physician encompasses over 20 years of direct patient care at various institutions. I had never experienced such overt disinterest in quality patient care, deliberately organized retribution towards exceptional employees, and blatant disregard for universal guidelines, as well as our countries laws, until I encountered leadership at the Hines VA in Illinois. Exposure to the corruption at Hines began almost immediately as the reality of a year long backlog of unread cardiac ultrasounds was brought to my attention by the technicians at the start of my tenure. The studies, hundreds of them, were stored in banker's boxes, and I was expected to interpret them to address the problem, and yet not ask any questions. My shock turned to horror as I realized many of the veterans had suffered cardiac complications, or already died, after the study was performed, but prior to it being interpreted. After reporting this to many supervisors along the chain of command, the nauseating reality that leadership was not only aware, but also complicit with the cover-up, quickly sank in. Please note that there is an Inspector General report from April 2014 that substantiated this significant backlog, however, no one was ever held accountable, and no patients were ever informed. In the real world, this type of malpractice and fraud would result in serious repercussions for the physician as well as the healthcare agency, with monetary damages to the patient and/or family. But this is the VA—a taxpayer funded agency, which is allowed to ignore the law and behave with brazen impunity.

The next stop on this journey of astonishing comparisons will focus on the VA Office of Inspector General—oversight agency which has a penchant for accelerating retaliation against the truth teller while failing the veterans by either ignoring the initial complaint, or engaging in a cover up. I have been on the receiving end of retaliation from both the leadership at Hines as well as the OIG, including defamatory remarks made to the public regarding my integrity. More troubling is a distinct pattern with almost every truth teller experience. It begins with the OIG first denying complainant anonymity, then personally disparaging the employees' reputation, and finally colluding with the agency to engage in various methods of calculated retaliation. These problems do not occur with every branch of the OIG. As a contrast, the U.S. Department of Health and Human Services OIG has worked with truth tellers and has partnered with the Department of Justice to arrest and convict individuals for healthcare waste, fraud, and abuse. To date it has recovered \$1.6 billion dollars in taxpayer funds.

To this point, let's return to the same Hines OIG report from 2014 that had substantiated that patients had received unnecessary coronary procedures including coronary artery stents and coronary artery bypass surgery, however, no one was ever held accountable, and patients were never notified. The current DOJ website lists numerous cases where cardiologists in the private sector have been indicted for these exact same charges and sentenced to Federal prison, and their employers fined because they were made aware of this malfeasance, but failed to act. The press release states "the DOJ will not tolerate those who abuse Federal healthcare programs and put the beneficiaries of these programs at risk". In order for one to justify this double standard, one must conclude that the men and women who sacrificed their lives for our country do not carry the same value as patients in the private sector.

Calculus is a marvelous discipline. You begin with an answer and work backwards. This is the VA OIG's approach in dealing with allegations of patient malpractice. They need to get to a certain answer to protect the status quo and their standing, and it matters little whether there is a cogent analysis to justify the outcome. Unfortunately, this is an inherently corrosive and ultimately defective approach to maintaining the integrity of a healthcare delivery system. Please do not confuse this issue with claims of a lack of resources, or sophomoric accounting practices. These are issues of management—operational breakdown, organized cover-up, and vindictive retribution to anyone who refuses to actively or passively contribute to the conspiracy—all illegal, and sadly, unpunished.

It is impossible to halt systemic corruption, deception and impropriety in the absence of accountability. Transformative action will need to involve three components:

1. *Responsibility.*—Leadership, both clinical and administrative, must be held responsible should care be compromised.
2. *Transparency.*—Employees who identify problems must be allowed to illuminate the issues that directly cause, contribute to, or hide inadequate and harmful patient care.
3. *Protection.*—Oversight must be consistent and empowered to act on behalf of the employees when malpractice, malfeasance, retribution, and retaliation are encountered.

These are far from novel concepts, and most certainly are codified in policy and procedure manuals. But without accountability such as that demanded of non-governmental agencies, the written words and statements have no value. They carry no weight. The heroes that we call our veterans, and the honorable people who strive on their behalf, deserve so much better treatment. The present system has empowered the wrong people, documented their criminal behavior, and failed to hold anyone responsible with the help of those who are tasked with the charge of protecting the victims and truth tellers. Worse yet, there is clear evidence that these oversight agencies have acted as confederates in the retaliation toward those who have risked their careers and their health acting on behalf of the veterans that we hold so dear. Unless substantive changes are demanded, nothing can change, and the victims will continue to suffer.

There are tangible and proven solutions to most of the deficiencies within the VA system. However when one operates in a state of cognitive dissonance rather than reality, these solutions can never be realized. There are many overwhelming obstacles that we all must face at different times in our lives. How we process, react, adapt and flourish from these defines us as a person. The American public deserves the truth, and when they find out the truth, they will not allow our veterans to be mistreated and marginalized. And this will define us as a nation.

Senator KIRK. Lisa, let me start off with a question for you. Tell me what behaviors in the cardiology department led you to blow the whistle at Hines.

HINES VAMC CARDIOLOGY DEPARTMENT

Dr. NEE. Well, they're numerous but, you know, at the end of the day it is about patient care, and to work in the private sector and realize that this was just a completely different world where the outcome of the patient didn't matter and standard of care didn't matter, quality assurance didn't matter, operational process didn't matter. It is not how things work but it is allowed to happen within the VA system.

Senator KIRK. I was struck by you comparing civilian medicine to VA medicine. In civilian medicine under Medicare, you have noted that the Department of Justice has indicted some cardiologists for the unnecessary procedures that you saw at Hines?

Dr. NEE. Correct.

Senator KIRK. You also told me in early interviews that you had a patient or two who had multiple stents. How many stents was evident in that patient?

Dr. NEE. That patient, it was somewhere between 10 and 11 which would be completely unacceptable.

Senator KIRK. Eleven stents all in the same person.

Dr. NEE. Correct.

Senator KIRK. Is that immediate grounds for malpractice?

Dr. NEE. Well, it really does depend on the case but if the patient keeps returning and there is no evidence to support that those lesions are significant, then no. There would be no reason to stent those lesions.

Senator KIRK. Thank you.

PHOENIX VAMC SCHEDULING PRACTICE

Senator KIRK. Dr. Mitchell, since you blew the whistle on the VA scandal, has anything changed at the Phoenix VA in your view?

Dr. MITCHELL. The scheduling practices have changed in that now patients are either being scheduled or they are being referred to Choice. The problem is that there is a delay in the community of getting Choice appointments scheduled. So they are still encountering delays from an administrative standpoint. From a culture standpoint, no. Retaliation is alive and well. I have many friends within the Phoenix VA that are scared to speak up. They call me with patient concerns and then I report them at the VISN level or I try to assist them in how they can address them without suffering retaliation.

Senator KIRK. Thank you.

HEART STENTS AT HINES VAMC

Dr. Nee, if someone is walking around with 11 stents in their heart, what is likely to happen?

Dr. NEE. Well, I mean, again, that is difficult based on every patient. It would depend on why the stents were placed in the first place. Most of the time people have multiple arteries. Then that requires stents and, possibly, would need bypass surgery.

But the goal is to make sure that the patient gets the proper treatment that they need, not just what the physician wants nor what looks good and to make sure that the patients are informed if they receive something that they shouldn't have. Because you can be on medications after those stents that would be counter-productive to other procedures or there are certainly sequelae suffered for unnecessary bypass surgeries.

Senator KIRK. Have any doctors been held accountable for this practice at the Hines VA?

Dr. NEE. Nobody was held accountable for the allegations that were substantiated except people were told not to do that again. So if that is someone's definition of accountability, then I suppose yes.

Senator KIRK. None.

BONUSES AT HINES VAMC

How many bonuses have been paid out at the Hines VA?

Dr. NEE. That is interesting to me. When I worked there, I wasn't really aware of the bonus system. It wasn't until after I left and had filed an additional report through the OSC and obtained bonuses through a FOIA request that I came to find out that I was

indeed the lowest paid in the department and every single person that worked in that department received multiple bonuses. I didn't receive anything.

Senator KIRK. Because of your whistleblower status?

Dr. NEE. Absolutely.

Senator KIRK. Senator Udall.

Senator UDALL. Thank you very much, Chairman Kirk. And once again, I just want to tell you how much I appreciate you calling this hearing because I think what you are trying to do is get to the bottom of what really happened. And these two witnesses have exemplified really what the problem is. And one of the things I just want to say at the beginning, I mean the behavior you have described is just absolutely appalling to me. The lack of care in terms of really realizing that these patients are veterans and they need the best possible medical care. And yet, you came forward and you were treated badly because you were trying to expose the things that were out there. That, to me, this is very, very damaging testimony.

TRANSFORMATIVE ACTION NEEDS

Dr. Nee, when you talk about transformative action, I think that is really what we do need. I don't have any doubt about it. I mean I think that we need to change the culture, we need to change the way of thinking about this. Have either of you visited with the secretary, Secretary McDonald, the new secretary that has come in? Has he reached out to you in any way?

Dr. MITCHELL. I have met briefly with him and we had probably a 20- or 30-minute talk. We talked mainly about the issues at the Phoenix VA and then, also, the fact that there is no standardized triage nursing protocols for the emergency department in the entire United States. I would not have a loved one go to an emergency room at the VA because it is the luck of the draw as far as the experience of the triage nurse recognizing that the symptoms were difficult. The VA is a national leader in training for physicians. There is no reason why the VA should not establish nursing triage protocols. They are very common in the community and that was one of the issues that we brought up, or I brought up.

Senator UDALL. Why do you think they don't, Dr. Mitchell? Why do you think they don't establish these protocols?

Dr. MITCHELL. I have absolutely no idea.

There is very little about the VA in terms of quality patient care that I understand. The VA consistently—I reported hundreds of cases where patient care was either compromised or was at risk for being compromised. What that resulted in was my evaluations being dropped, me being screamed at by the former chief of staff, me being put on unlimited schedules without compensation; things that a reasonable human being, if you bring up a patient care issue, you would think that they would do everything possible to correct the situation. Acknowledge the problem and correct the situation. That is what normal human beings do who actually care about patients.

I honestly do not understand the VA system. I want to stay within it to work for change because I think it has the potential to be the premiere healthcare leader in the United States. But at this

point, it makes no sense and I am hoping that Congress can inspire some common sense within the VA system.

Senator UDALL. And when you talk about the things that you have stayed in touch with the VA where you were working as a physician and stayed in touch with the people, and you say things haven't changed?

Dr. MITCHELL. Not the culture. People are still afraid to speak up. I have friends within the emergency room that have reported to me strokes that have gone unnoticed by the triage nurse, that stroke protocols are not being fulfilled, that elderly patients with potential blood infections are still being left in the waiting room, that the ER is overwhelmed at times even with all the new physicians that they have hired.

I reported that the new VA emergency room expansion is dangerous. The plans were dangerous when they were enacted and it is a waste of taxpayer money to build the facility as they are currently building it. I reported so many violations; so many things that needed to be improved urgently. And yet, the administration either locally or nationally is not addressing it.

TRIAGE NURSING PROTOCOLS

I came forward mainly, not for the retaliation against me, but mainly to improve the patient care at the level of the emergency department. And again, in all this time there has been no effort to standardize triage nursing protocols. They have standardized triage protocols for telephone triage. I have heard they have them in the ambulatory care clinic although I haven't independently verified that. But again, it is strictly the luck of the draw when you walk into an emergency room, if that triage nurse has the expertise and training to recognize subtle symptoms that need to be reported to a physician immediately.

Senator UDALL. That is appalling. Appalling.

Dr. Nee, did you have a chance to visit with Secretary McDonald at all?

Dr. NEE. I did.

Senator UDALL. You did. Okay.

Dr. NEE. I had a meeting with him here in Washington a while back. Mostly, to address the concern I had with the OIG report and the OIG retaliation against people who come forward. He stated he would look into it and get back to me, which he has not.

Senator UDALL. Now, did you stay in touch with—I know you are not still a part of the VA now and you are out in private practice?

Dr. NEE. I am out in the private sector working, correct.

Senator UDALL. Yes. And have you stayed in touch, as Dr. Mitchell has, with folks and seen if there are any changes back to your—

OVERNIGHT INVESTIGATIONS

Dr. NEE. I have. And it has actually gotten worse at Hines for the initial allegations I brought fourth with the OSC. The OSC wanted the OIG to look into these again. I was interviewed in Chicago in a two-hour interview by the OIG, but they have refused to provide me with the transcript. They came up with the same con-

clusion that they did the first time and subsequently the Office of Medical Inspector was brought in.

Interestingly, the Office of Medical Inspector has preliminarily substantiated some allegations. Unfortunately, the people who came forward at Hines to be witnesses during the Office of Medical Inspection are now being retaliated against and saying that there is nothing that is going to happen at Hines, nothing has ever happened at Hines. And now, the people who came forward are fearing for their jobs.

So that is a scary message to have three separate investigations by oversight agencies and nothing happened except, now, your job is threatened. I mean it really is a harrowing experience to go through and quite frightening if you're really want people to come forward to give veterans good care.

Senator UDALL. From both of your perspectives, if you were there and more able to be in a top management position, what would be the first things you would do to try to change the culture as you have described it?

Dr. NEE. There is really only one thing that needs to change. You have to have accountability and deterrence. I mean human nature is that people are going to try to game the system or they may try to do things not to their best ability. And I am not saying physicians aren't good in private practice, they are inherently good people, but people work within a system because they know, if they don't, there is accountability for their actions.

Dr. MITCHELL. Yes. I would agree.

Right now, the administrators that actively retaliate against individuals need to be disciplined. It needs to be made an example. Right now, that type of behavior is rewarded. In fact, the physician chain-of-command that retaliated against me is still in place even though physicians, five physicians, told him that the nurses were withholding reports from me, withholding EKGs, slowing down my orders. He absolutely refused to investigate. That is not an administrator who needs to be in a position of power making decisions, life and death, for patient care. Right now, behavior like that is totally—you are immune to punishment if you enact that type of behavior.

What happens is the VA settles whistleblower retaliation claims, settles EEO discrimination claims, and there is absolutely nothing that happens to the person that actually enacted the discrimination or the retaliation. That has to stop and it has to stop immediately. Once you send that message clearly, then that behavior will stop.

Senator UDALL. Well, let me just conclude by saying you both chose, rather than the anonymous route, to put your names forward which is a much more difficult route, but I think you have, through that, been able to really bring out some horrifying stories that I think have had an impact. I mean, for example, the law that was passed in the last Congress. So I appreciate your courage in terms of what you have done and I just want to thank you very much.

Dr. MITCHELL. Thank you.

OIG ANONYMITY AND CONFIDENTIALITY

I would like to state though that when I reported it, I reported it to keep my name confidential from the people because I feared for my job; I always heard that. I expected that they would keep my name confidential. They didn't. I am extremely concerned with the OIG's latest statement encouraging whistleblowers to come forward.

Again, the OIG routine hotline process, even if you keep your name confidential, the report is sent down to the VISN level; the VISN sends it to the facility or a portion of those to facility; facility has full access to the whistleblower's name and can retaliate against them with impunity. Unless the OIG explains itself and can say how it is going to enforce confidentiality at all levels, they should retract their statement.

Senator UDALL. Thank you.

Dr. NEE. I agree.

When I made my first report to the OIG hotline, I had already known that I was leaving. But, within 24 hours, the chief-of-staff came and told me that if I went forward with any patient information that he would bring me up on patient privacy violations. So not only did I not have anonymity, I could not come forward with allegations regarding patient care as a physician. That is a pretty harrowing thought to think that that is how we are treating people who only want to give good patient care.

Dr. MITCHELL. Yes. There is the option to report anonymously; however, what happens is, if you report anonymously, there is no one the investigators can get the information from so you have to give your name if you really want a valid investigation.

Unfortunately, in my case, the Inspector General chose not to interview me at all. In fact, no one from the facility has ever asked my any questions. The only thing that happened was the suicide project I was working on was stopped immediately.

Senator UDALL. Thank you.

Thank you, Mr. Chairman.

Senator KIRK. Thank you.

Mrs. Collins.

Senator COLLINS. Thank you very much, Mr. Chairman.

I am truly stunned by your testimony today and what you have endured in order to do the right thing for the patients at the VA.

The system is totally backwards. Those who were not providing adequate care are the ones who should have been disciplined and held accountable. And instead, both of you who came forward with your complaints, your concerns, your deep caring for the patients at the VA centers, were the ones who have paid the price. This is just completely unacceptable. And as I said, as someone who has worked hard to strengthen whistleblower protections, it is discouraging and appalling to hear the retaliation that occurred against you.

Now, Dr. Mitchell, you have just talked about the importance of being able to file a confidential complaint, or concern is really the better word. In the testimony today of the Acting Inspector General, the Deputy Inspector General, there is a section saying that the hotline's submission process has been improved to ensure ano-

nymity and confidentiality. Have you reviewed the changes that have been made and do you have any confidence that they would prevent what happened to you?

INVESTIGATION PROCESS

Dr. MITCHELL. They wrote a sentence on a piece of paper but they didn't explain how they were going to protect confidentiality. Currently, the process is when you file an OIG hotline complaint it goes into the Inspector General; the Inspector General sends the complaint to the VISN level, which is the Veteran's Integrated Service Network; it also copies the medical review services from the VA on to the e-mail. At the VISN level, they look at the complaint, they decide whether to investigate it themselves, whether to give it to a third party, or whether to send it to the facility.

Simply because of the sheer volume of complaints that come in, there is a significant portion that are investigated by the facility. The facility gets to set up its own investigation and write its own report. I can say at my VISN, the quality people try really hard to verify the accuracy and the completeness of the report. They do an outstanding job. However, I can't verify that in all VISNs. What happens with confidentiality is, if that report is sent anywhere other than the Inspector General, there is a potential for the name to be leaked; even sending it to the Medical Review Services there is a potential for the name to be leaked.

I would want to know specifically how the Inspector General is going to prevent that the names from being released. Many times it is important for the investigators to have the name of the person who filed the complaint because that person has a tremendous amount of evidence and that evidence is necessary to substantiate the allegations. Unless the Inspector General can state specifically how it is going to protect the confidentiality while still allowing the investigation to move forward, I wouldn't believe a single word they said.

Dr. NEE. What I would like to add is I would then want to know, if your anonymity is disclosed, what type of repercussions is that supervisor going to have to deal with because of that? That is what should be written in the policy.

Senator COLLINS. Very important questions.

Did either of you go to the Office of Special Counsel for assistance?

Dr. MITCHELL. I filed a complaint through the Office of Special Counsel.

Dr. NEE. I also did and I am still working with them. And I truly believe that that office works as hard as it can but that is not the office for patient care.

Senator COLLINS. Right.

Dr. NEE. And so, they get mired and dragged down into that and then somehow this unfair responsibility gets placed on them. That is not their responsibility.

PATIENT CARE

Senator COLLINS. Let me go to the issue of patient care. I find it astonishing, Dr. Mitchell, that after you brought forth this information that you were not even interviewed. And I also find it in-

credible that a facility would be asked to essentially investigate itself when there are physicians or other medical personnel there who are the subject of the concerns.

Dr. MITCHELL. Correct.

The investigation process for the OIG hotline needs to be overhauled and needs to be changed significantly because there is such a vested interest in suppressing negative information.

It is not just the Inspector General that needs to be overhauled. The Office of Medical Inspection has recently investigated my allegations of poor patient care. Those reports should be made public some time in the middle of August. They substantiated three of the four of my allegations. The fourth one was valid at the time I was there, but they did such an incredibly poor job of investigation that they missed the depth and the breadth of the problems.

In their report, they actually tried to smear my credibility by stating that they couldn't find any evidence of retaliation against me. However, when I spoke—I had access to the un-redacted witness list. When I spoke to some of the witnesses who are my friends, and just asked them what type of questions did they ask you without telling me what they said, they said they never asked us about you. Those questions were not asked.

And so, it is not to have a good, strong VA system with a good quality oversight, you need to have a strong Inspector General but you also need to have an honest OMI, Office of Medical Inspector. And I don't believe that exists today.

Senator COLLINS. My time has expired. Just one very quick question and answer.

Do you think the Inspector General has the expertise to do these kinds of investigations?

Dr. NEE. I would say no.

Dr. MITCHELL. I would say absolutely not. Or, they have the expertise but they are having the same problem within their system in that they are not allowed to legitimately report their findings.

Senator COLLINS. Thank you.

Senator KIRK. Mr. Reed.

Senator REED. Thank you very much, Chairman and Commander Kirk, U.S. Navy.

Doctors, thank you for the obvious concern you demonstrated for your patients by placing your own professional standing, your own name and, you know, out front. So I appreciate that very much. And I'm just, for context, you now or you have, I presume, worked in private hospital settings?

Dr. MITCHELL. I have never worked in a private hospital setting except during training for my 3 years of residency and 1 year of fellowship.

Senator REED. Then let me direct this to Dr. Nee.

Dr. NEE. Sure.

PRIVATE SECTOR PROCESSING OF COMPLAINTS

Senator REED. In terms of a private medical, these problems come up in terms of a doctor wanting to point out deficiency care. Do they have a much better system there?

Dr. NEE. Well, I honestly, when this first came up at the Veterans' Affairs at Hines with the backlog, because I had been in the

private sector, truly thought this is just an oversight and we just need to address this, read all the studies, and this will never happen again. There are operational processes in place in the private sector. There is quality assurance. There is a way to bring forth complaints from anyone. It doesn't have to be—it could be from lower level positions all the way to higher level positions because they are not necessarily looking to fix a blame on somebody, they are looking to fix the problem.

Senator REED. So there are models—

Dr. NEE. Oh, absolutely.

Senator REED [continuing]. Numerous models that could be adopted fairly quickly, presumably by the Veterans' Administration, to have a much more effective system of processing complaints.

Dr. NEE. Correct.

Senator REED. Again, not to fix the problem. Not necessarily to adjudication or punish anyone else just to fix the problem.

Dr. NEE. Correct.

Senator REED. One other aspect of this issue is that in this might be a tendency to not address the problem because the resources aren't available to fix it?

Dr. NEE. I would have to disagree with that.

Senator REED. No, I just asked that as a question. I don't ask that as a conclusion. Was that something you sense? And I am going to ask both of you to respond.

Dr. MITCHELL. My sense—

Senator REED. You know, I don't—I can't fix this so I don't want to—the problem doesn't exist. That kind of logic. I don't think it is correct, but does that logic and I'll—Dr. Mitchell and Dr. Nee, please?

ARTIFICIAL PERFORMANCE EVALUATIONS AND MEASURES

Dr. MITCHELL. No, I think the issue was that rule number one is you do not let any negative information rise above your level. And truly, because your proficiency and your annual bonuses are based on whether or not you have problems or not, there is an ingrained tendency to suppress all negative information. And it is not just in this last year; it has been in the VA system for decades. There are many, many really dedicated employees who try to work around the system because they know, if they speak up, they'll be fired.

Senator REED. Dr. Nee, please?

Dr. NEE. I agree. Even if there are people who want to work harder, you know, even if you didn't want to report something and just say, "You know what? I'll pick up the rest of the work."

Senator REED. Right.

Dr. NEE. That is looked down upon and strongly discouraged. And then, your life is made very difficult.

Senator REED. So one of the disincentives is this whole competition scheme that says, you know there are no problems here rather than, as I recently asked as a question, I know there is a problem here, but since I can't fix it, I am going to make it go away. It is really that the former, the notion of I can't admit any problems on my watch.

Dr. NEE. Correct.

Dr. MITCHELL. There is a problem with the way the physicians and other staff are evaluated. They are evaluated on performance measures and the performance measures are artificial. You can be an exceptional physician, do incredible patient care but, if you, like in the ER, if your waits are above six hours because we didn't have the resources, my evaluations were dropped because our waits were above six hours because we didn't have the resources. I wasn't necessarily evaluated on what a damned good physician I was.

Senator REED. So there is a resource connection in the sense that you are a very, very good physician but you don't have all of what you need to get the job done efficiently, therefore, you are downgraded.

Dr. NEE. Yes.

There is a system called Just Culture and that is where, if there is a problem identified, you look at the system issue not at the person issue. Many of the problems in the frontline are related to systems. Many of the problems in the middle and upper level management are related to people problems. There is truly administrative evil within the VA. They deliberately overlook issues of patient care, including life and death, in order to benefit themselves professionally.

Senator REED. Well again, the doctors, thank you for your commitment and for your care of your patients. I appreciate that very much.

Senator KIRK. Mr. Boozman.

Senator CASSIDY. May I interrupt?

I have to go upstairs to present a bill on Energy Committee.

Senator KIRK. Go ahead.

Senator CASSIDY. No, I have to be in two minutes. I just want to acknowledge Shea Wilkes who is a whistleblower from the Overton VA in Shreveport and ask unanimous consent his written testimony be included in the record.

Senator KIRK. So ordered.

[The statement follows:]

PREPARED STATEMENT OF SHEA WILKES

In early 2013 I addressed issues concerning faulty hiring practices and manipulation of numbers related to performance measures and scheduling with the Acting Chief of Staff of Overton Brooks VAMC (OBVAMC). No action was taken. In June 2013 I reported faulty hiring practices and manipulation of numbers related to performance measures and scheduling to the Office of Inspector General for the VA (OIG). I did not receive a response from the OIG related to this claim.

In April 2014 the story of the waitlist at the Phoenix VAMC surfaced in the media. I had heard of and seen wait-lists in Mental Health department of OBVAMC and I knew that waitlist were just one way that scheduling and numbers at the hospital were being manipulated. At this time I was no longer working in the Mental Health. I was being deliberately and systematically removed from the department for filing with OIG in June 2014. I ultimately requested removal from the department due to the manner in which I was being treated. Prior to requesting my removal from Mental Health Department, I discovered what I deemed to be Overtime and Comp Time fraud by the Operations Manager (Mental Health Leadership). I reported this to the OIG in January 2014.

After watching the Phoenix VAMC story develop, I decided that I could not wait any longer for OIG to take action on my complaints. I felt that I had exhausted all internal options to report the wrongdoings, so I hesitantly decided to take my story to the media. I worked with a Shreveport Times writer during the month of May 2014.

I was told that once the story hit the news that I would be contacted by TV and other media in our area. I believed that once the story was published that the list would disappear. This is when I secured a copy of the wait-list and informed the OIG of its existence.

The Shreveport Times wrote a story on the issues at the OBVAMC at the end of May 2014. When the story hit the news, as I anticipated, the list was removed from a share drive and replaced with a different list.

I contacted Senator Vitter's office in an effort to get OIG to OBVAMC to investigate the existence of the list. The day after Senator Vitter's office sent a letter to the VA OIG Director Richard Griffin requesting that the list be investigated, I received a call from a VA OIG Special Agent. The agent explained that he and another agent were there way to Shreveport from New Orleans and that they wanted to meet with me and obtain the list.

I believed that the OIG was calling in response to the request from Senator Vitter. It appeared that after months of trying to get the VA OIG's attention that the existence of the wait-list was going to be investigated.

A few hours after I received the call from the OIG Special Agents, I received another call from them telling me that they had arrived in Shreveport and wanted to meet with me. The OIG Special Agent asked me at is time if I wanted to meet them off station and provide them a copy of the wait-list. I explained that I did not feel comfortable taking the wait-list off hospital grounds and that one copy of the wait-list was on the computer's hard drive. The OIG Special Agents agreed to meet me in my office on the 10th floor.

When the OIG Special Agents arrived at my office we sat down and I signed a release and we began discussing the issues. The OIG Special Agents took the copies of the wait-lists and took the hard drive from my computer. They left and told me that they were going to speak to other employees.

I took the rest of the day off to settle my nerves. The next day the OIG Special Agents came back to speak with me. At this point I realized that their questions were related more towards how the wait-list was obtained and not about why the wait-list existed. I also realized that they were unaware of the request by Senator Vitter or of the recent news article.

Later that evening I spoke to a Mental Health RN who told me that OIG Special Agents had explained to her that if she had provided me access to the list that she could be a accomplice to a crime.

At this time I discussed the situation with my lawyer. My lawyer contacted the OIG Special Agents and asked them if I was under criminal investigation. The OIG Special Agents explained to my attorney that they were criminal investigators and that they were investigating the issue of how I obtained the list. My attorney at this time told the OIG Special Agents that all communication should go through him.

Shortly thereafter the OIG Special Agents contacted my attorney and asked if they could speak to me. My attorney explained to the inspectors that he would let the investigators talk to me about everything except how I obtained the list.

The OIG Special Agents met with my attorney at his office. They were accompanied by a polygraph tester. My attorney again reiterated to the OIG Special Agents that he would allow them to speak to me about anything except how I obtained the list. The agents said that they didn't need to talk to me about anything else.

It was at this point that I became totally discouraged and had to shift focus into a mode of protecting myself instead of advocating for Veterans' care.

Over the next several months I experienced the weight of an investigative agency of the Federal Government. The pressure from having the burden of a criminal investigation hanging over me was tremendous. I was also experiencing pressure from OBVAMC leadership and being called a liar. I became extremely frustrated that the OIG nor the VA leaders cared enough about the Veterans' care to do a complete investigation into reported wrongdoings. It was literally heartbreaking for me as an individual who only wanted to do two things in my life: (1) be a soldier (2) help Veterans. Despite my complaints I continued to witness poor care being provided to Veterans. I had put my career and livelihood on the line and all I gained by doing so was being purposely isolated by the VA and hung out to dry by the OIG.

There is no doubt in my mind the OIG's sole purpose of coming to Shreveport was to intimidate myself and other potentially whistleblowers for coming forward. Their main purpose was intimidation and damage control. The investigation was shoddy at best in my eyes. The OIG showed no interest investigating the wrongdoing. Rather they interviewed select persons with the intention of intimidating them and others not to come forward with information about how and why the wait-lists existed.

I had given the OIG Special Agents the names of numerous witnesses who could substantiate my claims of wrong doing. They did not interview them.

As I languished for a year under investigation for obtaining a list that wasn't supposed to exist I began to contact other whistleblowers. My anger started to increase as it became apparent the OIG had used the same scare tactics all over the country to intimidate other whistleblowers. To make matters worse the OIG began time and time again whitewashing reports and attacking whistleblowers in these same reports. This solidified my belief that the OIG was not going to help solve the problem, but that it in fact was part of the overall problem with the VA System.

After living a VA nightmare the last year it has become very apparent and saddens me to say that I see no real change in how VA operates. I believe that the problems with the VA are endemic to its structure. There will be no real reform until there is a independent agency that is willing to conduct thorough investigations and willing to hold individuals at every level accountable.

The VA has become a bloated bureaucratic system in which its leadership is more interested in perpetuating their own careers rather than caring for our veterans. When given a performance measure leaders don't look at how they can adapt their programs to meet the measure, rather they look at the performance measure and try to figure out a way to manipulate it to make it look like they have met the expected goal. The system needs true reform and its leadership needs to be held accountable for its failures.

Senator CASSIDY. Thank you.

Senator BOOZMAN. Well, thank the both of you for being here. We really do appreciate your courage in coming forward.

VA CULTURE

Tell me, I guess really I'd like to go to the culture.

Dr. Nee, why the boxes? I mean, how do you get in this situation where you inherit this type of situation? You have got people that are trying—how do you get in this situation where you're doing, somebody is doing a bunch of tests and nobody is even taking the trouble to read those? Is that not having enough staff or is it incompetence or is it—

Dr. NEE. I think it is people that—

Senator BOOZMAN [continuing]. Laziness?

Dr. NEE [continuing]. Don't want to work that hard. I mean there was plenty of staff within the department. Certainly, people could have pitched in. I was only one person when I arrived and my work ethic from private practice was inpatient ultrasounds were read that day; outpatients within 24 to 48 hours not 12 months. So I mean this was not a resource issue. This was people that just didn't want to work that hard and you are not going to come and tell us otherwise.

Senator BOOZMAN. So just really laziness and just the fact that there was very little care for the individuals involved that have had those tests.

Dr. NEE. I would have said—I mean, I can never imagine looking at those boxes and being okay with that. I still, to this day, don't know where they were at but many people knew that they existed.

Senator BOOZMAN. Right. Very good.

Tell me about the culture of the whole thing though. We have this situation where we have got people that are practicing and you are bringing forward facts where the practicing is not very good practicing. Again, is that because—take the boxes aside, but just in basic patient care. Is that because, again, they are incompetent or we minced incentives? You know the incentives of the appearance that good care is being done but is it a numbers-driven game where people are under the gun to—

Dr. MITCHELL. To put it in a nutshell, the VA cares more about its public image than it does about patient care. I can tell you that the frontline staff, the physicians and nurses that I worked with, are some of the best in the VA. But like all systems, there are some that are less than ideal or even should not be working in the VA.

I don't think that mixture is any different than in the private sector, but I do believe the difference is that speaking up and identifying problems, the first knee-jerk reaction is not to acknowledge the issue and then fix the problem. The knee-jerk reaction is not to let the problem be known by anyone else.

Although people have disparaged the VA, there are millions of quality care episodes that occur across the Nation because the VA does do incredibly good work. Unfortunately, when they drop the ball, they drop the ball so significantly that people die.

Senator BOOZMAN. No, and I think we have to be very, very careful in the sense that, again, not disparaging all of the people that are working very, very hard and there is some tremendous people. In fact, the vast majority of people in the VA are doing a great job and really do care about patients. But it is trying to figure out what in the culture of the VA, gets us in these situations where we have the experiences that both of you all have had.

Dr. NEE. Well, it is up in the higher level of the administration. It is not anybody in ancillary staff, direct patient care, absolutely. They wanted to work hard. But, when you come in from the private sector and you are trying to work those same workloads and they were making fun of it, you know in a sense of you are going to not do well here if you are going to working at that level.

So it is not because they didn't want to, but they have already been put in their place when they tried to and it is just an acceptance.

Dr. MITCHELL. Yes.

The direct administrators that retaliated against me, I actually don't hold that against them because they were between a rock and a hard place. If they spoke up and said that what you're asking us to do to Dr. Mitchell is wrong, they in turn would be retaliated against by their superiors. In fact, two of my chiefs of staffs are two of the most ethical physicians I have ever known, and yet they made decisions I certainly didn't agree with because I felt they were retaliatory. I also knew that they had no other choice. And in other ways, they tried to make it up to me. They tried to make sure that they made good patient care decisions, but their hand was forced multiple times by senior administration.

VA INSPECTOR GENERAL

Senator BOOZMAN. Dr. Nee, in your written testimony you were pretty scathing in your critique of the VA Inspector General.

Dr. NEE. Absolutely.

Senator BOOZMAN. How did they disparage your reputation?

Dr. NEE. Well, they wrote a letter to Senator Kirk that basically stated I had not presented any evidence to them on multiple occasions which was false. They had evidence the first time. They had evidence the second time. There is two hours of testimony that they refuse—I mean if I am truly am lying, then put forth the testimony.

Senator BOOZMAN. Sure.

Dr. NEE. But that is not forthcoming.

Senator BOOZMAN. Good.

Dr. NEE. And then, the preliminary Office of Medical Inspector has actually countered what they have said. So I mean you have to think about that. Someone is putting in a letter to a Senator of the United States and then it goes out on a press release that you are a liar.

Senator BOOZMAN. Who signed the letter?

Dr. NEE. Richard Griffin.

Senator BOOZMAN. Okay. Very good.

Thank you all very much.

Senator KIRK. Mrs. Capito.

Senator CAPITO. Thank you.

I want to thank both of you.

Thank you, Mr. Chairman.

Just a quick question. We read consistently about the lack of young professionals going to the VA; nurses, doctors, shortages. In light of what we have heard today, I think it will be more discouraging for a young physician to want to be a part of a health system that is as dysfunctional as you have described.

RECRUITMENT OF YOUNG HEALTH PROFESSIONALS

If we could maybe sort of fast-forward here, what could you tell that next generation of health professional why they would want to work at the VA and what kind of hope there would be for them that they would be able to exercise the professional abilities that they have gained? Do you have any sense of what the next generation is going to want to do in terms of being a health professional at the VA?

Dr. NEE. I personally, just being what I went through, would not encourage anyone to work at the VA currently. There has not been transformation. There has been talk, a lot of it, about reform, and that is not what this culture needs. It needs a complete transformation. And until that could be put into place, I personally would not encourage anybody to take a job there.

Dr. MITCHELL. I stay within the VA because the VA mission is important to me. I am willing to stay to make a change. But that comes at a personal loss to me because every day I face a sense of frustration, a sense of hopelessness, a sense of when will this madness stop.

I would not encourage a young professional to enter the VA system unless they fully understood that they were going into a corrupt, retaliatory administration. And that needs to change. There should be a line drawn clearly in the sand that anyone that retaliates against a frontline employee for bringing up will be brought up on charges immediately. It shouldn't be something that takes months and months or years.

Until that time, the VA has a great infrastructure. They are an amazing teaching facility. They have everything they need except the administrative competence to run it.

Senator CAPITO. Those are very powerful statements, I believe, from both of you.

DISMISSAL OF VA EMPLOYEES

The next kind of comment I would make is that we passed a bill, Mr. Chairman, you may help me with this, because recognizing on the heels of what came to light that the bureaucracy in the administrative forces at the VA, there was no structure to fire people. They were just moved from facility to facility. And I think it has come to light that there were maybe 800 administrators that were identified as being deficient and should be moved out of the system. And instead, I think only one has actually been fired; one or very few have actually been fired and the rest have been reassigned.

In your statement, you said, Dr. Mitchell, just quickly and I'm sorry I missed your opening statement. You said something about, well, if I did that I would be fired. So is it easier to fire a medical professional than it is to, the higher-ups of the administrative—I mean is it—obviously, it is.

Dr. MITCHELL. I don't know about the higher-ups. What I do know is what you said is correct. If someone is corrupt or poorly performing, they merely move them to a different offsite. The chief-of-staff that screamed at me routinely and told me it was my fault patients were dying because I was making nursing mad was just moved to another site. I don't know why they decided it is easier to get rid of the people that speak up, except that the people that speak up ruin the VA's image of perfect care.

Senator CAPITO. Outward.

Dr. MITCHELL. And again, they are looking at image. They are not looking at patient care. So it is much easier to kill the messenger than it is to fix the problem.

Senator CAPITO. Thank you.

Senator KIRK. Let me ask unanimous consent to enter into the record Germaine Clarno's written testimony.

[The statement follows:]

PREPARED STATEMENT OF GERMAINE M. CLARNO, LCSW, CADC

Chairman Kirk, Ranking Member Tester, and members of the subcommittee. Thank you for the opportunity to provide a written testimony to discuss the continued issues with the Veteran's Affairs Office of Inspector General.

My name is Germaine Clarno, I am a Social Worker and Local 781 President of the American Federation of Government Employees (AFGE). I have worked at Edward Hines, Jr. Hospital in Maywood, Illinois for 6 years, Social Work is a second career for me and I was committed to being able to work with veterans. When the opportunity to work at Hines VA presented itself, I knew I found where I wanted to be. 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 commitment and dedication to our veterans drove 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 a honored mission to change the culture at Hines.

Master Agreement (Union contract) Preamble

“This Master Agreement is made between the Department of Veterans Affairs (the Department) and the American Federation of Government Employees (AFGE) National Veterans Affairs Council of Locals (the Union).”

“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. The parties recognize that this relationship must be built on a solid foundation of trust, mutual respect, and a shared responsibility for organizational success. Therefore, the parties agree to work together using partnership principles, Labor-Management Forums, and the Master Agreement to identify problems and craft solutions, enhance productivity, and deliver the best quality of service to the Nation’s veterans.”

During my time as a union representative I have witnessed firsthand an environment that is not conducive to enhancing employee morale and efficiency. It is an environment that obstructs employees from performing at the highest level. An example of the obstruction is Dr. Lisa Nee’s experience. In the fall of 2012, after exhausting all avenues within her chain of command, Dr. Nee came to me with overwhelming evidence of wrongdoing by the leadership at Hines. In February 2013, I brought her allegations to Capitol Hill during a planned trip for AFGE legislative conference. Dr. Nee also submitted a disclosure with the Office of Inspector General (referenced below).

Dr. Nee’s Disclosure to the OIG.

“There have been numerous instances of deplorable patient care including a 9 month backlog on the processing of echocardiograms, the unnecessary placement of coronary artery stents leading to numerous complications, unnecessary open heart surgeries leading to complications and retaliation against physicians who have reported these horrific events and have demanded transparency. The chief of cardiology, assistant chief of medicine and chief of medicine have all been informed of this patient abuse and continue to cover up, falsify records and harass those who have spoken up. The billing system has been abused with cardiologists billing for procedures they have not performed—this would be grounds for dismissal in the private sector. Hines desperately needs an independent team to come in and search for the true numbers regarding morbidity and mortality—not just the data that the administration puts out. Veterans are suffering every day and it will take a committee outside of the Veterans Affairs to help expose the corruption and begin to repair the damage. The documentation is easy to obtain, as well as many witnesses in every department of patient care—including house staff from Loyola University”.

Also in 2013, another physician, a thoracic surgeon, also provided evidence of fraud, waste and abuse. Both employees experienced severe forms of retaliation. The retaliation included sham peer reviews, AIB (Administrative Investigation Board) false accusations, denial of leave, FMLA and threats of prosecution for HIPPA violation for bringing issues to legislators or any oversight agencies.

We were relieved when we received notification that the OIG would be conducting an investigation at Hines. This excitement was short lived when the investigators first requested documentation and interviews. I requested protection for the employees that I represented and was informed that they would not be given immunity for their disclosures. However, the investigators made it very clear they wanted specific patient information and the Chief of Staff was threatening to prosecute if patient information was shared with anyone. At this time Dr. Nee was no longer working at Hines and she was understandably concerned with making disclosures without written immunity from the OIG, which was denied. After numerous coercing emails, meetings and phone calls from the OIG, I made a decision to deliver the evidence, including patient information to the OIG on Hines campus so that they would not follow through on their threat to close the investigation due to the lack of patient information.

Finally, in April 2014 the VA OIG report was released. We were never given the opportunity to respond or review the report before its publication. We contacted the Office of Special Council to address the preposterous conclusion of this report by the OIG. *See attached email (attachment 1) and letter to Jennifer Pennington of the OSC (attachment 2).*

Due to the involvement of the OSC, the OIG agreed to reinvestigate Dr. Nee’s allegations. In January 2015 both Dr. Nee and I met with the same investigators for a 2 hour meeting in which we discussed further the preponderance of evidence that contradicted the conclusions of the OIG’s report. Again, the OIG came to the same

conclusion and closed the case. The Office of Medical Inspector was then asked to investigate and they conducted a facility site visit April 6–10, 2015. The preliminary report has been released to Hines administration prior to Dr. Nee receiving the report and given the opportunity to respond before the Hines administration. Hines leadership has taken retaliatory actions against employees that cooperated with the OMI. Leadership have made verbal claims they are looking for the “leak”. Again, putting fear in the courageous employees that came forward.

My journey with the Veterans Administration and the lack of accountability and oversight led to co-founding an organization of VA whistleblowers across the country. Christopher Shea Wilkes from Shreveport VA and I formed the group “VA Truth Tellers.” We currently have over 40 members from across the country. We have discovered that the experience Dr. Nee and I witnessed was not unique. Other VA Truth Tellers have reported the same shortfalls of the Office of Inspector General as have been reported by Dr. Nee and me. As a result, we are requesting that the council of Inspectors General on Integrity and Efficiency (CIGIE) investigate allegations of wrong doing made against the VA OIG. *See attached formal request (attachment 4).*

The allegations that the OIG substantiate in the Hines Cardiology report 13–02053–119 would have supported involvement of the Department of Justice, as done in the private sector. *See attached report from the U.S. Attorney’s Office Northern District of Ohio (attachment 3)*, the parallels of wrong doing that lead to prosecution is conclusive. Our Nation’s heroes deserve the same oversight as private sector health.

The veterans, ethical employees and taxpayers deserve a transparent VA OIG that instills the standards of CIGIE:

- Integrity is the cornerstone of all ethical conduct, ensuring adherence to accepted codes of ethics and practice. Objectivity, independence, professional judgment, and confidentiality are all elements of integrity.
- Objectivity imposes the obligation to be impartial, intellectually honest, and free of conflicts of interest.
- Independence is a critical element of objectivity. Without independence, both in fact and in appearance, objectivity is impaired.
- Professional judgment requires working with competence and diligence. Competence is a combination of education and experience and involves a commitment to learning and professional improvement. Professional standards for audits, investigations, and inspections and evaluations require continuing professional education (see the Managing Human Capital standard). Diligence requires that services be rendered promptly, carefully, and thoroughly, and by observing the applicable professional and ethical standards.
- Confidentiality requires respecting the value and ownership of privileged, sensitive, or classified information received and protecting that information, and safeguarding the identity of confidential.

(ATTACHMENT 1)

Germaine Clarno <gc0039@gmail.com>

Jun 23

To Jennifer

Hi Jennifer,

Is there any way that I can contact Carolyn Lerner? I read today’s press release and we had a cardiology inspection/report completed here at Hines a few months ago that included the same exact issues that was described in her letter. I would like this report included in the review. Below are some of excerpts from the report. I attached a copy for your convenience.

I have worked on these concerns for 2 years by trying every course of action available to us.

Per the OIG report:

We substantiated that two patients had questionable indications for coronary bypass surgery. Both of the affected patients had diabetes, a condition known to increase the risk associated with surgery. These patients had favorable outcomes but were subjected to open heart surgery and a substantial risk of death or stroke during and after surgery.

We substantiated that preoperative planning was inadequate for a patient who underwent coronary artery bypass surgery. This patient had valvular heart disease, which increases the risk of complications related to bypass surgery and warrants pre-operative consideration of valve repair or replacement. However, even though prior testing revealed the problem, it was not adequately evaluated until the patient was in the operating room. The patient suffered no apparent adverse effects, but the occurrence suggests a process failure that could lead to poor outcomes for other patients.

We substantiated that facility administrators did not ensure that weekly cardiac catheterization conferences were conducted. However, we identified no requirement for such conferences and noted that facility cardiologists regularly attended conferences at Loyola.

We found that coronary interventions may have been inappropriate for nine patients who had undergone cardiac catheterizations during 2010–2013. For each of these nine patients, angiogram images and reports were independently evaluated by two interventional cardiologists who agreed that the degree of coronary stenosis had been over-estimated. The patients suffered no apparent immediate harm, but some of them were subjected to an increased risk of bleeding from the medications required after placement of stents. The nine patients who had interventions that may have been inappropriate were receiving VA care 27–154 weeks after the procedures (median, 66 weeks).

2 cases: “Our review found that the degree of coronary stenosis was overestimated and the patient did not have symptoms that warranted bypass surgery”.

“We substantiated the allegation that the facility did not provide adequate equipment in the OR to ensure safe performance of cardiac surgery”.

“EHRs revealed no negative consequences associated with delayed interpretations”.

If Ms. Lerner is not the correct avenue can you let me know how to proceed. Thanks in advance for your assistance.

(ATTACHMENT 2)

July 1, 2014

To: Jennifer Pennington
United States Office of Special Counsel

From: Lisa M. Nee MD
Regarding Report No: 13–02053–119

Dear Ms. Pennington:

I am sending this correspondence to address the preposterous conclusion of the above referenced OIG report as well as the past and continuous corrosive culture that exists at Hines VA. As per our conversation, my interests are aligned with the health and well being of our Nation’s veterans in hopes that at least a singular oversight office at the Federal level will place political agenda aside for a broadminded review and much needed reform. The veterans, ethical employees and taxpayers deserve a transparent approach, which will instill long forgotten confidence in a system initially built on a foundation of conviction.

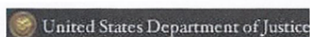
I will first address the conclusions of the OIG by a summary declaration credited to Joe McGettigan, lead prosecutor in the Sandusky trial. The statements made are a masterpiece of banal self-delusion, completely untethered from reality. In short-ridiculous. To suggest that patient’s have undergone unnecessary surgeries and invasive procedures and conclude that there was no apparent immediate harm is in fact a new definition of insanity. Malpractice occurs when the risks/cost exceed the likely therapeutic benefits to the patient. Performing unnecessary surgery/procedures is a major betrayal of the physician’s paramount obligation to place the patient’s best interest first in therapeutic decisions. All procedures, which involve the use of anesthetics and/or incisions, carry inherent risk. Not to mention the long-term sequela of prolonged cardiopulmonary bypass. The OIG inspectors conveniently left out the need for incident reports regarding the unnecessary procedures and the fact that the patient’s were never informed. Individuals were clearly harmed, and

to suggest otherwise in an exercise in dismissal, not thorough investigating nor process improvement. Performing unnecessary surgery can be a basis for malpractice liability or tort actions for fraud and battery while constituting fraud for knowingly claiming reimbursement. I would respectfully conclude that the scope and methodology of the OIG was at a minimum inadequate and more likely deliberately nefarious in nature, resulting in purposeless recommendations.

The next issue I will briefly address is the omnipresent, dysfunctional culture at Hines VA, which has been allowed to invade like an aggressive malignancy. To attempt to delineate all the egregious acts would require a herculean effort so I will sum it up in three major problems. 1. Inadequate care and malpractice because of negligent, self-serving behavior, 2. A system which rewards those for behaving inappropriately with malfeasance and 3. Punishment for anyone willing to attempt to make the system functional and responsible. All hallmarks of a corrupt and incompetent leadership. These issues have all recently been brought to light in system reports authored by acting VA chief Sloan Gibson, White House Deputy Chief of Staff for Policy Rob Nabors, as well as your own office. Specifically troubling is the conclusion in Mr. Nabors report that the VA has a history of retaliation towards employees raising issues and a lack of accountability across all grade levels. The absence of a reliable and transparent quality assurance program, coupled with retribution towards exceptional employees has created a defective culture at Hines that will require widespread reform. The leadership at Hines, whether actively or passively confederate in the dysfunctional process, needs to be removed if they cannot act in the best interest of the institution.

There are tangible and proven solutions to most of the dysfunction at Hines and the VA as a whole. Unfortunately, my own personal journey has led me to the conclusion that when one operates in a state of cognitive dissonance rather than reality, these solutions can never be realized. There are many overwhelming obstacles that we all must face at different times in our lives. How we process, react, adapt and flourish from these defines us as a person. It is my sincere belief that the tide will turn. The American public will not allow our veterans to be mistreated and marginalized. And this will define us as a nation.

(ATTACHMENT 3)



THE UNITED STATES ATTORNEY'S OFFICE
NORTHERN DISTRICT *of* OHIO

[U.S. Attorneys](#) » [Northern District of Ohio](#) » [News](#)

Department of Justice

U.S. Attorney's Office

Northern District of Ohio

FOR IMMEDIATE RELEASE

Thursday, August 21, 2014

Westlake Cardiologist Indicted For Performing Unnecessary Medical Procedures And Tests To Overbill Insurers By \$7.2 Million

A 16-count indictment was unsealed in Federal court charging a Westlake cardiologist with performing unnecessary catheterizations, tests, stent insertions and causing unnecessary coronary artery bypass surgeries as part of a scheme to overbill Medicare and other insurers by \$7.2 million, law enforcement officials said.

Dr. Harold Persaud, 55, was indicted on one count of health care fraud, 14 counts of making false statements and one count of engaging in monetary transactions in property derived from criminal activity.

The indictment was announced by Steven M. Dettelbach, U.S. Attorney for the Northern District of Ohio, Stephen D. Anthony, Special Agent in Charge of the Federal Bureau of Investigation's Cleveland Office, and Lamont Pugh III, Special Agent in Charge, U.S. Department of Health & Human Services, Office of Inspector General—Chicago Region.

"The charges in this case are deeply troubling," U.S. Attorney Dettelbach said. "Inflating Medicare billings alone would be bad enough. Falsifying cardiac care records, making an unnecessary referral for open heart surgery and performing needless and sometimes invasive heart tests and procedures is inconsistent with not only Federal law but a doctor's basic duty to his patients."

"This doctor violated the sacred trust between doctor and patient by ordering unnecessary tests, procedures and surgeries to line his pockets," Special Agent Anthony said. "He ripped off taxpayers and put patients' lives at risk."

"Medical providers have a duty and obligation to provide only those services that are medically necessary and are in the best interests of the patients under their care," Special Agent in Charge Pugh said. "The conduct alleged in this indictment outlines a disregard for patient needs in exchange for financial gain at taxpayer expense. The OIG will continue to work with our law enforcement and prosecutorial partners to identify fraudulent health care schemes and hold individuals accountable for their actions."

Persaud had a private medical practice at 29099 Health Campus Drive in Westlake and had hospital privileges at Fairview Hospital, St. John's Medical Center and Southwest General Hospital, according to the indictment.

Persaud devised a scheme to defraud and obtain money from Medicare and other insurers. The scheme took place between Feb. 16, 2006, through June 28, 2012, according to the indictment.

According to the indictment, his activities in furtherance of the scheme included but were not limited to:

- Persaud selected the billing code for each customer submitted to Medicare and private insurers, and used codes that reflected a service that was more costly than that which was actually performed;
- Persaud performed nuclear stress tests on patients that were not medically necessary;
- He knowingly recorded false results of patients' nuclear stress tests to justify cardiac catheterization procedures that were not medically necessary;
- Persaud performed cardiac catheterizations on patients at the hospitals and falsely recorded the existence and extent of lesions (blockage) observed during the procedures;
- He recorded false symptoms in patient records to justify testing and procedures on patients;
- Persaud inserted cardiac stents in patients who did not have 70 percent or more blockage in the vessel that he stented and who did not have symptoms of blockage;
- He placed a stent in a stenosed artery that already had a functioning bypass, thus providing no medical benefit and increasing the risk of harm to the patient;
- He improperly referred patients for coronary artery bypass surgery when there was no medical necessity for such surgery, which benefitted Persaud by increasing the amount of follow-up testing he could perform and bill to Medicare and private insurers;
- Persaud performed medically unnecessary stent procedures, aortograms, renal angiograms and other procedures and tests.

As a result of this scheme, Persaud overbilled and caused the overbilling of Medicare and private insurers in the amount of approximately \$7.2 million, of which Medicare and the private insurers paid approximately \$1.5 million, according to the indictment.

The indictment seeks to forfeit \$93,446 in an account in the name of Harold Persaud and \$250,188 in an account in the name of Roberta Persaud.

This case is being prosecuted by Assistant U.S. Attorneys Michael L. Collyer and Chelsea Rice following an investigation by the Federal Bureau of Investigation and the U.S. Department of Health and Human Services—Office of Inspector General.

If convicted, the defendant's sentence will be determined by the court after a review of the Federal sentencing guidelines and factors unique to the case, including the defendant's prior criminal record (if any), the defendant's role in the offense and the characteristics of the violation.

(ATTACHMENT 4)

Mr. Christopher Shea Wilkes
 Ms. Germaine Clarno
 VA Truth Tellers
 United States of America
 3646 Youree Drive
 Shreveport, LA 71105

July 20, 2015

Dear Senator,

This correspondence is being sent from members associated with the VA Truth Tellers organization in response to egregious misconduct within the Veterans Affairs Office of the Inspector General (VA OIG). Significant numbers of whistleblowers from across the country have brought forth complaints concerning patient harm/death, criminal activity, fraud, waste, abuse and/or mismanagement of VA programs and operations, only to find the investigations whitewashed and the whistleblower retaliated against. Many of us have filed formal complaints with the Office of Special Counsel (OSC) who has also advised us to file a complaint with The Council of Inspectors General on Integrity and Efficiency (CIGIE).

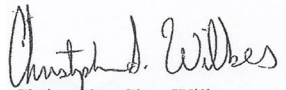
This letter shall serve as a formal request from each individual whistleblower to their respective U.S. Senators, to demand the CIGIE investigate these accumulating atrocities. Under the Inspector General Reform Act of 2008, CIGIE was statutorily established as an independent entity within the executive branch to address integrity, economy, and effectiveness issues that transcend Government agencies: and to increase the professionalism and effectiveness of personnel. To accomplish this mission, the CIGIE needs to be made aware of these issues of waste, fraud, abuse and retaliation. There is strength in numbers and the VA Truth Tellers, comprised of over 40 members from across the country, have organized complaints with similar patterns of whistleblower retaliation as well as incompetent investigations resulting in continuing harm and death to veterans.

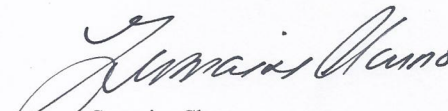
The CIGIE has an established Integrity Committee, which shall receive, review, and refer for investigation allegations of wrongdoing made against the VA OIG. We are requesting bipartisan congressional support for these investigations and each whistleblower will attach specific information relating to their case/complaint. The VA Truth Tellers continue to be overwhelmed with reports of retaliation against whistleblowers and denial of any agency wrongdoing, even when the evidence is irrefutable. We can no longer stand by as a nation as the veterans suffer with malpractice, abuse and denial of care.

On July 10, 2015 the VA OIG attempted to safeguard its own interests by issuing another statement regarding the protection guaranteed to Federal employees by the Whistleblower Protection Act. To continue a fraudulent rhetoric in the face of enormous evidence to the contrary is insulting to the employees, dangerous to the veterans, and wasteful to the taxpayers who are funding this impotent bureaucracy. The VA OIG is a deficient agency with retaliatory tactics that speak volumes of its ineptitude and overall paucity of morality. The agency requires a complete reformation in addition to a formal investigation from CIGIE.

The VA Truth Tellers will continue to work with Members of Congress in mending a clearly broken system. We are looking forward to including your name on our public list of Senators that have agreed with an investigation from CIGIE. We believe in the power of the truth, the importance of transparency, and the necessity of accountability. Thank you for consideration of our request.

Very Respectfully,


 Christopher Shea Wilkes
 CO-Founder VA Truth Tellers


 Germaine Clarno
 Co-Founder VA Truth Tellers

Senator KIRK. And I would call a temporary recess since we have the vote at noon coming up.

We'll go to panel two then.

Senator KIRK. Mrs. Brian, why don't you begin?

STATEMENT OF DANIELLE BRIAN, EXECUTIVE DIRECTOR, PROJECT ON GOVERNMENT OVERSIGHT

Mrs. BRIAN. Thank you, Chairman Kirk and members of the subcommittee, for inviting me to testify today.

POGO, the Project on Government Oversight, is a nonpartisan, nonprofit watchdog that, since 1981, has been championing government reforms including whistleblower protections. If it weren't for the brave work of whistleblowers like Drs. Mitchell and Nee that we heard from just now, none of us would know about the problems at the VA. As the avalanche of reports began last year, we at POGO had great concern and did something unusual. We held a joint press conference with the 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 what was going on at the department.

In our 34-year history, POGO has never received as many submissions from a single agency. In a 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.

Our 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, hundreds of people, who work inside the VA system who care so much about the mission of the department that they were still willing to take the risk to come forward in order to fix it. Some were willing to be interviewed by a POGO and quoted by name, but others said they contacted us anonymously because they are still employed at the VA and worried about retaliation.

VA whistleblowers are supposed to be able to turn to the VA's Office of Inspector General, but many have come to doubt the 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 is an example of oversight at its worse.

Last year, in the midst of our investigation, the VA Inspector General issued a subpoena to us at POGO demanding all of our record that we have received from current or former employees at the Department of Veterans' Affairs and other individuals or entities. Of course, POGO refused to comply with the subpoena. However, the subpoena was understandably cause for concern for many of the whistleblowers who had come to us. We believe the Inspector General successfully created a chilling effect and the number of VA whistleblowers coming to POGO slowed to a trickle.

As further evidence the VA Inspector General is hostile to whistleblowers rather being the haven it should be, just last month the Inspector General sent a white paper to dozens of congressional offices publicly attacking whistleblowers. Senator Johnson responded with a letter of his own in language that mirrored some of what we heard from Dr. Nee. He pointed out "In attempting to defend its work, the VA Inspector General criticizes and demeans the very individuals its healthcare inspection failed to protect in the first place; the victims and whistleblowers of the Tomah VA Medical Center. The paper impugns their motives, assassinates their char-

acter, and offers irrelevant information to discredit their accounts. These arguments are remarkable and unfortunate from an office whose duty it is to work with the Office of Special Counsel and other entities it is supposed to be protecting the whistleblowers.”

We were pleased to see Acting Inspector General Griffin step down and we are hopeful for a brighter future in that office with the new acting Inspector General, Linda Halliday, but she is still being advised by the same counsel responsible for that office’s past misconduct. And as Senator Collins noted, there is still not a permanent Inspector General after a vacancy of over a year and a half. And we believe that is a big part of the problem with that office.

In comparison, the Office of Special Counsel has been working to investigate claims of retaliation and getting favorable actions for many of the VA whistleblowers who have come forward and we commend their good work. By merely addressing isolated incidents is not enough. The VA is struggling with a toxic culture and something more systemic must be done.

POGO 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. Private meetings with them are not enough. He needs to be elevating their status from villain to hero with public accolades and awards as well as holding retaliators accountable.

Congress should also update legislation so that it meaningfully codifies accountability for those who retaliate against whistleblowers. Whistleblowers within the VA should be able to hold their retaliators accountable; something that is nearly impossible unless Congress lowers the burden of proof necessary to discipline retaliators.

Furthermore, the definition of wrongdoing as a cause for disciplinary action of VA managers should explicitly include retaliation against whistleblowers. Congress should also extend whistleblower protections to contractors and veterans who raise concerns about medical care provided by the VA.

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.

Thank you.

[The statement follows:]

PREPARED STATEMENT OF DANIELLE BRIAN

Chairman Kirk, Ranking Member Tester, and members of the subcommittee, thank you for inviting me to testify today on National Whistleblower Appreciation Day. I am Executive Director of the Project On Government Oversight (POGO). Founded in 1981, POGO is a nonpartisan independent watchdog that champions good government reforms. POGO’s investigations into corruption, misconduct, and conflicts of interest achieve a more effective, accountable, open, and ethical Federal Government.

FEAR AND RETALIATION AT THE DEPARTMENT OF VETERANS AFFAIRS

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 per-

sonal 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 a 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.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 take the risk 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

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 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 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 doesn’t appear to be 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 whistle-

¹ Scott Bronstein, Drew Griffin and Nelli Black, “Phoenix VA officials put on leave after denial of secret wait list,” CNN, May 1, 2014. <http://www.cnn.com/2014/05/01/health/veterans-dying-health-care-delays/> (Downloaded July 27, 2015).

² Statement for the Record, Project On Government Oversight (POGO), for the House Committee on Veterans’ Affairs’ Subcommittee on Oversight and Investigations Hearing on “Addressing Continued Whistleblower Retaliation Within VA,” April 13, 2015. <http://www.pogo.org/our-work/testimony/2015/pogo-provides-statement-for-house-hearing-on-va-whistleblowers.html>.

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

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

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

blowers have come to doubt the VA IG'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 IG's office issued an administrative subpoena to POGO that was little more than an invasive fishing expedition for whistleblowers. The IG 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.

Last month, the VA IG's office attacked POGO again. The Senate Homeland Security and Governmental Affairs Committee (HSGAC) requested my testimony about the need for permanent Inspectors General for a June 3 hearing. In an unusual step, the VA OIG later submitted a statement of its own, raising concerns about the hearing and about POGO's testimony in particular.⁷

The VA OIG's statement claimed that my testimony is "replete with inaccuracies and assertions supported, not by factual evidence, but by footnotes to media reporting."⁸ However, the OIG could provide almost no relevant or specific evidence to support its own claims or rebut POGO's arguments. Its statement is largely a misguided attempt to dismiss the investigative work of POGO, Congress, and the press, and to disparage allegations made by whistleblowers who have questioned the OIG's independence.

As further evidence that the VA OIG is hostile to whistleblowers rather than being the haven it should be, the next day the IG's office sent a white paper to all HSGAC members as well as to 22 other Members of Congress publically attacking victims and whistleblowers at the VA Medical Center in Tomah, Wisconsin.⁹

Senator Johnson, chairman of the subcommittee, responded with a letter of his own, harshly critiquing the IG for resorting to:

ad hominin attacks, misleading statements, and victim-blaming to defend the work of the office. . . .

In attempting to defend its work, the VA OIG criticizes and demeans the very individuals its healthcare inspection failed to protect in the first place—the victims and whistleblowers of the Tomah VAMC. The paper impugns their motives, assassinate their character, and offers irrelevant information to discredit their accounts. These arguments are remarkable—and unfortunate—from an office whose duty it is to work with the Office of Special Counsel and other entities in protecting whistleblowers. In light of the VA OIG's treatment of the victims and whistleblowers at the Tomah VAMC, it should not come as a surprise that VA whistleblowers and others would rather seek assistance from non-partisan good-government groups—like the Project on Government Oversight—than the VA OIG.¹⁰ (Emphasis in original)

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 IG, Linda Halliday, released two statements detailing steps she plans to take to improve the IG's whistleblower protection program, including seeking certification by the Office of Special Counsel.¹¹

⁶Letter from Richard Griffin, 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 (Hereinafter "VA OIG Statement").

⁸"VA OIG Statement".

⁹Department of Veterans Affairs, Office of Inspector General, "OIG Releases White Paper on Evidence Supporting Administrative Closure of 2014 Tomah, Wisconsin, VA Medical Center Inspection on Opioid Prescription Practice," <http://www.va.gov/oig/pubs/press-releases/VAOIG-whitepaper-20150618TomahOPPI.pdf> (Downloaded July 22, 2015).

¹⁰Letter from Senator Ron Johnson, Chairman of the Senate Committee on Homeland Security and Governmental Affairs, to Linda Halliday, Deputy Inspector General at the Department of Veterans Affairs, regarding the Tomah VAMC investigation, July 8, 2015.

¹¹Linda Halliday, Department of Veterans Affairs, Office of Inspector General, "Deputy Inspector General Announces Steps to Strengthen Whistleblower Protection Training for OIG Employees," <http://www.va.gov/oig/pubs/press-releases/VAOIG-WhistleblowerProtectionsPress>

But POGO remains concerned. There still is not a permanent VA IG in place. That position has been vacant for over 570 days—over a year and a half.¹² Our own investigations have found that the absence of permanent leadership can have a serious impact on the effectiveness of an IG office.¹³ Acting IGs do not undergo the same kind of extensive vetting process required of permanent IGs, and as a consequence usually lack the credibility of a permanent IG. Acting IGs 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.¹⁴ Perhaps most worrisome, given the significant challenges facing the VA IG, a 2009 study found that vacancies in top agency positions promote agency inaction, create confusion among 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.¹⁵

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. Since April 2014, the OSC has successfully obtained corrective actions for over 99 VA whistleblowers who filed retaliation complaints. But the OSC still has nearly a hundred 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.¹⁶

Although the VA has been cooperative with the OSC and receptive of their recommendations, merely addressing isolated incidents is not enough. The VA has been struggling with a culture problem for decades and something more systemic must be done.

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.

Clearly, an important first step will be for the President to nominate a permanent IG for the VA. Hopefully strong and committed leadership in that office will correct its current course. 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.

But it's not just the VA Secretary or IG who can work to fix this problem. The cultural shift that is required inside the Department of Veterans Affairs must be accompanied by statutory mandates—Congress should enact legislation that codifies accountability for those who retaliate against whistleblowers. The definition of “wrongdoing” must include retaliation. Legislation should ensure that whistleblowers are able to be confident that stepping forward to expose wrongdoing will

Release.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).

¹² Project 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>

¹³ Testimony 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?”)

¹⁴ Testimony of POGO's Jake Wiens on “Where Are All the Watchdogs?”

¹⁵ Anne Joseph O'Connell, “Vacant Offices: Delays in Staffing Top Agency Positions,” *Southern California Law Review*, Vol. 82, 2009.

¹⁶ Adam Miles, email message to POGO Executive Director Danielle Brian, “Re: for my Senate Approps testimony,” July 27, 2015.

not result in retaliation, and should provide a system to hold retaliators within the VA accountable.

Congress should also 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 this 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.

[CLERK'S NOTE.—See letter submitted by Danielle Brian at the end of the hearing in the “Material Submitted Subsequent to the Hearing”.]

Senator KIRK. Thank you.

Ms. Halliday.

**STATEMENT OF LINDA A. HALLIDAY, DEPUTY INSPECTOR GENERAL,
OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VET-
ERANS AFFAIRS**

Ms. HALLIDAY. Mr. Chairman, thank you for the opportunity to discuss how VA OIG interacts with complainants and whistleblowers. This is my first hearing as the Deputy Inspector General and I look forward to continuing a working relationship between the OIG and the Congress.

I have testified at congressional hearings in my previous role as the Assistant Inspector General for audits and evaluations, which was the largest line office within the OIG, and I now welcome the opportunity to share with you the work of all components of our Inspector General. I am accompanied by Ms. Maureen Regan, Counselor to the Inspector General, and Mr. David Daigh, the Assistant Inspector General for Health Care Inspections.

I assumed the position of the Deputy Inspector General on July 6th, 2015. In the past three weeks, I have taken several immediate steps to strengthen both the OIG's internal whistleblower program, as well as our Whistleblower Protection Ombudsmen Program. These actions are outlined in my written statement. I took these actions to establish clear expectations and set a tone at the top for our organization regarding the importance of how we protect whistleblowers' rights and confidentiality.

The OIG is the primary oversight body for receiving and reviewing allegations of waste, fraud, abuse, and mismanagement in VA programs and operations. And our hotline serves as the central point-of-contact for individuals to report allegations. We take this seriously, our responsibility not to disclose the identity of an employee who has made a complaint or provided information. When individuals contact us, we advise them of their right to submit their complaint anonymously, to identify themselves but remain confidential, or to waive the right of confidentiality and advise them of the potential consequences of the decision. All complaints are evaluated.

Using our available but limited resources, we must be highly selective in the cases we accept. We also make case referrals to VA in accordance with our complaint referral directive. We make every effort to make sure an official, separate from and at a higher grade than the alleged wrongdoer, is responsible for conducting the review of the allegations. We continue our inquiry until we are satisfied or we will open a case to review the matters further.

In many cases, these referrals involve veterans' complaints regarding specific episodes of medical care. And it is not possible for VA to review the complaint without the OIG disclosing the identity of the complainant.

Before taking any action, we advise the complainant and request that they provide their written consent to the OIG to disclose their identity. If they say no, it goes no further.

There is a lot of confusion on the role of the Inspector General regarding whistleblowers and allegations of retaliation. For example, the OIG does not make a determination as to whether an individual who makes a complaint or provides information to us has made a protected disclosure. This is a legal determination made by the Office of Special Counsel, the Merit Systems Protection Board, or the U.S. Court of Appeals for the Federal Circuit. These entities have the authority to provide direct whistleblower relief.

OIG faces many challenges in addressing allegations reported by complainants. Vague allegations often present a task akin to looking at needle in a haystack. For example, it is difficult for us to adequately review a complaint of poor quality of surgical care without details of which clinics involved. We cannot contact an individual to obtain additional information regarding an allegation if they choose to remain anonymous. Similarly, some complainants initially identify themselves, but later are unable to or decline to provide critical information that could enable VA OIG to focus resources more specifically.

The OIG works to protect the identity of complainants who request confidentiality, at times the complainants become known based on other sources of information. Some individuals who have requested confidentiality voice the same complaints to VA management, coworkers, media outlets, and they have made statements that they are going to come to us or they have come to us.

Everyone has their own perception as to what is going on. From the whistleblower perspective, they may see the OIG coming in and making sure that the i's are dotted and the t's are crossed. From our viewpoint, we are making sure that all the bases are covered. We have different challenges in verifying allegations; especially those complaints that could be criminal. The OIG looks to partially determine the who, what, when, where, and why while examining information in a fact-based approach.

We need whistleblowers to bring the central issue forward. Although whistleblower's perceptions are directly related to their complaint, at times they are not in a position to know all the facts or they over emphasize the viewpoint.

Mr. Chairman, we are not on anyone's side. We are here to find the truth. I appreciate the opportunity to hear from the whistleblowers today and to address these important issues. I am continuing to reevaluate our business processes to ensure that they

provide adequate protections for complainants including whistleblowers.

This concludes my statement and I would be happy to answer any questions.

[The statement follows:]

PREPARED STATEMENT OF LINDA A. HALLIDAY

Mr. Chairman and members of the subcommittee, thank you for the opportunity to discuss how the VA Office of Inspector General (OIG) interacts with complainants and whistleblowers. This is my first hearing as the Deputy Inspector General and I look forward to continuing the working relationship between the OIG and the Congress. I have testified at congressional hearings in the past regarding projects and reports of the OIG's Office of Audits and Evaluations, and now I welcome the opportunity to share with you the work of all components of the OIG. I am accompanied by Maureen T. Regan, Counselor to the Inspector General and John D. Daigh, Jr., MD, CPA, Assistant Inspector General for Healthcare Inspections.

BACKGROUND

Under the Whistleblower Protection Act of 1989, it is unlawful for agencies to take or threaten to take a personnel action against an employee who makes a protected disclosure—information he or she reasonably believes evidences a violation of any law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific danger to public health and safety. Personnel actions can include a poor performance review, demotion, suspension, or termination. In addition, the law prohibits retaliation for filing an appeal, complaint, or grievance; helping someone else file or testifying on their behalf; or cooperating with or disclosing information to the OIG.

The OIG does not make a determination as to whether an individual who makes a complaint or provides information to the OIG has made a protected disclosure as defined under the Whistleblower Protection Act of 1989, as amended, and applicable case law to be considered a “whistleblower.” This is a legal determination made by the U.S. Office of Special Counsel (OSC), the U.S. Merit Systems Protection Board (MSPB), or the U.S. Court of Appeals for the Federal Circuit.

The OIG Whistleblower Protection Ombudsman program provides education about protections for current or former employees of VA, VA contractors, or VA grantees who make protected disclosures. The Ombudsman coordinates with VA administrations and staff offices to increase awareness of prohibitions on whistleblower retaliation. In addition, the program disseminates information on rights and remedies against retaliation for making protected disclosures. Specifically, the Ombudsman provides complainants with information on how to contact organizations that address reprisal allegations. This program was authorized by the Whistleblower Protection Enhancement Act of 2012, which became law on November 27, 2012. The OIG Ombudsman cannot act as a legal representative, agent, or advocate of the employee or former employee.

OIG HOTLINE PROCESS

Complainants, including whistleblowers, are the lifeline of OIG organizations, and the OIG is committed to protecting their identities, understanding their concerns, objectively seeking the truth, and ensuring VA pursues accountability and corrective action for wrongdoing. The Inspector General Act of 1978 (IG Act), as amended, authorized the OIG to accept allegations from individuals concerning criminal activity, fraud, waste, abuse, and mismanagement of VA programs and operations.

The OIG Hotline serves as the central point of contact for employees, veterans and their family members, other Federal agencies, and the general public to report allegations. The OIG Hotline receives contacts via telephone, email, Internet, U.S. mail, and facsimile. The OIG takes seriously the provisions of Section 7(b) of the IG Act that prohibits the disclosure of the identity of an employee who has made a complaint or provided information to the OIG unless the employee consents to the disclosure or, in very rare occasions, the VA Inspector General personally determines such disclosure is unavoidable during the course of an investigation. When individuals contact our Hotline, they are advised of their right to submit their complaint anonymously, to identify themselves but remain confidential, or to waive the right to confidentiality, and of the potential consequences of their decision. Confidential status allows further communication between the OIG and the complainant

after the original complaint is received. It is more advantageous to both the OIG and the complainant than anonymous status.

All complaints are logged and receive a preliminary evaluation by a Hotline analyst. Based upon the nature and substance of the complaint, the Hotline analyst determines whether the complaint merits referral to one of the Directorates within the OIG—the Office of Investigations, the Office of Audits and Evaluations, or the Office of Healthcare Inspections—for further evaluation. If one of these Directorates accepts the complaint, the Hotline analyst will notify the complainant that a case has been opened.

Because we receive more complaints than we have the resource capacity to review, we also make case referrals to VA of the complaints that are not appropriate for an OIG case but that appear to warrant further review, such as allegations of staff rudeness or medication refill problems. In these instances, the appropriate VA facility or program office is responsible for conducting an independent review and promptly reporting back to the OIG on the findings of their review within 60 days. The OIG does not identify the complainant to VA when making these referrals without the complainant's authorization.

The OIG does not evaluate complaints regarding matters that are unrelated to the programs and operations of VA or that can be addressed in other legal or administrative forums. When possible, the OIG refers the complainant to the appropriate VA program office or Federal agency that can provide further assistance on the matter. For example, individuals with complaints regarding claim adjudications for VA disability and pension benefits are advised to contact the Veterans Benefits Administration (VBA); individuals with complaints regarding discrimination are advised to contact VA's Office of Resolution Management (ORM); and individuals with allegations of prohibited personnel practices, including reprisal for whistleblowing, are advised to contact OSC. We also do not review complaints of poor quality of care when the veteran or family has filed an administrative tort claim. Those investigations are the responsibility of the Office of General Counsel.

For the 18-month period of October 1, 2013, through March 31, 2015, the OIG Hotline received more than 62,000 contacts. Over 7,800 (12.5 percent) of those contacts came from VA employees, and 1,545 (2.5 percent) contacts were from individuals raising concerns about retaliation or reprisal. Despite changes to our Hotline website that advise complainants of the limitations of anonymous submissions, approximately 20 percent (297) of the 1,545 complaints were from anonymous sources. Unfortunately, in these situations, the OIG can only provide generic education and instruction on whistleblower avenues of relief, which is available on our website. For the remaining 80 percent of complaints received via the Hotline:

- 477 complainants were advised to contact OSC.
- 54 complainants were advised to contact MSPB.
- 717 complainants were advised to contact ORM.

OIG INTERACTION WITH THE U.S. OFFICE OF SPECIAL COUNSEL

When OSC receives a complaint from a current or former employee alleging retaliation for making a protected disclosure to the OIG, OSC investigators contact the OIG's Release of Information Office to obtain relevant records and other information. In response, the OIG has provided the records requested, consistent with applicable laws and regulations affecting those records, engaged in discussions relating to what records or other information we have regarding any disclosures to the OIG, and made OIG personnel available for interview.

CHALLENGES FOR THE OIG AND COMPLAINANTS

Vague Allegations From Anonymous Complainants

It is critical in most instances that the OIG be able to communicate with the complainant to understand the nature of the complaint so as to effectively address the issue; otherwise, we are often left with a task akin to looking for "a needle in a haystack." For example, if a complainant makes a serious but vague allegation that surgery at a medical center is of poor quality, but does not provide any further information, it is difficult to address the complainant's issues. The OIG's ability to contact the complainant to obtain additional, more specific information is of paramount importance to fully address the complainant's issue. Examples of information critical to completion of our reviews could include which surgical service is involved (General Surgery, Neurosurgery, or Podiatry); location (inpatient operating room or outpatient day surgery); specific providers' names; the time period; and the definition of quality of care (timely, mortality rate, or morbidity rate).

When an individual chooses to remain anonymous and does not provide sufficient information to assess or conduct a review of the complaint, the OIG cannot contact

that person to obtain additional information regarding the allegation such as testimonial or documentary evidence, the identity of the patients impacted, the providers involved, or other witnesses, and we cannot inform the complainant as to what action the OIG has taken on the complaint. Similarly, a complainant may initially identify himself or herself to the OIG but later declines to provide critical information to enable the OIG to conduct a thorough review of the allegations. In these instances, we often have no choice but to discontinue processing the complaint.

The Need to Disclose a Complainant's Identity

In certain circumstances, it may be unavoidable to disclose a complainant's identity to VA in order for the allegation to be reviewed. For example, we receive many veteran-specific complaints regarding specific episodes of VA medical care, contracting issues, and mismanagement. Because we receive more allegations than we have the resources to review, we often make a case referral to the appropriate Veterans Health Administration (VHA) facility or other VA program office for review. In cases where it is not possible to review the complaint without disclosing the identity of the complainant, we advise the complainant and, before taking any further action on the complaint, request that they provide their written consent for the OIG to disclose their identity.

Protecting Complainant Confidentiality

On rare occasions, we receive complaints that OIG staff breached the confidentiality of a complainant. When this occurs, we investigate the allegations and take administrative action when the complaint is substantiated. There are also many instances where individuals who have requested confidentiality with the OIG have made the same complaints to VA management, coworkers, or media outlets, or they have made statements that they have gone to the OIG or threatened to go to the OIG. Even though the OIG does not disclose the identity of the complainant, either overtly or by refusing to confirm that the individual submitted a complaint, VA knows or, at a minimum suspects, that the individual filed the complaint. Furthermore, under certain circumstances, the very nature of the allegations brought forth by the complainant may render the complainant's identity obvious or possible to deduce by others outside the OIG.

Budgetary Constraints

The surfacing of allegations in fiscal year 2014 related to wait times and delays in care at the Phoenix VA Health Care System (PVAHCS) was a watershed event for VA and the OIG. The national attention sparked by reporting on PVAHCS led to an increased public awareness of the OIG and resulted in a dramatic increase in the number of contacts to the OIG Hotline, in the number of inquiries sent to us by Members of Congress, and by veterans and their families. In fiscal year 2014, the OIG Hotline received almost 40,000 contacts, which represented a 45 percent increase from fiscal year 2013.

During the first half of fiscal year 2015, we received over 22,400 contacts, which puts us on pace to surpass fiscal year 2014's record-breaking year. Similarly, we saw a 38 percent increase in the number of inquiries from Members of Congress, and we expect this upward trend to continue.

The OIG operates in a resource constricted environment with respect to the number of allegations and national reviews we are able to address. Because of this, the OIG must be highly selective in the cases we accept. In fiscal year 2013, the OIG opened cases for 1,227 (4.5 percent) of the 27,420 contacts we received. In fiscal year 2014, although we received more contacts (39,874) and opened more cases (1,330) than the previous year, the percentage of cases opened dropped to 3.3 percent.

Due to significant and sustained increases in the number of Hotline contacts the OIG receives, we have increased our Hotline staff by three positions within the last year. At present, there are 15 staff members in Hotline including 3 supervisors and 12 analysts. I am reviewing staffing levels throughout the organization including OIG line directorates; however, the outlook in fiscal year 2016 is not advantageous to increasing staff levels in one part of the organization without increasing levels in other Directorates.

RECENT INITIATIVES

I assumed the position of Deputy Inspector General (IG) on July 6, 2015. On July 10, 2015, I announced that one of my first acts as Deputy IG would be to ensure that all OIG employees are fully trained on protections and remedies guaranteed to Federal employees by the Whistleblower Protection Act of 1989, the Whistleblower Protection Enhancement Act of 2012, and related laws. To this end, the OIG has registered with OSC to participate in the OSC's 2302(c) Certification Program

and expects to complete all required actions for certification by December 2015. Undertaking the certification process will help strengthen our past training efforts so that all OIG employees—from our Hotline analysts who are a complainant's first point of contact with the OIG to our auditors, investigators, and healthcare inspectors who interact with complainants in the course of their daily work activities—can assist complainants in making protected disclosures and by educating them on their right to be free from retaliation for whistleblowing and other prohibited personnel practices.

I have also taken several actions to further strengthen the OIG's Whistleblower Protection Ombudsman program.

—*Improved Hotline submission process.*—In order to better serve complainants and address complainant concerns of potential retaliation in an informed manner, we have created additional forms on our website designed to ensure anonymity, confidentiality, or allow for full identity disclosure. Providing these different classifications will allow complainants a greater degree of confidence that their personal information is appropriately protected. We also rewrote in plain English the notice Hotline sends to individuals who contact us so that there is a clear understanding of what to expect when making a complaint.

—*Reinvigorated the OIG Rewards Program.*—To promote greater utilization of the OIG's cash reward program to individuals who disclose information leading to felony charges, monetary recovery, or significant improvements to VA operations or programs, each OIG Directorate and the OIG Whistleblower Ombudsman will proactively conduct a semiannual review of disclosures made to the OIG to identify potential recipients for cash rewards. Rewards will be based on such factors as the significance of the information, risks to the individual making the disclosure, time spent and expenses incurred by the individual making the disclosure, and cost savings to VA. Recipients will be recognized at either a public or private presentation according to their preference.

—*Enhanced crime awareness education briefing.*—These briefings, provided by our criminal investigators as part of cyclical inspection reviews of VHA and VBA facilities, will be expanded to better define how VA employees can make disclosures of protected health information, the roles and responsibilities of the Whistleblower Protection Ombudsman, and the avenues of relief available to VA employees. For the period fiscal year 2014 to present, a total of more than 300 briefings were attended by approximately 20,000 VA employees nationwide.

CONCLUSION

The OIG recognizes the critical role complainants and whistleblowers play in exposing serious problems and deficiencies in VA programs and operations, and I will continue to review and evaluate ways in which the OIG can enhance its interactions with complainants. We are committed to protecting the identity of any person who comes forward to the OIG to report serious allegations of criminal activity, fraud, waste, abuse, and mismanagement; getting to the bottom of those allegations; and monitoring VA to ensure they pursue accountability and corrective action when wrongdoing is found. We are committed to work on behalf of complainants and whistleblowers to ensure that VA operates in a manner that is befitting those veterans who have served to protect our country and our country's principles. Mr. Chairman, this concludes my statement and I would be happy to answer any questions that you or members of subcommittee may have.

[CLERK'S NOTE.—See three letters and a fact sheet submitted by Linda A. Halliday at the end of the hearing in the "Material Submitted Subsequent to the Hearing".]

IG SUBPOENAED POGO

Senator KIRK. Ms. Halliday, let me ask you a question. We have Danielle Brian here from POGO. Where her organization set up a hotline for VA employees, she got 800 complains. You hit POGO with a subpoena asking for all those names. It would seem that you wanted to retaliate against all of POGO's whistleblowers. Why did you issue that subpoena?

Ms. HALLIDAY. I did not issue that subpoena. And I think there might be a communications breakdown.

From what I understood, the concern of the Inspector General was to understand all of the issues with relation to the manipulation of wait times, to make sure that we had the sites identified, and we had all of the sites where potential patient harm could occur. That was the method used. Certainly, we understood that POGO did not have the authority to investigate these and we did.

Senator KIRK. Do you understand the feeling that, based on this record that this subcommittee has received, you were subpoenaing POGO to make sure that you could retaliate against those 800 people?

Ms. HALLIDAY. I understand that POGO could have that perception. I do not think that was the perception of the Inspector General.

We had 98 sites identified where there was potential manipulation of data. VA had approximately 150 sites plus all at CBOCs. We were not sure if we had all the information and something that POGO may have received and we didn't even care if we had the name; as far as I knew. We just needed to know the site and should we look at it, what's the egregiousness of the complaint. So I do think that there might have been some communication issues here.

Ms. BRIAN. Mr. Chairman.

Senator KIRK. Ms. Brian, if the situation is as Ms. Halliday says, that the confidentiality is at the cornerstone of the Inspector General's work, then they have no interest in getting the identities of the people who complained at POGO.

Ms. BRIAN. Yes. Thank you, Mr. Chairman, for an opportunity to clarify. There was no confusion. It is true that Ms. Halliday wasn't there at the time. But Counselor Maureen Regan, of her office, contacted POGO's General Counsel and we told them right away we were very happy to work with them to give them any information that we were getting without having to give any identifying information about the individuals with whom we were speaking. We had every interest and we wrote that in an email to them saying, "Give us a second, we're overwhelmed, but as soon as we get capacity to let you know what we're finding and where it is we are happy to talk to you." And then the next day, we received a subpoena specifically asking for the identities of the people who had contacted us.

Senator KIRK. Ms. Halliday, if I asked you to withdraw that subpoena, what would you say back to me?

Ms. HALLIDAY. At this point, I would hope that there was no information at POGO that would have resulted in patient harm that we wouldn't know about to go take a look at. I'd like to ask Maureen Regan to come up—

Senator KIRK. Behind you—

Ms. HALLIDAY [continuing]. If she'd like to—

Senator KIRK. Behind you is Dr. Lisa Nee who, within 24 hours of complaining to the Inspector General, her identity was disclosed to her workmates. It seems that the disclosure of a confidential source is routine at the Inspector General's office.

Ms. HALLIDAY. I'd like to speak to that. I definitely heard Dr. Mitchell, what she said. And I believe what the confusion is her complaint went from Senator McCain's office to VA. It did not come

directly to us. As a result, it is very hard for us to protect confidentiality, and I do not believe that the reprisal actions came from our office based on the facts that I'm looking at now. However, it did go to VA and it came down the tree from VA headquarters to the VISN, to the the medical center. And I can understand some of the frustration that Dr. Mitchell has.

Senator KIRK. Danielle, I would expect that—could you talk about this quashing the subpoena and the work on that? I would expect that if you gave the information to the Inspector General's office, those 800 employees would receive severe retaliation.

Ms. BRIAN. Oh, there is no doubt in our mind that that was an unacceptable step for us. The purpose of our organization is to protect the people who are coming to us and so that there is never a question that we were never going to turn over the identities. So I agree with you, sir.

Senator KIRK. Could you describe the prospects of not complying with the subpoena?

Ms. BRIAN. Well, it has expired and we are waiting because they haven't withdrawn the subpoena. What the VA Inspector General need to do is go to a court and have the court enforce it and there has been a number of Senators, like yourself, who have questioned the Inspector General and why they have done this and would they withdraw it. And they haven't been willing to do so. I believe that this matter has been turned over to the CIGI Integrity Committee for review as well.

Senator KIRK. It would seem to me, Ms. Halliday, that your predecessor made a mistake by issuing this subpoena. I would ask you to withdraw it.

Ms. HALLIDAY. I will take that under strong consideration.

Senator KIRK. Thank you.

Ms. BRIAN. Thank you, Chairman.

Senator KIRK. You bet.

Okay, Ms. Lerner.

OFFICE OF SPECIAL COUNSEL

STATEMENT OF CAROLYN M. LERNER, SPECIAL COUNSEL

Ms. LERNER. 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 VA whistleblowers.

Given the time limitations, my statement today will focus on just three areas. First, OSC's role in whistleblower disclosures and whistleblower retaliation cases. Second, an overview of progress made in the past year. And finally, some areas of ongoing concern.

Starting with our role, OSC helps employees who make disclosures of wrongdoing and those who experience retaliation for doing so. There are separate processes for these two types of cases. If an employee discloses a health or safety concern or a violation of law, rule, or regulation and it meets a very high standard of review, I send the matter to the agency for investigation. After investigating, the agency head must then submit a report to my office. The whistleblower is given an opportunity to comment on that report. I then determine whether the report contains the information required by

statute and also whether the findings of the agency appear to be reasonable. This includes whether appropriate corrective action, including discipline, has been taken. I then send that information and our findings to the President and Congress, and I also post them on our public Web site. That is the process for disclosures.

OSC also protects Federal workers from prohibited personnel practices, especially retaliation for whistleblowing. Unlike disclosure cases, where we do not have independent investigative authority, in retaliation cases OSC conducts the investigation and determines if retaliation has occurred. We can get relief for the employee including a stay of any disciplinary action, reversing a termination, and damages for any losses they may have suffered as a result of retaliation. So that, in a nutshell, is our process for whistleblower disclosures and whistleblower retaliation complaints.

In over the past year, there has been a tremendous surge of cases from the VA. I will talk now about how our agency is addressing them and some signs of progress.

OSC has about 140 employees with jurisdiction over most of the Federal Government. So we are stretched pretty thin. But we have reallocated our resources to prioritize our work on VA cases. And perhaps most significantly, we implemented an expedited review process for retaliation cases. This process allows OSC to present strong cases to the VA at an early stage saving significant time and resources and getting quicker relief for employees.

In the past year, we have obtained 22 corrective action for VA whistleblowers through this expedited process, including a settlement on behalf of Dr. Katherine Mitchell, who you heard from earlier, and two other Phoenix VA employees who were at the heart of the wait time scandal. My written testimony summarizes a number of the other cases we resolved through this expedited program, including three VA whistleblower complaints settled just last week.

It is a sign of progress that the VA leadership agreed to the expedited review process and also agreed to resolve many more cases through our regular processes, including mediation; 99 to be exact. We are also encouraged that VA leadership has enlisted our assistance in training its counsel in retaliation law.

On the disclosure side, our work has led to important improvements at the VA as well as discipline for over 40 officials with many more cases pending. These disciplinary 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. So these are some of the positive steps that we are seeing.

There are, however, several ongoing areas that require more attention. Of particular concern, is the accessing of employees' medical records. In many instances, VA employees are themselves veterans and receive care at VA facilities. In several cases, their medical records have been accessed without adequate justification, possibly to discredit them. We have and will continue to pursue relief for these whistleblowers, and discipline for those who improperly access medical records. I have also notified the VA that it should consider system-wide corrective action, which could deter these types of breaches.

Finally, I want to comment briefly on the two whistleblowers who testified on the first panel. OSC recently received the VA reports generated in response to the disclosures made by Drs. Mitchell and Nee. After our review, and Drs. Mitchell and Nee had the opportunity to comment on those reports, we will formerly transmit the information to Congress and the President. Given where we are in the process, I can't provide details about these matters at this time. However, I can say that Drs. Mitchell and Nee exemplify the courage and tenacity that are 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 care in Phoenix and at Hines and I want to thank them both.

In conclusion, we appreciate the committee's interest in our efforts to protect VA whistleblowers. Thank you for this opportunity to testify and I am happy to answer any question that you many have.

[The statement follows:]

PREPARED STATEMENT OF CAROLYN M. LERNER

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 13 "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 percent, 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 2 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 subcommittee 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 website.

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 percent, of these disclosures will be filed by VA employees.

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 modern-

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 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 2 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.
- 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.

izing 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 fiscal year 2016 and beyond. The changes may increase the number of retaliation complaints.

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 co-workers. 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 subcommittee'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.

[CLERK'S NOTE: Attachments 1 and 2 were provided to be included with Carolyn Lerner's prepared statement.]

(ATTACHMENT 1)

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 percent 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 percent of our incoming cases will be filed by VA employees. This is up from 20 percent 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, Maryland.*—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 5-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, Texas.*—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, Colorado.*—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.

(ATTACHMENT 2)

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 3 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 percent over the last 5 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.

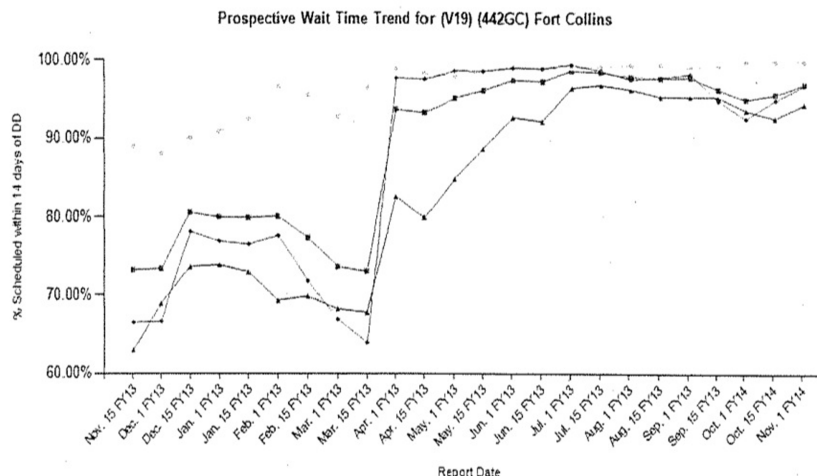
To help illustrate the negative consequences of this approach, we will highlight three cases that were addressed in the June 23 letter.

1. Ft. Collins, Colorado

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, Wyoming, 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 percent. 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 unsupported 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, Massachusetts

In a second case, a VA psychiatrist disclosed serious concerns about patient neglect in a long-term mental healthcare facility in Brockton, Massachusetts. 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 7 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 8 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 healthcare 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 healthcare facilities.

3. *Montgomery, Alabama*

Finally, in Montgomery, Alabama, 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 2 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 healthcare 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.



The Special Counsel

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

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, Wyoming, 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 unsupported 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 healthcare facility in Brockton, Massachusetts. 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 7 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 8 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 account-

ability 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, Alabama, 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, Colorado, 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, Michigan, 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, New York, OMI substantiated a whistleblower's allegation that healthcare 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, Arkansas, 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, Texas, 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, Puerto Rico, 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 healthcare 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 healthcare 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

RETALIATION THROUGH EMPLOYEE'S MEDICAL RECORD

Senator KIRK. Thank you.

I would like you to go into detail the method of retaliation you are describing. Is it the retaliator for the VA who goes into the employee's medical record? Maybe that employee has been a veteran and has sought care inside the hospital wherever there and will use that employee, that medical information to retaliate against the employee?

Ms. LERNER. Yes. That's—

Senator KIRK. That sounds particularly heinous.

Ms. LERNER. That is one thing that we are seeing. It may not necessarily always just be someone who is interested in retaliating. It could be a colleague of the veteran as well.

Senator KIRK. As I understand it, about 40 percent of your case load at the OSC is from VA employees?

Ms. LERNER. That is correct.

Senator KIRK. Yes.

Ms. LERNER. That is correct and both the disclosure side and on the retaliation side.

Senator KIRK. What was the worse case of where they access the whistleblower's medical record to retaliate that your office dealt with?

Ms. LERNER. You know I'm a little hard-pressed to say the very worse case, but what I can tell you is this is a very important issue. And my written testimony provides more detail on it but I want to stress two steps that the VA should take.

One, they should make it much harder to access these medical records. They need a better lock on the system. Doctors need to have access to medical records. Coworkers and colleagues do not and they shouldn't. And it seems like a pretty easy technological fix to put a lock on the system so that only those who have a need to know get into those medical records.

The second thing in the bigger picture that I think the VA can do is evaluate how it stores information and stop commingling the medical information with the demographic information. So for ex-

ample, what we are hearing sometimes from the VA is that, “Well, we need the employee’s address to mail the W-2 or a paystub so we go into their medical records.”

There is no need to go into someone’s, or there shouldn’t be a need to go into an employee’s medical records to get their home mailing address. So, if they can stop commingling those two systems, it would I think to go a long way to solving this problem.

Senator KIRK. I am told that you guys have 316 retaliation open cases now in 43 States. Is that true?

Ms. LERNER. Yes, that is correct.

And that is just on the one side. That is not on the disclosure side. We have—

Senator KIRK. It shows how widespread this corruption is.

Ms. LERNER. It is happening nationwide. That is right.

I can talk more about the numbers if you’d like me to or—

Senator KIRK. That’s great.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

I want to thank you for holding this valuable hearing and thank you to our witnesses for your time and your insight.

As I have seen in the Tomah, Wisconsin VA facility and, indeed, in the rest of the Nation, the role of whistleblowers is critical to running an effective organization, and agencies need to be open to accepting constructive criticism in order to improve; especially agencies such as the VA. This has been tremendously important to the mission of taking care of our veterans.

So, Ms. Lerner, I wanted to thank you for mentioning Ryan Honl in your statement. People like Ryan truly make a difference, and in particular he helped turn around what was happening at the VA in Tomah, Wisconsin.

After considering the testimony that witnesses have given, and I apologize that I was quite tardy in getting here, but I just have a few questions that I think get to the heart of some of the problems at the VA. I want to talk about the culture that I have just seen against whistleblowers.

Ms. Lerner, you said that no other Federal agency has taken such a proactive approach to training managers on whistleblower protections. Yet, complaints about reprisals are up. In fact, your statement reads that the OIG is on track to receive more than 3,800 prohibited personnel practice complaints in this year. And that more than 1,300, or approximately 35 percent of those, will be filed by VA employees. You also make this point: VA now surpasses Department of Defense (DOD) in the total number of cases filed with OSC despite the fact that DOD has twice the number of civilian personnel.

Ms. LERNER. Yes.

Senator BALDWIN. Now, I know that Secretary McDonald and his team are working to change the culture at the VA. Yet, complaints keep coming. More must be done to change the culture at the VA and I, you know, to improve the system so that there is aggressive action against those who retaliate against whistleblowers.

CHANGE THE VA CULTURE

So the question I have for you is, but I would also like to hear what Ms. Halliday has to say, is what specifically do we need to do to change the culture here?

Ms. LERNER. I think there are several steps that we can take. There are no easy fixes, but there are important steps that the VA can take.

First of all, we have to keep working to change the culture to embrace whistleblowers. Changing the culture begins with an understanding that we need employees to come forward and report health and safety issues. We don't shoot the messenger, we reward them. We give awards to people who identify problems.

Deputy Secretary Gibson came to our Public Servant of the Year Award Ceremony last fall where we honored Dr. Mitchell and two other VA whistleblowers. That's great. They should have their own award ceremonies.

I understand the Secretary tries to meet with whistleblowers when he goes and visits facilities. That is terrific but, after he leaves, what is happening? You know, the hospital administrators need to be told to recognize and support whistleblowers. They need to keep meeting Secretary Gibson. Deputy Secretary Gibson, Secretary McDonald, they need to keep meeting with whistleblowers, listen to them, praise them, and repeat it over and over again until it takes hold.

The second thing that they can do is train managers. They are doing a lot of training now; they need to do more. This means hospital administrators and doctors need to get trained in why whistleblowing is important. It may not be intuitive to them as administrators and doctors why whistleblowers are important, but they are and the more they are trained the more it will really help.

Senator BALDWIN. And I regret cutting you off but I'd love the rest of your statement in writing, if you could? But I did want to give Ms. Halliday a chance to also respond to that question.

Ms. HALLIDAY. Thank you.

PROTECTION OF WHISTLEBLOWERS FROM REPRISALS

I believe you really have to enforce accountability here when you have reprisals against whistleblowers, and it has to be tough. It has to be a point where somebody would take great pause to do that. I think you need training in the VA system with regards to the HR personnel practices. You need training in leadership. I think leaders have to step forward and protect whistleblowers. I don't think they always do. Maybe they don't have the right tools in their pocket to do that, but it is clear that they need to improve in that area.

I personally, in the three weeks I was here, I added a component of training on whistleblower rights when we go out and do our combined program assessments, out at the medical facilities and people in the medical facilities, attend these briefings; our criminal investigators normally give that. I told them I wanted that piece in there so there is better training. That doesn't touch everyone in the VA system but it touches a lot of people.

So those would be some of the things I would look at immediately.

Senator BALDWIN. Thank you.

Senator KIRK. Mr. Boozman to wrap up.

Senator BOOZMAN. Yes, very quickly. Mr. Chairman, I know we've got a vote so I won't take a lot of time. But, Ms. Lerner, the 40 percent of your cases are VA so that means 60 percent are the rest of the Federal agencies?

Ms. LERNER. That is right. We have jurisdiction—

Senator BOOZMAN. Which is really remarkable. Go ahead about your—

Ms. LERNER. Yes. We have jurisdiction for the entire, most of the civilian workforce.

Senator BOOZMAN. I mean we talk about DOD and, you know, twice and all that. But the reality is 40 percent of all of the agencies. That is remarkable that it is occupying such a significant case load of yours.

Ms. Halliday, you know I agree we need training and leadership and all of those things. But we also need accountability for those that do go after whistleblowers and very strong actions in that regard. And the best I can tell that is simply not happening. The other thing is it does appear that in some cases there appears to be collusion with the Inspector General with the administration perhaps telling them too much facts regarding the whistleblowers and you really need to look into that.

The other thing is I think the HIPAA laws are being used in an inappropriate way to prevent people from going forward. You know that's the excuse. So again, like I said, I think that is just a huge job for you and Ms. Brian. But you know we haven't had a full Inspector General for over a year, well over a year.

So I appreciate you holding this hearing, Mr. Chairman. I think it is so important. And if we are not going to have a full Inspector General, if we are not going to go forward, we are going to have to just step forward and try and do that in place of that.

So thank you. Thank you, Mr. Chairman.

Senator KIRK. Let me just finish up and ask Ms. Brian, how does the VA Inspector General compare to the other 24 Inspector Generals?

Ms. BRIAN. There's actually many more Inspector Generals across the Federal Government at this point and I, without reservation, can say it is the worst shop in the Government.

Senator BOOZMAN. That was easy.

Ms. BRIAN. Simple.

Senator KIRK. That is pretty decisive.

SUBCOMMITTEE RECESS

Senator KIRK. On that, I will let our members go to the—we'll be in recess here.

[Whereupon, at 12:12 p.m., Thursday, July 30, the subcommittee was recessed, to reconvene subject to the call of the Chair.]

MATERIAL SUBMITTED SUBSEQUENT TO THE HEARING

SUBMITTED BY LINDA A. HALLIDAY, DEPUTY INSPECTOR GENERAL,
OFFICE OF THE INSPECTOR GENERAL, DEPARTMENT OF VETERANS
AFFAIRS



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

AUG 10 2015

The Honorable Mark Kirk
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

This letter is in regard to the hearing held before the subcommittee on July 30, 2015, on whistleblower claims at the Department of Veterans Affairs. I am requesting that my letter and the enclosed fact sheet be included in the hearing record.

I became the Deputy Inspector General on July 6, 2015, after serving as the Assistant Inspector General for Audits and Evaluations for more than 3 years. As I testified, I am reviewing the operations of the organization and have instituted additional training requirements for Office of Inspector General (OIG) staff regarding interactions with individuals who contact the OIG with complaints about VA programs and operations. However, please do not infer from these actions that the criticisms made against the OIG by hearing witnesses are founded. As you will read in the enclosure, the OIG did not release Dr. Katherine Mitchell's name to VA in September 2013 or at any other time. We first received Dr. Mitchell's complaint, which was addressed to Senator John McCain, in April 2014—some 6 months later—when Senate Committee on Veterans' Affairs staff made us aware of her complaint for the first time. Another witness, Dr. Lisa Nee, never contacted the OIG Hotline with her complaint. We first learned of her complaint through an inquiry from a congressional office in February 2013. More detailed information is enclosed, and I hope the members and staff will review it carefully to clarify the record.

I do however wish to emphasize that the U.S. Office of Special Counsel (OSC) has found that VA whistleblowers have experienced reprisal actions, and that those actions are inappropriate. Whistleblowers have also raised valid and important concerns to our organization. Their concerns regarding reprisals should not be taken lightly, and as we move forward it is my hope that the OSC will actively investigate complaints of such reprisal actions to the fullest extent possible and that VA will hold accountable any VA official who engages in retaliatory actions.

Regarding the statement from the Project On Government Oversight (POGO) Executive Director, Ms. Danielle Brian, that the VA OIG is the "worst IG in Government today," I want to state my vigorous disagreement with her opinion. Her statement was not offered based upon a complete assessment of all of the work VA OIG has completed in the past few years and it was not supported by any objective performance measures or facts. I attribute the statement to an adversarial event that occurred last year regarding the OIG's subpoena to POGO in connection with the

Phoenix review and not a thoughtful objective review encompassing the body of our past work. Because the hearing ended before I could make a rebuttal, I offer the following on behalf of the more than 600 OIG employees who work hard every day on behalf of the Nation's veterans.

- On April 30, 2015, the Center for Effective Public Management at The Brookings Institution issued a paper assessing the benefits OIGs bring to Government. The paper focused on Return on Investment (ROI)—the most quantifiable metric of agency performance—for the last 5 fiscal years. The Social Security OIG ranked first with an average ROI of \$43:1, the VA OIG ranked second with \$38:1, and HUD OIG ranked third with \$30:1.
- In the last 6 years, the Council of the Inspectors General on Integrity and Efficiency recognized the OIG with 25 Awards for Excellence across all disciplines—Audits, Evaluations, Investigations, and Administration.
- The frequency of OIG witnesses at congressional hearings—10 in fiscal year 2015—is a clear indication of the respect for the quality of our work and independence. With more than 1,900 reports and more than 70 appearances at congressional hearings in the last 6 years, the VA OIG is among the most prolific in the Inspector General community in terms of transparent reporting on the programs and operations within a Federal department and making recommendations for corrective action.
- The Partnership for Public Service's annual "Best Places To Work" ranking listed the VA OIG as the second highest OIG in Government in terms of overall employee satisfaction based on the 2014 Office of Personnel Management Federal Employee Viewpoint survey.
- Since fiscal year 2012 to present, the OIG has provided nearly 300 briefings to Members of Congress and staff on the results of OIG oversight activities and engaged in countless contacts with congressional staff to meet our responsibilities of dual reporting to Congress and VA and to build strong relationships based on the mutual goal of improving services and programs for our Nation's veterans. The OIG has a long history of reporting serious problems and major mission critical challenges to VA to take corrective action. Some of these issues include:
 - Data integrity over patient wait times for medical appointments
 - Inappropriate patient scheduling practices and the identification of inappropriate appointment scheduling practices
 - Lack of appropriate staffing standards and deficiencies in staffing throughout VA's clinical positions
 - Lapses in delivering healthcare services consistent with Veterans Health Administration clinical guidelines and acceptable private sector medical care practices
 - Deficiencies in cleaning and sterilizing reusable medical equipment that place veterans at risk for contracting blood-borne diseases
 - Lapses in VA's acquisition support and contract administration that resulted in substantial waste of Federal funds and has not protected the veteran or the Department as vital services were provided
 - Weaknesses in Information Security and the vulnerabilities associated with adequately protecting veterans and their families' information
 - Weaknesses in VA's call centers that veterans rely upon for help and appropriate action
 - Serious problems with the financial stewardship of Federal and taxpayer funds
 - Significant criminal and administrative investigations addressing issues across VA

The staff at the OIG is committed to objectively reviewing, inspecting, auditing, and investigating VA operations and programs and reporting on the results. We are proud of the OIG's legacy of independent and objective reporting that has generated countless significant improvements in VA's delivery of service to veterans, such as the establishment of VA's Veterans Crisis Line which to date has answered more than 1.6 million calls and made more than 45,000 lifesaving rescues. I would welcome the opportunity to discuss this further with you or any member of the subcommittee.

Sincerely,



LINDA A. HALLIDAY
Deputy Inspector General

Enclosure

Copy to: All Subcommittee Members

OFFICE OF INSPECTOR GENERAL
DEPARTMENT OF VETERANS AFFAIRS

FACT SHEET

Subcommittee on Military Construction, Veterans Affairs, and Related Agencies,
Committee on Appropriations
United States Senate

“Whistleblower Claims at the U.S. Department of Veterans Affairs”

July 30, 2015

TESTIMONY OF DR. KATHERINE MITCHELL

Initial Contact with the Office of Inspector General.—Dr. Mitchell stated in her written statement for the record, her oral remarks, and in response to questions that she submitted a confidential complaint to the Office of Inspector General (OIG) through Senator John McCain's office in September 2013, regarding life-threatening conditions at the Phoenix VA Health Care System (VAHCS). She further testified that she was disciplined for misconduct for providing confidential information through the OIG channels. Her testimony is inconsistent in regard to our records of her interactions with the OIG.

The OIG first received information relating to allegations made by Dr. Mitchell in April 2014, and that information was provided by the Senate Committee on Veterans' Affairs. We determined through inquiries with relevant congressional and VA staff that Dr. Mitchell submitted her complaint to the office of Senator John McCain in September 2013, and that Senator McCain's office sent that information to the VA Congressional Liaison Service. VA's Congressional Liaison Service assigned the correspondence to the Veterans Health Administration (VHA) and an investigative team from the Veterans Integrated Service Network 18 was tasked with conducting an investigation into her allegations. The OIG was not aware of and did not participate in any review or investigation conducted by VHA. Dr. Mitchell's testimony implies that the OIG breached her confidentiality, which is simply untrue because, although she may have intended to, she did not file a complaint with the OIG in September 2013.

OIG's Investigation of Her Complaints.—On page 4 of her written statement, Dr. Mitchell stated: “in February 2014 my Senator's office was able to verify the OIG had been involved in an investigation of my complaint. I have never seen the official OIG report on my 2013 complaint and believe one does not exist. My Senator's office made attempts to locate the report for me without success.” As stated above, the VA OIG was not involved in the investigation of Dr. Mitchell's complaints because the complaints were not sent to the OIG; therefore there is and never was a report.

Also, there is no record of Senator McCain or anyone else requesting a review into Dr. Mitchell's allegations. The VA OIG did not issue a specific report on Dr. Mitchell's complaint but did issue two broader and more comprehensive reports related to the issues negatively impacting the timely delivery of healthcare services at the Phoenix VA Health Care System (VAHCS). While the issues raised by Dr. Mitchell to Senator McCain were important, the issues already under review by the OIG were in fact more systemic and had even broader potential to harm more veterans who could not get access to needed medical care.

Interview with OIG Staff.—Dr. Mitchell stated the OIG did not interview her. As discussed above, we learned of her complaints in April 2014. However, during our review of the allegations of wait time manipulation at the Phoenix VAHCS, an interdisciplinary team from the OIG interviewed her on May 2, 2014.

OIG Report, "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System."—Dr. Mitchell raised concerns about the conclusions of cases included in the August 26, 2014, OIG report, "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System." Specifically, she made medical judgements based on reading the summary we included on each case. The case summaries in any OIG report do not include all the information in the medical records to protect the patient's privacy, and for this reason we question the validity of judgements about the appropriateness of treatment based solely on summary information. The OIG staff conducting the medical review of the cases included board certified physicians and other healthcare professions. Their reviews were based on the most complete information available, including VA medical records and records from private facilities when available, to reach conclusions regarding the appropriateness of care. The thoroughness of our review in no way minimized the issues that Dr. Mitchell was raising, but we did examine more information than she had available to her within her position.

Dr. Mitchell referenced the then-Acting VA Inspector General's testimony at the hearing before the House Committee on Veterans' Affairs. Contrary to her statement, he did not admit that the delays "contributed to deaths." He said that our report stated "these delays may have contributed and there is no denying it may have contributed." The specific quote from the report reads: "we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans."

OIG Hotline Referral Process and the Results of Referrals.—Dr. Mitchell's testimony describes the OIG Hotline complaint referral process. The OIG receives more complaints than we have the capacity to fully review, and while it is accurate that we refer allegations that are not selected for an OIG review to VA for an internal review, this process does not enable the facilities to investigate themselves without any oversight. In fact, the OIG Hotline complaint referral process is well-documented in VA policy. VA Directive 0701, "Office of Inspector General Hotline Complaint Referrals," dated January 15, 2009, outlines VA responsibilities with regard to case referrals from the OIG, which must include:

- Evidence of an independent review by an official separate from and at a higher grade than the subject/alleged wrongdoer
- Specific review of all allegations
- Findings of each allegation, which are clearly identified as either substantiated or unsubstantiated
- Description of any corrective action taken or proposed
- Supporting documentation for the review
- Designation of a point of contact for additional information

Dr. Mitchell also stated that this process "exposes the whistleblower to retaliation because the Hotline complaint is sent back to the same people who may be retaliating against them or who ignored the problem in the first place." As indicated above, OIG takes extraordinary precautions to ensure a review must be conducted by an official separate from and at a higher grade than the subject/alleged wrongdoer. Furthermore, the OIG does not release the name of the complainant to VA unless it is absolutely necessary in order to enable VA to review the allegations. In these situations, we advise the complainant that we plan to make a referral to VA and request permission to release their identity as the complainant to facilitate review of the allegations. If they refuse to provide permission, we advise them that we will not take further action on the complaint. The new Deputy Inspector General offered this information in her oral statement at the hearing to clarify any misconceptions with our process.

Lastly, Dr. Mitchell stated that "OIG Hotline reports damaging to VA are consistently suppressed. In fact, it's not clear to me if any OIG Hotline reports are re-

leased.” As an example, Dr. Mitchell cited a 2014 Hotline case referral, which she inaccurately referred to as a “Hotline report,” concerning the St. Cloud VA Medical Center. The confusion here is that this is not an OIG report, and the OIG did not conduct the review in question. This is an example of the Hotline case referral process outlined above. The report in question was prepared by VA and shows the review was conducted by officials from the Veterans Integrated Service Network 23, who were separate from and at a higher grade than the alleged wrongdoers. Their review did substantiate several of the allegations and described corrective actions that were underway. Furthermore, even though the complainant in this case did not request confidentiality, the OIG adequately protected and did not release the individual’s identity to VA when referring the matter.

TESTIMONY OF DR. LISA NEE

Initial Contact with the OIG.—The OIG first learned of Dr. Nee’s complaint when we received a copy of her email from congressional staff in February 2013 with a request to review the allegations in her email. We have no record of any prior contact to the OIG Hotline. Upon accepting the case for review, we made multiple attempts to contact Dr. Nee directly and through a union representative for an interview about the allegations. She declined all requests. Regardless we had also received similar information from other VA staff regarding problems in cardiology at the Hines VA Hospital, thus we notified the congressional office that even though Dr. Nee had declined our requests for an interview, we had received additional information from other sources sufficient to initiate a review. The result of that review was the publication on April 8, 2014, of our report, “Healthcare Inspection—Questionable Cardiac Interventions and Poor Management of Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois.” That report contained four recommendations that the Veterans Integrated Service Network Director agreed to implement and provided appropriate action plans.

OIG Report “Healthcare Inspection—Questionable Cardiac Interventions and Poor Management of Cardiovascular Care, Edward Hines, Jr. VA Hospital, Hines, Illinois”.—Dr. Nee believes the report is flawed because patients were not notified of possible unnecessary medical procedures and no VA employees were held accountable as a result. The OIG is not the appropriate office to make institutional disclosures to patients or family on possible unnecessary procedures or to hold VA staff accountable. Those are the responsibilities of VA officials. There are clear legal procedures that VA must follow for notifying patients that preserve patient rights and legal protections. There are also legal protections afforded to VA employees that VA must follow or risk having a poor performing employee returned to service due to procedural violations.

OIG Interview in January 2015.—After Dr. Nee contacted the Office of Special Counsel (OSC), the OIG again attempted to interview Dr. Nee at OSC’s suggestion, but she declined. Through Office of Special Counsel’s intervention, OIG staff conducted and recorded an interview with Dr. Nee on January 9, 2015. On May 7, 2015, Dr. Nee requested the transcript through our Release of Information Office, but because of increases in that office’s workload, we were unable to meet the deadline for response under the Freedom of Information Act, which was June 5, 2015. However, we responded on July 29, 2015, and provided Dr. Nee with her entire statement with only patient names redacted.

Correspondence between Senator Kirk and the OIG.—Dr. Nee states that the OIG released correspondence between the OIG and Senator Kirk in the press. We did not release that letter in any type of press release.

TESTIMONY OF MS. DANIELLE BRIAN

OIG Subpoena to the Project on Government Oversight (POGO) in June 2014.—In April 2014, the OIG was requested to review complaints of poor quality of care at the Phoenix VAHCS Center relating to long wait times for appointments and the manipulation of wait times data by VA personnel. Many congressional committees including this subcommittee requested that the OIG extend its reviews nationwide and demanded that VA personnel be held accountable for their actions.

The subpoena was issued to POGO by then-Acting Inspector General, Richard J. Griffin, and requested:

All records that POGO has received from current and former employees of the Department of Veterans Affairs, veterans and other individuals or entities relating in any way to wait-times, access to care, and/or other patient scheduling

issues at the Phoenix, Arizona VA Health Care System and any other VA medical facility.

In hindsight, communications could have been better between the OIG and POGO, as both organizations have common goals to protect the identity of whistleblowers. However, communications did not occur to discuss the scope of the subpoena and identify a possible accommodation to meet the needs of both parties and thus ensure the health and safety of veterans. Today, we are trusting that POGO will follow through on their statement to Fox News on June 9, 2014, when POGO “promised to issue an investigative report to assist the VA Inspector General without identifying the sources of the group’s reporting.” We plan to work with senior POGO officials in hopes that they will share information that does not compromise any complainants’ identities but enables the OIG to investigate any previously unidentified Department of Veterans Affairs sites where inappropriate patient medical scheduling practices are occurring or where data manipulation schemes are in practice that have the potential to harm veterans.

Our concern remains valid that POGO lacks the authority to investigate the complaints that POGO received and that when allegations are not investigated no one can be held accountable. The OIG has performed numerous investigations throughout VA healthcare facilities some of which are ongoing. We are also planning follow up oversight work as we move into fiscal year 2016. Thus the importance of receiving POGO’s de-identified information cannot be understated to provide assurance that we have investigated potentially valid allegations at all healthcare sites within VA. Again, both POGO and the OIG have common goals and responsibilities to help ensure no veteran is harmed by the failure to investigate serious allegations.

As promised at the July 30 hearing, the Deputy Inspector General has taken the Subcommittee Chairman’s suggestion to not enforce the OIG subpoena to POGO under advisement and decided not to enforce the subpoena. The Inspector General Act provides that an OIG subpoena may be enforced in any Federal District Court. The subpoena that the OIG issued set a return date of June 13, 2014, for the requested documents from POGO. Because the return date has lapsed and we did not elect to press the Department of Justice for judicial enforcement, the subpoena is moot.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

AUG 10 2015

The Honorable Mark Kirk
Chairman
Subcommittee on Military Construction,
Veterans Affairs, and Related Agencies
Committee on Appropriations
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

I have reviewed the issue of withdrawing the subpoena that the VA Office of Inspector General (OIG) issued to the Project On Government Oversight (POGO) as you asked in the July 30, 2015, subcommittee hearing titled “VA Whistleblower Claims.” I have decided not to enforce the subpoena. The Inspector General Act provides that an OIG subpoena may be enforced in any Federal District Court. The subpoena that the VA OIG issued set a return date of June 13, 2014, for the requested documents from POGO. Because the return date has lapsed and we did not elect to press the Department of Justice for judicial enforcement, the subpoena is moot.

I do plan to work with senior POGO officials in hopes that they will share information that does not compromise any complainants’ identities but enables my orga-

nization to investigate any previously unidentified Department of Veterans Affairs sites where inappropriate patient medical scheduling practices are occurring or where data manipulation schemes are in practice that have the potential to harm veterans. I believe that both POGO and the OIG have common goals to protect whistleblowers' identities and hold VA officials accountable. We still have ongoing investigations and other reviews of many VA facilities experiencing waiting times and access to care issues. My goal moving forward is to ensure we have rooted out all the schemes and inappropriate practices that have potential to delay vital services to veterans.

Sincerely,



LINDA A. HALLIDAY
Deputy Inspector General



AUG 11 2015

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Ms. Danielle Brian
Executive Director
Project On Government Oversight
1100 G Street NW, Suite 500
Washington, DC 20005

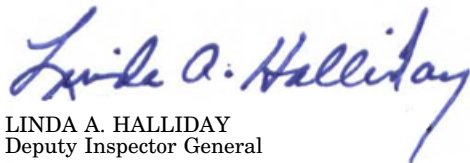
Dear Ms. Brian:

At the July 30, 2015, hearing on VA whistleblower claims held before the subcommittee on Military Construction, Veterans Affairs, and Related Agencies, United States Senate, Subcommittee Chairman Mark Kirk suggested I review the VA Office of Inspector General's (OIG) subpoena issued to the Project On Government Oversight (POGO) on May 30, 2014. I have decided not to enforce the subpoena. The Inspector General Act provides that an OIG subpoena may be enforced in any Federal District Court. The subpoena that the OIG issued set a return date of June 13, 2014, for the requested documents from POGO. Because that return date has lapsed and we did not elect to press the Department of Justice for judicial enforcement, the subpoena is moot.

During the questioning of witnesses at the July 30 hearing, you stated that POGO was willing to provide to the OIG any information from the hotline that POGO set up in May 2014 without giving identifying information about the individuals who contacted POGO. I am proposing that my staff work with POGO to obtain relevant de-identified information in the approximately 800 complaints received from VA employees and veterans that will enable the OIG to investigate any previously unidentified Department of Veterans Affairs sites where inappropriate patient medical scheduling practices are occurring or where data manipulation schemes are in practice that have the potential to harm veterans. Please have a POGO staff member contact Mr. Roy Fredrikson, Deputy Counselor to the Inspector General, at (202) 461-4533 to discuss how we can best accomplish the transmission of the information.

I believe that both POGO and the OIG have common goals to protect whistleblowers' identities and hold VA officials accountable. My goal moving forward is to ensure the OIG has rooted out all the schemes and inappropriate practices that have potential to delay vital services to veterans. I appreciate your cooperation in facilitating this matter.

Sincerely,

A handwritten signature in blue ink that reads "Linda A. Halliday". The signature is written in a cursive style with a long, sweeping tail on the letter "y".

LINDA A. HALLIDAY
Deputy Inspector General

SUBMITTED BY DANIELLE BRIAN, EXECUTIVE DIRECTOR, PROJECT ON
GOVERNMENT OVERSIGHT



August 14, 2015

Ms. Linda A. Halliday
Deputy Inspector General
Department of Veterans Affairs
Office of the Inspector General (50C)
801 Vermont Avenue, NW
Washington, DC 20420

Dear Ms. Halliday:

We are writing in response to your letter received by the Project On Government Oversight (“POGO”) on August 11, 2015. We appreciate the fact that you have decided not to enforce the subpoena issued by your predecessor to POGO on May 30, 2014.

We accept your offer to work with OIG staff to exchange information we have received from VA employees and veterans, but due to continuing incidents of whistleblower retaliation by the VA and the VA OIG, POGO is erring on the side of caution to ensure that the identities of our sources are in no way disclosed, in order to prevent putting them at risk to personal attacks, professional retribution, or reduced medical care.

We are reaching out to all of our sources to reassure them that POGO will only be providing information generalized to Veterans Integrated Service Network (VISN) and that their identities will remain confidential. POGO is currently in the laborious process of compiling and organizing the information that we received by each VISN and categorizing them by complaint topic. Although your letter states that you are only interested in learning about inappropriate patient medical scheduling practices or data manipulation schemes, we intend to inform your staff about other systemic breakdowns in VA operations and patient care that we have learned of.

I will contact you as soon as we complete these procedures, and please be assured we are moving apace to be able to help address these matters.

Sincerely,

Danielle Brian
Executive Director