ADDRESSING CONTINUED WHISTLEBLOWER RETALIATION WITHIN VA

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION

OF THE

COMMITTEE ON VETERANS' AFFAIRS U.S. HOUSE OF REPRESENTATIVES

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ADDRESSING CONTINUED WHISTLEBLOWER RETALIATION WITHIN VA

Monday, April 13, 2015

HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 4:00 p.m., in Room 334, Cannon House Office Building, Hon. Mike Coffman [chairman of the subcommittee] presiding.

Present: Representatives Coffman, Roe, Benishek, Huelskamp, Walorski, Kuster, Rice, and Walz.

Also Present: Representative Roby.

OPENING STATEMENT OF CHAIRMAN MIKE COFFMAN

Mr. COFFMAN. Good afternoon. This hearing will come to order. I want to welcome everyone to today's hearing, titled Addressing Continued Whistleblower Retaliation Within VA.

I would like to ask unanimous consent that Hon. Martha Roby from the State of Alabama be allowed to join us at the dais as she has been very active in this case—in the case of one of our witnesses here today. Seeing no objection.

Additionally, I would like to ask unanimous consent that three statements be entered into the hearing record, two from whistleblowers and one from the Project on Government Oversight. Hearing no objection, so ordered.

Mr. COFFMAN. The hearing will focus on the treatment of whistleblowers within the Department of Defense—I'm sorry—within the Department of Veterans Affairs, particularly the types and levels of retaliation they experience when reporting problems. This will serve as a follow-up to the hearing conducted by the committee on July—in July 2014, where we will address what progress the Department has made since then to correct its retaliatory culture and where VA has failed to protect conscientious employees who seek to improve services for our Nation's veterans.

The three whistleblowers we will hear from today come from VA facilities across the country. The hostility they received for their conscientious behavior shows that the retaliatory culture, where whistleblowers are castigated for bringing problems to light, is still very alive and well in the Department of Veterans Affairs.

The truth of the matter is that Congress needs whistleblowers within Federal agencies to help identify problems on the ground in order to remain properly informed for the development of effective legislation. For example, the national wait time scandal that this

committee revealed at a hearing just over a year ago, which resulted in the Secretary of the Department resigning, simply would not have occurred without responsible VA employees stepping forward to fix problems. In the years since that scandal originally came to light, a new Secretary has come to the Department and he has stated that one of his primary missions is to end whistleblower retaliation within VA.

The Congress also passed legislation that makes it easier for the Secretary to fire poor performing and bad acting senior executive service employees. And who, in some cases, perpetuate and encourage retaliatory behavior.

Despite these efforts, retaliation is still a popular means used by certain unethical VA employees to prevent positive change and maintain the status quo within the Department. In January, full committee Chairman Jeff Miller introduced legislation, which I cosponsored, that would improve protections provided to whistleblowers within VA. It will also discourage supervisors and other managerial employees from attempting to retaliate against whistleblowers by imposing more strenuous penalties for engaging in retaliation, including suspension, termination, and loss of bonuses.

It is very simple. If you retaliate against or stifle employees who are trying to improve VA, for our Nation's veterans, you should not be working for VA and you certainly should not receive a bonus for your despicable actions. To that end, I encourage Members to join with numerous VSOs and whistleblower protection groups in support of H.R. 571, the Veterans Affairs Retaliation Prevention Act.

Along with the whistleblowers here today, we will hear from the Office of Special Counsel regarding the efforts VA has made since our last hearing to improve its treatment of whistleblowers and where improvements remain absent and needed.

I was very pleased to learn that the Office of Special Counsel recently took action on behalf of a whistleblower in the VA from the Eastern Colorado healthcare System. This employee was removed from her nursing duties and assigned to a windowless basement after reporting the misconduct of a coworker. Thanks to the efforts of OSC, this whistleblower has returned to her nursing duties at another clinic while her reprisal claims are being investigated.

Representatives of VA will also be here to address why whistleblowers continue to have their livelihoods jeopardized for attempting to make VA a better service provider for our Nation's veterans. I look forward to the discussion we will have here today on this important issue.

With that, I now yield to Ranking Member Kuster for any opening remarks she may have.

[THE PREPARED STATEMENT OF CHAIRMAN MIKE COFFMAN APPEARS IN THE APPENDIX]

OPENING STATEMENT OF RANKING MEMBER ANN KUSTER

Ms. KUSTER. Thank you, Mr. Chairman. And thank you to our witnesses for being with us today.

This afternoon, the Subcommittee on Oversight and Investigation is holding a follow-up hearing to the hearing that our full committee held last July. I believe that some of the most effective hearings this subcommittee holds are follow-up hearings. They enable

us to examine progress that has been made and current problems that still exist at the VA. That is the core of our work here, to identify problems and work together to fix them and ensure the highest quality of care is being delivered to every veteran.

Today's hearing will focus on VA's treatment of whistleblowers who play a crucial role in ensuring the VA is held accountable for providing quality care for our Nation's veterans. Whistleblowers were instrumental in helping this committee uncover the wrongdoing in Phoenix, Arizona, which helped inform our drafting of the Veterans Access Choice Accountability Act of 2014. We must ensure that no one is afraid to come forward to report instances of mismanagement or wrongdoing that hinders our veterans' ability to receive care.

In terms of the Department of Veterans Affairs and its treatment of whistleblowers, a great deal of progress has been made. VA has established the Office of Accountability Review and has reorganized the Office of the Medical Inspector. The VA is also the first Cabinet-level agency to satisfy the requirements for the Office of Special Counsel's Whistleblowers Certification Program. In addition, the VA and the OSC have implemented an expedited review process for whistleblower retaliation claims. I am pleased to hear that the VA has taken these steps moving forward. However, there are still too many problems that exist regarding how the VA treats and handles whistleblowers.

OSC is responsible for whistleblower complaints from all across the Federal Government, yet it estimates that 40 percent—40 percent, close to half of its incoming cases in 2015, will be filed by VA employees. OSC reports that the number of new whistleblower cases that VA employees remains "overwhelming", and that its monthly intake of new VA whistleblower cases remains high, at a rate of nearly 150 percent above historic levels. According to OSC, these alarming cases include disclosures of "waste, fraud, abuse and threats to the health and safety of our veterans."

The large number of complaints received from VA employees is, to some extent, a reflection of the size of the VA, but it also raises serious red flags as to the continuing problems that are systemic throughout the VA and its treatment of VA employees.

The OSC testimony highlights some troubling concerns that the VA sometimes investigates the whistleblowers themselves rather than investigating allegations raised by those whistleblowers. The OSC also references several cases where the medical records of whistleblowers were improperly and unlawfully accessed in what seems to be attempts to discredit some whistleblowers. As a New York Times article last year outlined, there is a "culture of silence and intimidation and a history of retaliation at the VA."

According to the whistleblowers testifying before us this afternoon, this is still the case today. They will testify about this environment of intimidation and retaliation and the use of sham peer reviews and investigations in order to silence whistleblowers.

As I stated before, I believe that the VA has made some progress in this area, but clearly more remains to be done. VA's culture of retaliation and intimidation did not happen overnight, but it is the culmination of decades of problems that are deeply ingrained in the VA system. We must also not forget that the vast majority of VA

employees are involved in healthcare, an industry that also is seen by many to be intolerant of whistleblowers. This culture of intimidation and fear for VA employees cannot be changed overnight. But for the sake of our veterans and the sake of ensuring that the VA is providing the highest quality of care, this culture must be changed.

Many of the VA's problems that we will discuss today highlight the VA's lack of accountability and the absence of collaborative spirit between VA leadership and VA employees in order to seriously address whistleblower complaints. This afternoon, let us begin the process of identifying what steps the VA needs to take going forward as the VA works toward the Secretary's goal of "sustainable accountability."

I am hopeful that this subcommittee can continue to work in a bipartisan fashion to find ways to assist the VA in its monumental task of changing this longstanding culture and reform the manner in which whistleblowers are treated, by improving the process whereby all VA employees are working toward the common goal of helping and serving our veterans.

Mr. Chairman, again I thank you for holding this follow-up hearing. And before I yield back, I want to take a moment and thank our whistleblowers for appearing before us today. It takes real courage to put your careers at risk for coming forward and calling attention to these problems and concerns. It is my hope that we move forward creating a culture at the VA that welcomes whistleblowers and acknowledges your importance in better serving our veterans. I hope that, in the months and years ahead, the VA will be known as an organization that welcomes and encourages all employees to work together to solve problems.

And I yield back.

[THE PREPARED STATEMENT OF MS. ANN KUSTER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Thank you, Ranking Member Kuster.

Mr. COFFMAN. I ask all members waive their opening remarks as per this committee's custom.

With that, I invite the first and only panel to the witness table, that is seated at the witness table. On the panel, we will hear from Ms. Meghan Flanz, Director of the VA's Office of Accountability Review; the Hon. Carolyn Lerner, Special Counsel; Dr. Christian Head, M.D., Associate Director, Chief of Staff, Legal and Quality Assurance for the Greater Los Angeles VA healthcare System; Dr. Maryann Hooker, M.D., Neurologist and President of AFGE Local 342 at the Wilmington VA Medical Center; and Mr. Richard Tremaine, Associate Director of the VA Central Alabama Healthcare System. All of your complete written statements will be made part of the hearing record.

Ms. Flanz, you are now recognized for 5 minutes.

STATEMENT OF MEGHAN FLANZ

Ms. FLANZ. Thank you, Chairman Coffman, Ranking Member Kuster, and members of the committee. I appreciate the invitation today to present an update on the Department's activities related to whistleblower protection. VA exists to serve veterans. That service takes place through interactions between veterans and frontline

VA employees: Doctors and nurses, claims processors, cemetery workers, and countless others upon whom VA depends to serve veterans with the dignity, compassion, and dedication they deserve.

We depend on those same employees to have the moral courage to help us serve veterans and taxpayers better by helping to make our processes and policies better, safer, more effective, and more efficient. The Department's responsibility to protect whistleblowers is an integral part of our obligation to provide safe, high quality healthcare and other benefits to veterans in legally compliant and fiscally responsible ways.

It is important to keep in mind that the underlying purpose of the whistleblower protection rules is to encourage candid disclosure of information, so problems can be quickly identified and corrected. VA is fully committed to correcting problems in VA programs and to ensuring fair treatment for employees who bring problems to light.

Secretary MacDonald talks frequently about his vision of sustainable accountability, which he describes as a workplace culture in which VA leaders provide the guidance and resources employees need to successfully serve veterans. And employees freely and safely inform leaders when challenges hinder their ability to succeed. We need a work environment in which all participants, from frontline staff and first-line supervisors to top VA officials, freely share what they know, whether good news or bad, for the benefit of veterans and as good stewards of the taxpayers money.

To reach these goals, the Department has taken several important steps. Last summer, the Secretary reorganized and assigned new leadership to the VA office of the medical inspector, which investigates disclosures related to patient care. He also established my office, the Office of Accountability Review or OAR, to ensure leader accountability for serious misconduct, including whistleblower retaliation.

In addition to its ongoing work investigating leader misconduct, OAR is also working to improve the Department's ability to track whistleblower disclosures and actions taken in response to those disclosures across the entire VA system.

VA has also improved its collaboration with the Office of Special Counsel. Last summer, VA requested and received certification under OSC's 2302(c) Certification Program. That certification reflects the Department's commitment to educating employees and supervisors about the whistleblower protection rules. VA has also negotiated with OSC an expedited process to speed corrective action for employees who are experiencing retaliation.

More recently, we have asked OSC to help us expand that collaborative process to facilitate more efficient accountability actions against supervisors who engage in retaliation. We are also working with OSC to create a robust new face-to-face training program to ensure all VA supervisors fully understand their roles and responsibilities under the whistleblower protection rules.

Since Secretary McDonald was confirmed last July, he and other VA leaders have made it their practice to meet with whistleblowers as they travel across the VA system and to engage with those who have raised their hands and their voices to identify problems and propose solutions. They do that both to acknowledge the critical

role whistleblowers play in improving VA programs and to model to supervisors throughout VA the engaged, open, and accepting behavior they expect them to exhibit when subordinates step forward to express concerns.

The Department deeply appreciates the assistance of this committee and other congressional offices in supporting whistleblowers and identifying problems VA needs to address. Last month, I had the opportunity to appear before this subcommittee to provide the Department's views on several pending bills, including two related to whistleblowers. At that time, I acknowledged—and I reiterate today—that the Department still has work to do to ensure that all whistleblower disclosures received prompt and effective attention and that all whistleblowers are protected from retaliation.

I acknowledged then, and I reiterate today, that notwithstanding significant efforts on our part, VA is still working toward the full culture change we must achieve to ensure all employees feel safe disclosing problems and that any supervisor who retaliates is held accountable.

On behalf of the Department, I am committed to continue to work with OSC and with this committee to get things right. I am honored that Secretary McDonald and Deputy Secretary Gibson have asked me to assist them in this critical effort. This concludes my testimony. I look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF MS. MEGHAN FLANZ APPEARS IN THE APPENDIX]

Mr. COFFMAN. Ms. Lerner, you are now recognized for 5 minutes.

STATEMENT OF THE HON. CAROLYN LERNER

Ms. LERNER. Thank you. 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 and our ongoing work with whistleblowers from the Department of Veterans Affairs.

Last July, I spoke to this committee about OSC's early efforts to respond to the unprecedented increase in whistleblower cases from the VA. Since then, there has been substantial progress. For example, the OSC and the VA started an expedited review process for retaliation claims, as has been noted. This process has resulted in relief for many VA whistleblowers, including landmark settlements on behalf of Phoenix VA employees.

In total, OSC has secured relief for over 45 VA whistleblowers. These settlements are putting courageous public servants back on the job and serving veterans. These settlements are also sending a message to other VA employees that if they come forward and report problems, they will be protected from retaliation.

In my earlier testimony, I also addressed several serious problems with investigations by the VA's Office of Medical Inspector or OMI. In response to my concerns and this committee's concerns, the VA directed a comprehensive review of all aspects of OMI's operations, and this review has led to positive change.

A recent whistleblower case is demonstrative. The case concerns a whistleblower disclosure from an employee at Beckley, West Virginia. In response to OSC's referral, the medical inspector deter-

mined that the Beckley facility was trying to save money by substituting medications with older, cheaper drugs. The substitutions were made over the objections of mental health providers, and the decision was driven solely by cost concerns without any legitimate medical basis. This was a clear violation of VA policies.

OMI's investigation found the substituted medications created medical risks to veterans. In a call for review of all patients who were impacted to determine if there was any harm caused as a result of the drug substitution, OMI also recommended that discipline be considered for Beckley leadership and others who are responsible.

While the facts of this case are very troubling, the OMI response is a sign of progress from where we were just 9 months ago. In an organization the size of the VA, problems are bound to occur. Therefore, it is critical that when whistleblowers identify problems, they are addressed swiftly and responsibly. A properly functioning OMI is key to doing so.

Finally, since last year, the VA became the first Cabinet-level Department to complete OSC's whistleblower certification program. In addition to fulfilling the basic certification requirements, the VA is working with OSC to conduct additional trainings for managers, supervisors, and lawyers at the regional level.

The commitment we are seeing from VA leadership to correct and eliminate retaliation has not consistently filtered down to the regional facilities, so additional training for regional employees may help address this issue.

I want to close by flagging one additional and ongoing area of concern. Often where a whistleblower comes forward with an issue of real importance, the VA's investigation focuses on the whistleblower instead of their disclosure. There are too many problems with this approach. First, by focusing on the whistleblower, the health and safety issue that was raised may not receive the attention that it deserves.

Second, instead of creating a welcoming environment, it could chill future whistleblowing if employees believe that by reporting problems their own actions will come under intense scrutiny.

The VA's focus should be on solving its systemic problems and holding accountable those who are responsible, not on going after whistleblowers. We look forward to working with the VA and the committee to further address this important issue.

In conclusion, we very much appreciate the committee's ongoing attention to the issues we have raised. I thank you for the opportunity to testify today, and I look forward to taking your questions.

Mr. COFFMAN. Thank you, Ms. Lerner.

[THE PREPARED STATEMENT OF MS. CAROLYN LERNER APPEARS IN THE APPENDIX]

Mr. COFFMAN. Dr. Head, you are now recognized for 5 minutes.

STATEMENT OF CHRISTIAN HEAD, M.D.

Dr. HEAD. Thank you, Mr. Coffman, Ms. Kuster, and all other members for inviting me again to, I think, a very important meeting.

Since my last testimony in July of 2014, when I returned back to West LA VA Hospital, in my position as associate director, my

leadership, my direct leader was—essentially reassigned—I basically was assigned to a chief of staff outside of West Los Angeles, to Long Beach Hospital, who I have never met and still have never met.

I started to notice that my patients were being reassigned mid-therapy to other surgeons. When I questioned this, senior leadership at my hospital, essentially the chief of staff said, "If you don't like it, you are a whistleblower, take it to Congress. There is nothing they can do to me." I reported this statement to Congress and also to the Office of Special Counsel.

Following that, I was prevented to go into the operating room when I had a patient under anesthesia. I was told my credentials to go in the operating room had been revoked. When I questioned that, an hour later, they were told, "Oops. We made a mistake. It is okay, Dr. Head." Unfortunately, veterans and other hospital officials overheard that conversation.

I have essentially been removed from my office in the chief of staff suite, transferred to the fourth floor. The cleaning crew told me they believe it used to be a nursing storage unit. There is a hole in the floor. The computer monitor was cracked, nonfunctional, along with some of the other equipment in the room. A group of the janitors got together and said, "This is a shame. Let's get together and clean up this room for Dr. Head." When this was reported to chief of staff, a piece of plastic was placed over the hole in the floor. The janitorial service said it was a trip hazard and that I shouldn't go to that office. So effectively I have been functioning without a real office since I have testified to Congress.

There have been investigators who came out to the hospital, but other employees have reported that it seemed to be more of an investigation into me than my actual complaints. When Donna Beiter was questioned about this, it turns out that VA submitted court records saying the reason why I was removed from the chain of command was because I testified in Congress. There is a sworn affidavit submitted by Donna Beiter that said I questioned her authority and that is why I was transferred out of the chief of staff offices. Because I questioned her authority in Congress. I don't remember actually mentioning Donna Beiter's name personally during my original testimony.

Through all of this, I have always placed veterans ahead of me, essentially. And today I think we should focus on the veterans. I will—because of the way I was brought up, I will always take a stand for—this population is extremely vulnerable at this time.

You remember I made reference to an email in November of 2012 that is part of the packet I have submitted where I questioned the irregularities of the consults. I also noticed that there were a number of patients, after review of the number of colon cancers, that were entering the system but later appearing with advanced cancer. I did this as a team player, asking for a briefing to all of the chief of staff. I was rebuffed.

I want to go on the record to be more specific. One, I witnessed the systematic deletion of 179 consults. Two, that the systemic deletion of these consult reviews, most of them were done by nonmedical staff. Three, I witnessed the direct batch deletion, the order

given by my immediate supervisor, of 40,000 consults. The number of deletions is three to four times what happened in Phoenix.

The other thing I want to go on record—and I realize this will probably result in me losing my job, but I think the veterans deserve better—$25,000 was given to our VA. Where is it? It was reported as being given for informatics.

I'm sorry, I have run out of time.

Mr. COFFMAN. Could you review that number with us again?

Dr. HEAD. I'm sorry. $25 million was appropriated over a 2-year period to our hospital to improve access for veterans. Thank you.

Mr. COFFMAN. Thank you.

[THE PREPARED STATEMENT OF DR. CHRISTIAN HEAD APPEARS IN THE APPENDIX]

Mr. COFFMAN. Dr. Hooker—I'm sorry.

STATEMENT OF MARYANN HOOKER, M.D.

Dr. HOOKER. Mr. Chairman and members of the committee, thank you for the opportunity to speak on continued whistleblower retaliation within VA. My written statement outlines the types and extent of reprisal against Federal employees that continues unabated. Retaliation against whistleblowers is destructive and costly to our Nation in so many ways and too convenient a weapon to be used without any fear of its consequences. When whistleblowers sound an alarm, it is for the safety and well-being of the veterans we serve. Veterans and whistleblowers are inextricably linked. Harm to one is harm to the other.

My written statement speaks of VA as a house divided, with power and resources for the VA itself gained at the expense of care provision to the veterans we serve. For example, I had the honor of meeting an 88-year-old World War II veteran several weeks ago. He arrived in an electric wheelchair as he was unable to walk due to injuries many years prior that were not related to military service. Same for the loss of use of his left arm and hand, as well as the loss of use of his right shoulder. He was unable to see out of his right eye due to glaucoma causing near blindness.

He related that he was living in a room at the YMCA in downtown Wilmington, Delaware, that being all he could afford on $500 a month Social Security and $500 a month nonservice-connected pension. He was sent to the Y after a stay at our medical facility as an answer to homelessness.

Years ago, he could have called our facility's extended care section his home. But due to yearly mandates progressively reducing the percentage of beds in the facility's community living center earmarked for extended care in favor of more rapid turnover and hence more billables and collections, this 88-year-old World War II veteran was sent to live at the YMCA. Because he is not service-connected, VA feels no obligation to provide long-term care to him.

Whose community is the community living center and what type of living is being provided? True to this 88-year old World War II veteran's generation, he believed that a bed in our community living center must be needed for someone in worse shape than he. This from a man with no effective use of his legs, no effective use of his arms, and almost no sight.

What do we look at when we evaluate success? Are efficiency and expediency the only measures of a productive day? What is the most important thing?

There is a spirit that enters the body at birth and a spirit that leaves the body at death. Our Nation was founded on spirit, the spirit of liberty and justice for all. Our veterans defend our Nation with their body, their mind, and their spirit. When they come to the VA for care of their body and mind, must they have their spirit crushed? And when healthcare providers advocate for veterans needs, must they suffer abuse?

Whistleblowers are passionate people who care about veterans and the true mission of VA. VA for Veterans, not VA for itself. Thank you for the honor of representing them.

Mr. COFFMAN. Thank you, Dr. Hooker.

[THE PREPARED STATEMENT OF MARYANN HOOKER, M.D. APPEARS IN THE APPENDIX]

Mr. COFFMAN. Mr. Tremaine, you have now 5 minutes.

STATEMENT OF RICHARD TREMAINE

Mr. TREMAINE. Thank you, Chairman Coffman, committee members and our Representative Roby. I am here with you today to testify about the unacceptable vicious and ongoing retaliation against Dr. Sheila Meuse and myself for our whistleblower activity at Central Alabama's healthcare system where the director, James Talton, became the first senior executive servicemember in history fired for neglect of duty. The chief of staff, also under investigation, was on paid leave for 6 months and quietly retired in December of 2014.

With disingenuous claims of improvement, there remains an atmosphere of exclusion and retaliation against those who did not support Talton or subsequently the dangerously inexperienced leadership and ineffectual management of Mr. Robin Jackson, the deputy network director over Talton during his tenure and who was immediately supplanted as interim director by Charles Sepich, division director.

Dr. Meuse and I were two seasoned and experienced yet idealistic newcomers to the leadership team of CAVHCS in March of 2014. Although we both identified scheduling manipulations, illegal hiring practices, continued use of paper wait lists, severely delayed consults, critical levels of understaffing, fraud, and a complete breakdown of human resources and the business office directly to Talton, we quickly concluded he would not support our efforts to hold staff accountable.

In June of 2014, we were forwarded an email sent to Talton in April of 2013 alerting him to critical scheduling manipulations from a staff position. Since Talton was publically claiming no prior knowledge of any scheduling manipulations, we became seriously concerned about his integrity and, on June 11, raised those concerns directly to Robin Jackson and Charles Sepich. We also informed them that we had been contacted by Representative Martha Roby on June 10, regarding her face-to-face meeting with Talton.

Immediately after our June 11, confidential disclosures to Sepich and Jackson, the severe retaliations from Talton escalated exponentially. We later learned it was because Sepich and Jackson had

communicated every word of our confidential conversation about Talton directly to Talton that very same day.

On June 24, I sent an emergent email plea to Sepich informing him of continued violent outbursts and management—excuse me, mismanagement by Talton. The very next morning, I was forced off the Montgomery VA campus by order of Robin Jackson. I was devastated to realize that I had been betrayed.

I was constructively removed from my leadership responsibilities and prevented in acting in any leadership capacity by Talton and subsequently by Jackson in humiliating all-employee emails.

Although Sepich had promised me that he would immediately begin a fact-finding to help us, in fact, 4 days earlier he had already chartered a fact-finding to investigate fabricated allegations by Talton and Jackson against us. That fact finding was chaired by a subordinate of Sepich. As a result, Sepich and Jackson requested an AIB from VACO on us without any specific charges. The AIB was conducted by OAR the week of October 27, with the results due on January 19, 2015. Instead the AIB requested additional onsight testimony, citing a new allegation put forward by a union president who was not selected for a promotion, thus extending the investigation and its scope. One of the AIB members, a sitting director, was also a former subordinate and friend of Charles Sepich.

Incredulously, during my first year at CAVHCS, I had been under the weight of investigations for 305 out of 365 days without a single charge and beginning within my first 45 days of work. It is difficult to describe the level of disrespect, harassment, and retaliation we endured from Talton, Sepich, and Jackson as he removed hospital services from my authority, initiated major reorganizations and realignments adversely impacting my position and without my input. My direct reports bypassed me, reporting directly to him at his request. I was excluded from key informational resources, blocked from critical administrative reports on major program assessments and important site reviews. In fact, when I asked for the complete administrative assessment done by Jackson himself a month before I arrived, he told me, "If you want to see it, request it through a Freedom of Information Act."

In an amazing failure of leadership, Sepich and Jackson actually detailed Dr. Meuse out of the State for 90 days in the middle of this crisis.

I speak with you today with a heavy heart disgusted by the continued coverups and a discrediting campaign through open-ended investigation and the attempted destruction of my career by the VA that I have always loved serving and being a part of.

So many VA employees are closely monitoring this issue and hoping VA leadership at all levels will demonstrate a commitment to true excellence and transparency by creating an environment free from whistleblower reprisal and retaliation.

If the retaliatory actions from CAVHCS and VISN 7 against a dedicated veteran executive and a brilliant career woman executive, both who have committed their lives to serving our veterans is tolerated in the least, it will most certainly have a chilling effect on any others considering stepping forward to protect the organization we all love serving veterans through.

I have feared the loss of my job and career, and we both fear a further loss of our personal and professional reputations. But Dr. Meuse and I sat in disbelief a year ago and agreed, at that moment in time, that we didn't have a choice because it was more important to protect our veterans than protecting either one of our own careers.

We respectfully request that you immediately address the overt whistleblower retaliation that has become rampant in our VA. Again, thank you for your commitment to our veterans, and I am available to answer any questions.

[THE PREPARED STATEMENT OF RICHARD TREMAINE APPEARS IN THE APPENDIX]

Mr. COFFMAN. Well, thank the panel so much for your testimony today and particularly to the whistleblowers.

You know, as a combat veteran, my heart is out to you. I think you are fighting for our Nation's veterans today who have made tremendous sacrifices in defense of this country.

And I would like to ask the whistleblowers a question first, all three of you, and that is: To your knowledge, has there been any disciplinary action taken, to those that have, you know, intentionally created the kind of hostile workplace that you have testified today, in terms of retaliation against you?

Start, Mr. Tremaine.

Mr. TREMAINE. Chairman, there has been none.

Mr. COFFMAN. Dr. Hooker.

Dr. HOOKER. None.

Mr. COFFMAN. Dr. Head.

Dr. HEAD. None.

Mr. COFFMAN. Okay.

Question now. Ms. Lerner, if you look at the number of cases from the VA that have gone before the USC, compared to other agencies of the Federal Government, it seems substantially higher. I think a simple comparison would be to the Department of Defense. I believe that has double the number of Federal civil service employees and yet there are more cases last year, I think, that came forward from the Department of Veterans Affairs than the Department of Defense. Can you explain the—just the nature of the volume of cases coming from the VA?

Ms. LERNER. We have a Map Quest in the back first.

We do get more retaliation cases and disclosures from the VA than any other Federal agency, any other department in the government, and the numbers are increasing. Just for comparison, as you have said, the complaints that we get from the VA are higher than the DoD, which has double the number of employees.

So, you know, we know that people come forward when they, you know, feel that they, you know, have to, to protect the life of a veteran or the health and safety, and so the fact that people are coming forward is a very positive sign. While the numbers are bad and they are increasing and that has to stop, I personally am encouraged that more people are coming forward because, A, we need to know where the problems exist. We can't fix them until we do. And so I am encouraged that people feel confident that they will get some relief when they come to our agency and that they will get some results.

We know—the number one reason whistleblowers come forward is because they feel an obligation. The number one reason they don't come forward is because they feel that they are not going to get any results. Nothing will happen if they come forward. So, you know, it is a double-edged sword. On the one hand, we are not happy that the numbers are increasing and our staff is completely overwhelmed by the work. On the other hand, we are glad that they feel comfortable and confident coming to us and so that is a positive thing.

Mr. COFFMAN. Okay. Ms. Flanz.

Ms. FLANZ. I would certainly echo what Ms. Lerner has said. We are encouraged to know that people do feel comfortable raising disclosures whether it is to members of this committee, members of Congress——

Mr. COFFMAN. I don't—Ms. Flanz, I don't know if they feel comfortable. I think they are willing to take a risk.

Ms. FLANZ. And I would agree with that. I also really want to thank the whistleblowers who have come forward today to provide their stories. It is an act of courage and it is something that we in the Department need to learn to celebrate, because disclosures about problems give us an opportunity to fix those problems. If we don't know about them, don't learn about them, then, we are not able to improve service.

To Ms. Lerner's point, we do need to understand what it is that is driving these numbers, continuing to drive these numbers and to be careful not to assume either bad or good things about the numbers. The fact that people are coming forward with their concerns is an indicator that we continue to have some issues that require attention. But again, the fact that they are bringing them forward means we have the opportunity to identify those problems and move forward with solutions.

Mr. COFFMAN. Ms. Flanz, can you comment to me about—can you give me some idea—so we just had testimony from the witnesses here, that are whistleblowers, that no disciplinary action has been taken against those who have retaliated against them.

Can you give me any data in terms of actions that the VA has taken in terms of disciplining those who have retaliated against our whistleblowers?

Ms. FLANZ. Absolutely. I cannot speak to the cases of the individuals at the table here. As I understand it from my colleagues at the Office of Special Counsel, their issues remain pending, so I am not going to speak to the particulars——

Mr. COFFMAN. How many pending cases can you refer to?

Ms. FLANZ. We currently have, in my office, 80 ongoing investigations of which 15 involve, among other things, whistleblower retaliation. We also—we keep a database of employee disciplinary actions taken across the Department. Until the late summer of last year, we did not have any particular database that showed discipline across the VA. We have begun to collect that data. Among the things that go into that database are general descriptions of the charges that are used to support the discipline. One of the charges is, something having to do with prohibited personnel practice. That is a generic term that includes whistleblower retaliation, among other things. Another type of charge is retaliation.

The information that I have is that, in the approximately one year we have been collecting information, we have 22 actions in our database that include charges related to prohibited personnel practices or retaliation. It is not a large enough number. I will say that right now. We have more work to do to ensure that the individuals who have retaliated against whistleblowers. As Ms. Lerner and her staff bring cases to us to provide corrective remedies to the employees who have been subjected to retaliation, we need to be able to move expeditiously——

Mr. COFFMAN. Okay. I am sorry. I am running over my time—I am running over my time.

I just want to say that this seems like such a typical hearing when you are giving us a lot of great news. We have three individuals here who have testified, not just—who have testified before, that no disciplinary action is taken against those who have retaliated against them and that situation remains unchanged.

Ranking Member Kuster.

Ms. KUSTER. Thank you, Mr. Chairman.

I want to address my remarks to Ms. Flanz and Ms. Lerner, but I do want to thank the whistleblowers for bringing your individual cases and encourage you to work with our good colleagues. I know Representative Roby is on the case for you, Mr. Tremaine—and encourage you to work with the Office of Special Counsel as well to make sure that you get the protection that you deserve and we don't have any other tragedies.

Mr. TREMAINE. Yes, ma'am. May I just say that, absolutely, the Office of Special Counsel has been a lifeline. Working with Paige Kennedy and Nadia Pluta throughout this ordeal for the last year made a huge difference. I don't think there is any question they are totally understaffed, but the opportunities I had to speak with them made a huge difference in my ordeal.

Ms. KUSTER. Good. I hope your situation will get resolved. It sounds like we have got 45 settlements of VA whistleblower cases which hopefully did bring some relief. I know there have been reinstatements with back pay and such, and it is important to send that signal to others.

One of the issues that I wanted to get at is this issue of VA culture and—because it seems to me that the idea that it has gone to the OSC is sort of a recognition that this issue has blown up to a place where it wasn't resolved at a lower level. And I want to make sure that we have a collaborative workplace throughout the agency.

I did note, of the chart that we received, of the top agencies providing case work, it is true that the VA is higher than the DoD. What is interesting for me—and I don't know if they can get this on the camera—but that the VA and the DoD are right at the top, and then it dropped dramatically down for every other agency in the Cabinet. I am curious about sort of the hierarchal nature and structure of VA and DoD and whether it is a greater challenge to change the environment.

But I am also curious—and this is to Ms. Flanz—what steps are being taken to foster a more collaborative workplace? And in the interest of time, I will just combine this with my follow-up question. We hear about steps that are taken here in DC for improve-

ment. But how are these—what are the specific steps that are being taken to improve VA culture and ensure accountability on the frontline at the VISNs step by step with the people that can protect the lives of these whistleblowers and protect the quality of service to all veterans?

Ms. FLANZ. I want to speak to both of those questions. I think I heard two of them.

Ms. KUSTER. Okay.

Ms. FLANZ. One with respect to improving the culture at the frontline across the VA system. The Veterans Health Administration has an office call the National Center For Organization Development, and that office is looking at an issue of psychological safety and how psychological safety can be improved in VA workplaces. Psychological safety is a larger term of which I think protecting whistleblowers is very definitely a component.

The head of that National Center For Organization Development speaks in terms of four cornerstones of the just culture that is required to ensure that patient care is provided in an environment in which people feel safe and the workplace is as we want it to be. Those four cornerstones are transparency, accountability, psychological safety, and risk-taking and innovation. Those four things need to be in balance. To the extent that transparency perhaps is stressed above all other things, you may get people feeling less safe and/or less willing to engage in risk taking and innovation. Similarly, if accountability is overly stressed, you may sacrifice some of the other issues. So the experts are focusing on tools for employees and supervisors across the VA system, to improve psychological safety within the framework of those four cornerstones.

With respect to accountability for whistleblower retaliation, we are working on a number of things. First, we need to capture the attention and understanding of medical center directors, regional office directors, and regional counsel, right there at the facility level. Ms. Lerner's staff, they are coming to give a training program to our regional counsels who are coming to town later this month. We will address them, and then we will begin with some training, new training that we are going to roll out to supervisors, training first regional counsel attorneys and H.R. professionals from the facility level and then having them serve as the trainers.

So we really need to get at two things. We need to make sure that the environment in the workplace is appropriately safe, and we also need to improve understanding on the part of supervisors and attorneys as to what the ramifications are for retaliation.

Ms. KUSTER. Thank you very much.

Mr. COFFMAN. Ms. Flanz, just a quick question. On April 9, 2014, the story emerged about the wait time scandal in the Phoenix VA. How many—since that time, how many disciplinary actions have been taken against those who have retaliated against whistleblowers? Not pending cases, but how many cases have been finalized?

Ms. FLANZ. I apologize. The numbers that I brought I didn't breakdown by month or year. So——

Mr. COFFMAN. How many cases have—you talked only about pending cases. How many cases have been finalized where those who have retaliated against whistleblowers have been disciplined?

Ms. FLANZ. I am aware, through my office, of three. But as I said, the numbers from the facility level are kept in our database, and I could—I would love to provide you specifics, which I just don't have at my fingertips.

Mr. COFFMAN. You are here to testify before the Congress on this issue and you don't have specifics?

Ms. FLANZ. I have the specifics that I have which——

Mr. COFFMAN. That is—how convenient. I will ask you for those on record, for you to submit those to this committee.

Mr. COFFMAN. Dr. Benishek.

Dr. BENISHEK. Thank you, Mr. Chairman.

Frankly, I am—I kind of agree with the chairman. I am a little bit frustrated by this, because these—Dr. Head, I think you testified earlier that you are not familiar with his case.

Ms. FLANZ. I am actually quite familiar with it, but given some ongoing litigation, I am not free to speak to the specifics of it here.

Dr. BENISHEK. Are you familiar with all the cases?

Ms. FLANZ. I am.

Dr. BENISHEK. Are you familiar with all the cases that are in your department?

Ms. FLANZ. Those that involve senior leaders in terms of culpability, yes.

Dr. BENISHEK. Are there 80 active cases? Is that—is that the number?

Ms. FLANZ. We have 80 active investigations of which approximately 15 involve some element of an allegation of whistleblower retaliation.

Dr. BENISHEK. Well, how many cases have you closed in the last year?

Ms. FLANZ. My office has been operating since July of 2014. We have closed dozens. I could get you that number.

Dr. BENISHEK. In only three cases of those dozens have there been disciplinary action in, is that what you are saying?

Ms. FLANZ. Each of our cases results either in a specific finding that the alleged misconduct couldn't be substantiated or it results in a recommendation around discipline, yes.

Dr. BENISHEK. Let me ask a question about—concerning Ms. Lerner's written testimony. There is all kinds of cases here she has documented, you know, specific cases.

Are the people involved—Ms. Lerner, you don't get involved in the discipline of the person who did the—who retaliated against the whistleblower. You are primarily concerned that the whistleblower is restored; is that correct?

Ms. LERNER. Generally our attention is on relief for the whistleblower.

Dr. BENISHEK. Do you then report these issues to Ms. Flanz's——

Ms. LERNER. Yes.

Mr. BENISHEK [continuing]. Department, then, so that she can act on those?

Ms. LERNER. Sure. Yes. We are working with Ms. Flanz and the Office of Accountability Review to expedite their identification of cases where disciplinary action is appropriate.

I also just want to mention that we know of at least 40 disciplinary actions against employees who were complicit in the wrong-

doing identified by whistleblowers. So, on the disclosure side where people come to us and make a disclosure of health and safety problems or the wrongdoing, as part of our review of the agency's investigation, we look to see whether they have taken disciplinary action. And on that side of the equation, we know of at least 40 since—about 2 years ago.

Dr. BENISHEK. All right.

Ms. LERNER. So that is a little bit encouraging.

Dr. BENISHEK. I am just disappointed that, Ms. Franz, you are only aware of three cases in all these—three cases of disciplinary action being taken amongst all the cases in the last year. It seems surprising to me. Especially in view of the fact, like Dr. Head here, was here last summer and, you know, is still under investigation. Mr. Tremaine, it seems like he is under quite a bit of distress here.

Let me ask Dr. Head. Dr. Head, what have you been doing in the last—you know, since your last, well, your last testimony here? What actions have you taken because it seems like you are still having trouble?

Dr. HEAD. Well, I continue to report each and every retaliatory event. You know——

Dr. BENISHEK. Has anybody come to you like from Ms. Flanz's department to ask you questions about what has been going on?

Dr. HEAD. From the Office of Special Counsel, they have communicated with us, more recently the investigative unit.

Dr. BENISHEK. Does the Office of Accountability Review talk to you?

Dr. HEAD. They have, but I—it has been disappointing.

Dr. BENISHEK. Okay. Mr. Tremaine, I heard you testify earlier that you have been in contact with Ms. Lerner's department. Is there anybody else you have been talking to?

Mr. TREMAINE. No, sir. Other than the—other than the AIB after about six—I want to say 12, 13 hours of grilling over 2 days, over—I'm sorry—over 3 days.

Dr. BENISHEK. They were talking to you?

Mr. TREMAINE. They were talk—they weren't talking. They were grilling.

Dr. BENISHEK. Well, what do you mean grilling? What were they doing?

Mr. TREMAINE. Well, they were investigating. You know, they were—I thought—and I told them, I clearly thought it was a sham and I expressed that to them on multiple occasions during the investigation.

I mean, one of the—one of the most interesting questions, the question they wanted asked or answered the most, dealt with the fact that I had identified a vehicle that was driving—a government vehicle on a Friday night at 8:30 in the evening, after I left the office at 8:30, it didn't have any taillights on it at all. So I stopped that vehicle and notified the driver there weren't any taillights on before the driver got on a darkened highway. And then the next Monday, I inquired about what the vehicle was doing out at 8:30 because, you know, we had had vehicles destroyed by staff and we had had vehicles used to take staff to crack houses. And I had a concern about why that vehicle was out.

The OAR AIB investigation was more concerned—excuse me—was more concerned why I stopped the vehicle. And when I expressed that—you know, I was born in Ohio and I suspect that, maybe as just a good Samaritan, all three of the AIB members advised me that they would never have done anything like that. And I thought that was incredulous. And then they questioned me why I questioned the employee on Monday without a union representative. And I told them, well, you know, I am still number two in the organization at the time and I felt I had a responsibility to ask what the vehicle was doing out there at 8:30 at night. That is my——

Dr. HEAD. I also——

Dr. BENISHEK. I am out of time here, I guess, Mr. Chairman. Thank you.

Dr. HEAD. I just wanted to say one thing. I also felt that a lot of times these investigations were more about us, but not necessarily about the facts of what we have complained about. And my experience is very similar to that.

Mr. TREMAINE. Yes.

Mr. COFFMAN. Miss Rice, you are now recognized for 5 minutes.

Ms RICE. I am going to try and organize this. I am at a loss for words.

First of all, I don't understand your attitude, Ms. Flanz, with all due respect to you. The fact that you can sit there and come here with literally no information and you can't answer a question with any specificity is very, very disturbing.

I don't understand how the two of you, Ms. Flanz and Ms. Lerner, can say that there has been progress, when we have Ms. Lerner saying that she attributes the increase in complaints from people at the VA to the fact that people are feeling more comfortable coming forward at the same time that Ms. Flanz is admitting that there has been literally no accountability on the part of the people retaliating against whistleblowers.

Can either one of you explain that conundrum to me?

Ms. FLANZ. I would like very much to try.

Ms RICE. Great.

Ms. FLANZ. We are committed to ensuring that supervisors who retaliate against whistleblowers are held accountable.

Ms RICE. Let me stop right here. I just have to interrupt you.

It seems to me that—and maybe this is my prosecutorial background—if you want to send a message that people, wrongdoers are going to be held accountable, you actually have to hold at least one accountable. And if you look at the numbers of complaints, they far outweigh any level of accountability.

So please explain that.

Ms. FLANZ. Again, I would like to, very much.

We have ongoing investigations right now that will provide us with the evidence necessary to hold employees, supervisors accountable. Until very recently, we have not had the collaboration with OSC that we have now that allows us to use the evidence that they have pulled together to give us a jump start so we don't have to start fresh with our investigations.

We will, whenever the evidence shows that retaliation has been engaged in——

Ms RICE. Okay.

Ms. FLANZ [continuing]. We will hold people accountable.

Ms RICE. So let me ask you this. Why is it that a determination that a whistleblower was not giving accurate information a much easier determination to make than retaliation against a whistleblower?

You answer that question for me. Because what I am hearing from the three whistleblowers here is you guys have no problem saying this whistleblower was wrong but you have no ability to hold a wrongdoer accountable. Explain that.

Ms. FLANZ. With all due respect, that is not really how the process works. We are——

Ms RICE. No, no, no, no, no. I have to stop you, because I have very limited time.

This is a very simple question. Why is it that you are able to come to the conclusion that whistleblowers have made allegations that were not based in fact, and you can do that pretty expeditiously, seems to me, and you can't do as expeditious an investigation when it comes to holding a retaliator against a whistleblower accountable?

Because guess what? The numbers support what I am saying. You can give whatever explanation you want, but I am telling you right now, the level of disrespect that you are showing to the veterans—who, by the way, if—and we know allegations are true, in terms of the treatment, mistreatment of patients, the lists—all the laundry list of stuff that we know is going on. Okay? Everyone knows that it is there.

You are telling me that you are spending all this time to try to hold someone accountable. Let's forget about what is happening about actually fixing the problem, where veterans are not getting the services that they need. That is another disturbing thing to me. That is almost an afterthought to you.

So I can't hear an explanation that includes some kind of, well, you know—and, believe me, I am a lawyer, so I get the whole, "There is an ongoing investigation, so I can't answer." It is a very convenient way of getting out of answering a question that you don't want to answer. So I know that. And I apologize. My blood is boiling, and this is a disgrace.

So please give me a succinct answer, and then I will end, on why it is that it is easier for you to come to the determination that whistleblowers are wrong before you can come to the—in a faster way than you can say that these retaliators are wrong.

Because the number-one way we know we are going to stop this is just hold one retaliator accountable. And I don't mean docking their pay. I mean firing them.

Go ahead.

Ms. FLANZ. I understand. It has to do with the burden of proof. When we do fire an employee, we are required to show that the preponderance of the evidence supports the action. It really is——

Ms RICE. Okay. I get the whole "burden" thing. Then that is why you should have more people working on that to do it even faster. Because this system is not going to get fixed—and you can talk about, oh, we changed the culture, here we did this, we set up that,

oh, it is all so much better—if retaliators aren't being held accountable. That is the bottom line. And I don't see that.

Thank you very much, Mr. Chairman.

Mr. COFFMAN. Thank you, Miss Rice.

Dr. Roe, you are recognized for 5 minutes.

Dr. ROE. Thank you, Mr. Chairman.

I guess the direction I want to go is with Dr. Head and Mr. Tremaine and Dr. Hooker too.

When you make an allegation, obviously, you are not a team player right then. So what is it to lead me to believe that you are just not an incompetent employee, you know, you are a troublemaker, you don't want to work with the team? We have all been on the team before.

And when you are looking, what is to make me—because I have seen this happen before, where you—how do I know Dr. Head is really a very good doctor? You just might not be very good, so we just move you out of the clinic and put you in a closet or somewhere and essentially move you out of clinical care just to get you out of the way.

And it is very hard to protect your reputation if you have two or three or four senior people ahead of you who are making those allegations. So how do you protect yourself from that, to follow up on Miss Rice's statements? How do you do that?

Dr. HEAD. It is a——

Dr. ROE. How do I know you are not, sitting here?

Dr. HEAD. Well, my reputation speaks for itself. And my education and clinical expertise and track record speaks for itself. A lawsuit has never been filed against me. I have never had what is called a level 3 complaint filed against me until after I testified in Congress.

Dr. ROE. I am being facetious, Doctor.

Dr. HEAD. I understand. I understand, but I think the whole world needs to understand this.

I am a team player because I have followed the chain of command. Every complaint I have made, every allegation of malfeasance, the problems with the wait times, the deletion of consults, suggesting perhaps medical staff should review the consults or deletions rather than non-medical expertise, rather than students, should be do the deletions.

It is common, though, to—as I said before, what is the first thing they do? They take the whistleblower, they isolate them. Second, they defame them. Third, they push them out.

Once they have them isolated and defamed—and then they try to go back and rewrite history, suggesting, perhaps, it is something that they have done to cause the action against them. And they send out their surrogates, usually trained professionals without the institution, to suggest that perhaps that person is a bad person, not a good doctor.

But you know something? My strength comes from my patients, actually. And I often tell them, I get much more out of seeing you than I give you. And I do my best every day of the week to make sure that I give them the best care possible. The mistake I made initially during this process was to allow them to push me out of

care. But I am stronger now only because I have insisted and I fight to see as many veterans as possible.

Dr. ROE. I think the problem is when you stick your head up.

Dr. HEAD. Yes.

Dr. ROE. It is easier to keep your head down. You don't get arrows if you do that.

Dr. HEAD. Yes.

Dr. ROE. If you stick your head up and speak out, you get a lot of arrows. And the point is the people shooting the arrows don't seem to have any going back their way.

And, Mr. Tremaine, here you come into a new shop, you know, you are working in there, you see some issues, you point them out, and what happens is you, then, become the problem.

Mr. TREMAINE. Yes, sir. And with 24 1/2 years of VA experience at eight different facilities and never anything less than an outstanding rating and nothing, including a letter of counseling, in those 24 years.

After arriving in central Alabama, really quickly we discovered and I discovered and then, simultaneously, Dr. Meuse, as the assistant director, we started kind of comparing notes a little bit, and we both realized we were team players. And we would have done anything on the team that was going to fix things. But I promise you, we are never going to be on the wrong team. We are not going to be on the team that disrespects or harms veterans.

I mean, I am a veteran myself, an Air Force—who comes from a family of veterans. I have my son here, who will most likely be an Air Force veteran. I would rather he go back to University of Colorado in Boulder, my alma mater, but if he wants to go serve, I will support him 100 percent.

But when he gets out, you know, I want to make sure he walks into a VA—any VA across this Nation, the minute he crosses that threshold, he should be treated with respect and dignity, period, bottom line. It shouldn't be a matter of, well, which team are you going to be on? There is only team, and that is the right team.

And when we got down to CAVHCS, both Dr. Meuse and I realized the wrong team was in place. And we tried our best to help that team, to reenergize that team, but, as it turned out, that team didn't want to be helped. That team wanted to protect themselves and attack us. But neither Dr. Meuse or I would give up that fight and give up on our veterans.

Dr. ROE. Well, I thank the three of you for being here and speaking out.

I think it will help other people, Mr. Chairman, around the country to have the courage to stick their head up instead of keeping their head down and letting things go by that shouldn't, that potentially could harm veterans.

I yield back.

Mr. COFFMAN. Thank you, Dr. Roe.

Mr. Walz, you are now recognized for 5 minutes.

Mr. WALZ. Thank you, Chairman.

And thank you all for being here.

The VA can't achieve its mission of providing the highest quality care to our veterans if we have a culture of fear or a culture where the practitioners aren't able to do what they need to do.

And it feels like, since I have been here—and I know I am somewhat biased, as a cultural studies teacher. This issue of culture is never far from us, and we have talked about it. It is difficult.

We were out in Tomah, a week ago or so, on a field hearing on this very issue of overprescription of opioids. And a whistleblower, if you will, Christopher Kirkpatrick, was one of those people who brought that to people's attention. He was backed up on that by the IG's report. And Christopher is now dead.

We have another whistleblower out there whose medical record, a veteran, was looked into with the very clear example of trying to find a mental health issue to try and discredit them, which is so despicable on so many levels, because the very stigmas we are trying to overcome amongst mental health and mental parity is being used against the people who are talking about it.

So this is a cancer. And I know the attempt to try—and I am grateful that we start to bring it to light. But in so many of these cases, the difficulties to overcome—and I think Miss Rice was hitting on this, this whole preponderance of the evidence. And we understand that you have to make a case and you can't just accuse people and there is workplace safety and you have collective bargaining agreements and things that make sense. They are there to protect, which I will come back to. Thank goodness for Dr. Hooker and the Local 342 for providing some democracy in the workplace, where management can't just run roughshod over employees.

But with that being said, this issue seems to me—and I know this runs deeper than all of you at the table. I just looked up in the dictionary, the Webster's dictionary, looked up "whistleblower." Do you know what the synonyms are? "Betrayer," "fink," "informant," "nark," "rat"; related words, "collaborator." That says something about our culture that runs deep, and this is hard. That is why what you two are doing becomes even more important, to ensure us that the integrity is there.

And I am going to hit on where Dr. Benishek was and I think Dr. Roe was getting at. I went through the list—and I am grateful that it appears that we are starting to get some justice for the whistleblowers. But that is one piece of this. The accountability piece you talked about—the thing that troubles me most in the nine cases you listed—now, I may be wrong, because they are summaries. But it appears that only Charles Johnson at the Columbia VA actually led to changes in how business was done in a hydration practice that was wrong.

Am I wrong to assume—because my concern on this is that this is threefold: justice for the whistleblower, accountability for the perpetrator, and improved quality of care to stop that. Because, really, when you adjudicated these things, all you gave them back is what they should have had in the first place. You don't get a pat on the back for doing the right thing. And that is what it appears like we are asking for. "Look at us. We paid them back the money." Oh, because you fired them incorrectly in the first place.

So could—I don't know if it is Ms. Flanz or Ms. Lerner, and I know maybe we are talking to the wrong people for implementation of these changes, but are we seeing true change, in your mind, or are we just going through the motions and paying people backpay that they should have never been taking anyway?

And, by the way, it is not the VA who settles, it is the taxpayer who settles, when they do this wrong, just to be clear.

Ms. FLANZ. Absolutely. We are seeing changes, not as quickly and not as profoundly as we should. We will get there. We are seeing changes.

The Office of the Medical Inspector, in particular, when they go out to investigate a disclosure that comes to us through Ms. Lerner's office, if it is a disclosure having to do with a problem with patient care, their recommendations include, if there is a whistleblower who is named, not just protection for that individual, but substantive change around whatever the problem is that was disclosed. And the Department has an obligation to provide the information about what it is going to do and provide updates in terms of progress toward the correction of the problem.

So, absolutely, that is—it is fundamental. That is really what the whole process is about.

Ms. LERNER. Let me just add a couple of things.

I mean, I think culture change requires many elements. This is not a problem that just developed overnight. It has been around for a long time. It is not going to get solved overnight. But here are things that we see that really make a difference in changing a culture.

Number one, you have to have a message from the top. Leadership has to be very strong. Some of the things that we have seen Secretary McDonald do, like meeting with whistleblowers when he goes to visit facilities, that sends a great message. So that——

Mr. WALZ. This troubles me, though, if I could interrupt you. Was Secretary Shinseki unethical?

Ms. LERNER. I am sorry.

Mr. WALZ. Was Secretary Shinseki unethical then? Did you ever get an impression that he didn't care about this? Or those that came before him in——

Ms. LERNER. I mean, I think a lot of the problem under Secretary Shinseki's term was that the Office of Medical Inspector was doing nothing when they found a problem. So when there was a disclosure, what the Office of Medical Inspector would do is say, yes, in this isolated incident, maybe the whistleblower is right, but it is not really a problem, there is no harm to patient care——

Mr. WALZ. And that is different now?

Ms. LERNER. And that is very different now. The Office of Medical Inspector is different. After our report almost a year ago, the Office of Medical Inspector was changed around. The person who was heading it left.

We are seeing a change, as I mentioned in my testimony, in the types of investigations that they are doing, including disciplinary action as a——

Mr. WALZ. My time is up, but when we come back around again, I would like to have the other three address that. Because I think that is fundamental, if this has made a significant difference, because that is an important piece.

I yield back.

Mr. COFFMAN. Dr. Huelskamp, you are now recognized for 5 minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I appreciate you holding this hearing. I wish it were not necessary. I wish we had seen the type of changes—I think we wouldn't be sitting here if we were comfortable with what has happened.

I want to follow up on one thing that was just mentioned, and that was, I believe Ms. Lerner mentioned the travel by the Secretary and other top VA leaders.

Have they visited—and this may be a question for Ms. Flanz. She makes reference that, visiting with whistleblowers.

Has the Secretary, current Secretary, visited the L.A. facility where Dr. Head works?

Ms. FLANZ. Yes, he has.

Dr. HUELSKAMP. And did he meet with Dr. Head at that time?

Ms. FLANZ. I honestly don't know. Dr. Head would know.

Dr. HUELSKAMP. Okay.

Mr. Head.

Dr. HEAD. Yes, I was prevented from meeting with the Secretary. I was told that my ID badge was—there was a problem with my badge. I went to human resources——

Dr. HUELSKAMP. Say that again. Something wrong with your badge?

Dr. HEAD. I was told that you had to have an updated PIV card on your badge, that mine had expired, and that I would not be allowed to see the Secretary. And so I——

Dr. HUELSKAMP. Did that expire when you were before the congressional committee, by any chance?

Dr. HEAD. There is a possibility it could have expired soon after.

Dr. HUELSKAMP. And I appreciate that, Doctor. I am going to go back to——

Dr. HEAD. But I was instructed to get that taken care of. I went to human resources. When I was in human resources trying to resolve the issue, which was resolved, they had instructed me that a block had been placed on my ID and they had a problem with the block.

And I was called, saying, you can meet with the Secretary now. Dr. Norman has said that it is not necessary to have an updated PIV card. The problem is the Secretary had just finished his presentation.

Dr. HUELSKAMP. Very troubling.

Ms. Flanz, any response to that? I mean, you made the claim that—I mean, this is a very public whistleblower. Dr. Head has put his reputation on the line in, I think, a very courageous move, very public. Was he not searched out to sit down and say, let's solve this problem?

Ms. FLANZ. I was not consulted. If I had been, I sure would have wanted to try to intervene.

The Secretary does make a point to model the behavior he wants to see in all supervisors. I am very sorry that Dr. Head wasn't able to meet with him because I know that conversation would have been of use to both of them.

Dr. HUELSKAMP. Are there any other whistleblowers—I mean, you made the statement that he would like to meet with whistleblowers. Any others that he skipped that you know of? Or how many times has he met with whistleblowers?

Ms. FLANZ. It is my understanding he seeks them out every time he goes to a VA facility.

Dr. HUELSKAMP. Except for Dr. Head's situation, I guess?

Ms. FLANZ. This is the first that I am hearing that Dr. Head was unable to meet with him.

Dr. HUELSKAMP. Well, I would appreciate that when you make statements for the record—and we have lacked a lot certainty. This is a pretty certain statement, that, boy, we are really working hard on that.

So I want to confirm, if I understood correctly earlier, that no VA supervisors have been fired for retaliation against whistleblowers?

Ms. FLANZ. That is not correct.

Dr. HUELSKAMP. So how many have been fired?

Ms. FLANZ. The ones that I know of fall within the jurisdiction of my office, which only looks at senior managers, so I can't speak to the folks below that level. We have been involved in recommending termination for three individuals whose charges included whistleblower retaliation.

Dr. HUELSKAMP. So they have been terminated?

Ms. FLANZ. Yes.

Dr. HUELSKAMP. The second question will follow up on the issue of whistleblower medical records—and may we have the names of those who were terminated?

Ms. FLANZ. Not in this public forum, but I would be happy to provide them.

Dr. HUELSKAMP. I will follow up, then, on whistleblower medical records.

Ms. Lerner, you made reference to that later in your written testimony, that perhaps supervisors or others have accessed illegally medical records of whistleblowers in order to discredit them.

Can you describe that situation? This is just shocking and astonishing, that that would actually be occurring in the VA.

Ms. LERNER. I mean, we have raised some of these concerns directly with the VA and with the IG. What we are seeing is a pattern of not just accessing medical records but investigations opened after someone comes forward for things like HIPAA violations or Privacy Act violations, relatively minor violations that become the focus of the investigation, rather than the underlying disclosure that the whistleblower came forward with initially.

And it is really problematic from, you know, lots of perspectives. One of them is that, obviously, the underlying disclosure isn't being looked at, but it also has a very chilling effect on other whistleblowers. And so we are——

Dr. HUELSKAMP. But the HIPAA violation is by the VA retaliating against the whistleblowers, as I understand, not the whistleblowers——

Ms. LERNER. Well, it is both—it is all of those things. It is——

Dr. HUELSKAMP. My question is about medical records of whistleblowers being accessed. So that actually has occurred? Do you have any idea roughly how many times that has——

Ms. LERNER. I don't know the number. I can find out for you. I know we have cases that involve improper access to the whistleblower's medical records. Because, obviously, lot of the people who

work at the VA get their care from the VA, and so their medical records are there, and——

Dr. HUELSKAMP. Of course, the VA, as a governmental agency, is exempt from HIPAA. Is that correct?

Ms. LERNER. I don't——

Dr. HUELSKAMP. So, Ms. Flanz, you are shaking your head. So, then, what is the penalty for inappropriately accessing whistleblower medical records?

Ms. FLANZ. There is a range of penalties. And in each case, we have to look to see whether, in fact, the individual who accessed the record had a business reason to do so.

I am also deeply troubled by this. We do see it far more often than you would expect. I don't know whether that is because so many of our employees are veterans who receive their care at VA facilities. It is a deeply troubling phenomenon.

Dr. HUELSKAMP. Well, I would say my idea for penalty for that would be immediate dismissal.

I yield back, Mr. Chairman.

Mr. COFFMAN. Thank you, Dr. Huelskamp.

Ms. Roby, you are now recognized for 5 minutes.

Ms. ROBY. Well, first, thank you to the chairman for the invitation to join you today. Many of you know I don't sit on your committee, but I do sit on the Appropriations MILCON-VA Subcommittee. And Mr. Tremaine is my constituent.

And I am very grateful to have you here today.

Two observations, quickly—and to the ranking member, thank you.

One, two huge understatements: first, to say that these people are coming forward shows that there are issues that still need some attention; as well as this saying that we hear over and over again that you can't change a culture overnight. Well, it has been a year, it has been almost a year since Mr. Tremaine and I had our first conversation. So we are kind of tired of hearing you can't change this culture overnight. It hasn't been overnight; it has been a year.

And so here we are today—and, Mr. Tremaine, I was traveling up here today, and I was thinking about us being in this room together today and how significant that is. And I just want to thank you for being willing to tell me the truth when no one else was. For you and Dr. Meuse to step forward to reveal the horrible circumstances in Montgomery and Tuskegee just says a lot of about who you are.

And I just want to—I have thanked you many times for this, but I am going to take this opportunity today publicly, Mr. Chairman and Ranking Member, to thank Mr. Tremaine and the other whistleblowers that are here, who I don't know, but I appreciate your courage, as well.

Thanks to Mr. Tremaine, we uncovered layers of scandal at the Central Alabama VA, thousands of missing x rays, manipulated medical records, as Mr. Tremaine referenced, the VA employee who took a recovering veteran to a crackhouse and only—it took a year and a half, even though the administration knew that this had happened, it took a year and a half for that individual to be fired. This is the culture that we are talking about.

And, here, a year later, we have taken a step backwards, when an AP article that we saw at the end of last week showed that Montgomery and Tuskegee, the two hospitals that Mr. Tremaine worked at, were number one and number two for the worst in the country. Because there is a new scam now, Mr. Chairman and Ranking Member. It is, let's schedule the appointment within the timeframe required, but we will cancel it 30 minutes before the appointment and reschedule it so that on the books, once again, it looks as though the VA is doing what they are supposed to do.

And, by the way, if they come in—I learned this just last week, and you probably already know this. But if a mental health patient comes in and asks to be seen as a walk-in, they only get reimbursed for half their travel expenses than they otherwise would have as an appointment-holder—which, by the way, was only canceled 30 minutes prior to their arrival.

This is the kind of stuff that we are hearing directly from veterans. And I have to tell you, nothing has improved. We have taken steps backwards.

And so, Mr. Tremaine, thank you for being here.

But, to that point, I want to ask you—because I have asked nicely for a year, and all apologies to those who raised me, but I am a little over being nice at this point—how often, Mr. Tremaine, in the last 6 months did a professional staff member from the Secretary of the VA's office here in Washington sit in your regularly scheduled staff meetings at CAVHCS?

Mr. TREMAINE. Zero, as far as I know, Congresswoman.

Ms. ROBY. Zero. Right. Zero.

So Senator Shelby from Alabama and myself sent a letter, when all of this information was revealed, that we wanted Washington VA to come down and directly oversee what was happening at Central Alabama VA.

Over the last 6 months, has there been any presence from the national VA in Central Alabama, a direct link to the Secretary's office here in Washington, to oversee what is happening at CAVHCS in the last 6 months?

Mr. TREMAINE. Not to my knowledge, ma'am.

Ms. ROBY. Okay. And so, in your view, has the Secretary and other top leadership here in Washington shown a direct, sustained interest and investment in correcting the problems at CAVHCS?

Mr. TREMAINE. No, ma'am.

Ms. ROBY. So would you say that Washington followed through with its promise to directly oversee the overhaul at CAVHCS, or was the work staffed out to Mr. Sepich and Mr. Jackson? Who, by the way, Mr. Sepich was the VISN 7 director, and Mr. Jackson is now the acting director after Mr. Talton was removed.

Mr. TREMAINE. Yes, he was placed there by Mr. Sepich. He was the deputy network director. And when Mr. Talton was fired, Robin Jackson came in as the director. And, again, I think I pointed out that I thought he was woefully——

Ms. ROBY. And I am a visitor here, so I have to be real careful not to violate your rules of 5 minutes, but if I can just point out one other thing.

Ms. Flanz was in the room with me and the Deputy Secretary when I asked Mr. Sepich to be included in the same investigation

that Mr. Tremaine and Dr. Meuse were subject to intense interrogation. Because Mr. Sepich was the boss of the first senior administrator that was fired for mismanagement and misconduct under the law that this Congress passed last August. Mr. Sepich quietly retired 1 week ago.

Thank you for letting me be here, Chairman and Ranking Member.

Thank you to Mr. Tremaine and Dr. Head and Dr. Hooker. I just can't tell you how much I appreciate your courage and your willingness to help us help get this right.

Mr. TREMAINE. Well, thank you, Representative. And I think that, you know, your passion speaks for itself.

And I think when I mentioned about being on the right team, I mean, there is no question that, you know, our Representative, Martha Roby, has been an advocate for veterans that, you know, we haven't seen the likes of.

So thank you so much for that, ma'am.

Mr. COFFMAN. Ms. Kuster.

Ms. KUSTER. Thank you very much.

Just a brief follow-up along the lines of Representative Rice. And I want to ask Ms. Lerner—this is sort of procedural, but I think it will get at an important point.

You talked about the Office of Medical Inspector now doing a more proactive or interactive follow-up to the recommendations, and you mentioned including disciplinary action. And that seems to be what is hanging in the room over this hearing, our disappointment that it sounds as though it is a more rigorous investigation of the whistleblowers than of those that have been standing behind retaliation.

And, to me—and I think this is what Representative Rice is getting at—if you want to actually change the culture, you have to change the view, not just it is the first step that we will take care of whistleblowers and treat them fairly, but that something will actually happen to those employees who enter into retaliation.

I am an attorney, I understand the burden of proof. But can you follow up with this role—maybe we don't have the right witness here, in terms of the Office of Medical Inspector—what types of disciplinary action? And can we ask for any data that may be available on the disciplinary action that has actually been taken?

Ms. LERNER. Sure.

I think there are two different processes here. The Office of Medical Inspector investigates once we get a disclosure that we refer for investigation. So that process is separate. And one of the things that we look at when we decide whether the Office of Medical Inspector's investigation report is adequate and before we report to the President and to the Congress is, have they taken appropriate corrective action? Where they found a problem, has someone been disciplined? Has relief been provided?

And that is not—what they do is not really retaliation investigations. Where we are seeing the problem with retaliatory investigations is with the IG and with the regional counsel. The problem really is that, when someone comes forward with a disclosure, then an investigation is often opened up into their own behavior.

So, about 80 percent of the time, when people come to us with a disclosure, they experience retaliation. We can protect them from retaliation if they come forward, but the Office of Medical Inspector is really just looking at the underlying disclosure.

Ms. KUSTER. So then there is a procedure that is missing. Because my colleague Mr. Walz talked about how you need to deal with protecting the whistleblower, you need to deal with making the long-term changes for the health and well-being of the veterans, but I want to get at the crux of the matter.

Who is investigating the retaliatory action, and what is the disciplinary procedure for that person? Do you follow me? We are——

Ms. LERNER. Sure.

Ms. KUSTER. We are going to miss the forest for the trees here.

Ms. LERNER. Yes. When someone makes a disclosure and they experience retaliation, they have a number of options. They can go to the accountability review. They can go to the IG. They can come to OSC. They can come to Congress.

If they experience retaliation, we can open up an investigation, or we can use our expedited review process to try and get relief very quickly for them. And we have been able to get relief quickly for at least——

Ms. KUSTER. But you are still talking about relief to protect them. I want to follow—keep——

Ms. LERNER. Protect the whistleblower.

Ms. KUSTER [continuing]. Keep going on the track. What is the procedure for a disciplinary proceeding to set the example?

I mean, look, that is half of what the criminal justice system is all about, it is part of what an employee justice system is about, to set this example. Here, we are modeling the behavior of this collaborative approach. Over here, we don't want this to happen, sending somebody to an office with a hole in the floor, sending somebody else to an office with no windows. You know, these are things that are not tolerable, and we are going to demonstrate that to all the other employees in this VISN by saying, oh, that person was let go, they didn't uphold a standard of cooperative, collaborative spirit that we hold dear in our workplace.

Ms. LERNER. Disciplinary action is really key to accountability. There is no question about it. In terms of changing a culture, you have to hold people accountable. It deters future violations, as well.

Our primary focus is on making the whistleblower whole and putting the whistleblower back. You know, we have 130 employees for our agency, and we have to prioritize where we put our efforts.

Ms. KUSTER. Sure. But——

Ms. LERNER. But what we do is, where we identify a case where we think disciplinary action is appropriate, where someone has been retaliated against, we work with the Office of Accountability Review, we work with the VA general counsel, and we try and get the agency to take disciplinary action. And we have several cases in the pipeline right now, in fact, that will involve disciplinary action. We are trying to pivot and focus more and more on disciplinary action as an agency.

But our first priority has been getting people back to work. When someone has been fired, we want them back to work. When some-

one has been moved to the basement, we want to get them back. And we have been very successful, actually, in doing that.

Ms. KUSTER. Well, my time is up, but I want to make the point that the sooner you can get to the disciplinary action for the retaliatory behavior, the shorter the list of cases you are going to be piling through for years on end of examples such as these. So you need to set an example. But thank you.

And I apologize for going over.

Mr. COFFMAN. Dr. Benishek, you are now recognized for 5 minutes.

Dr. BENISHEK. Dr. Head, you still don't have an office, basically, because you were put in this bad office?

Dr. HEAD. It is shameful. And it is kind of——

Dr. BENISHEK. But is that true? Are you still basically——

Dr. HEAD. Well, I have that office that they would like to——

Dr. BENISHEK. Ms. Flanz, why hasn't he gotten his regular office back?

Ms. FLANZ. I don't know, but I will find out.

Dr. BENISHEK. I think that is a pretty good question to ask, because obviously he is here in good faith, and I would like to get an answer to that question.

Dr. Head, the guy, your supervisor, is that the same supervisor you have had all the way along for this whole ordeal?

Dr. HEAD. No. On paper, it is Dr. Norman Ge. He is the chief of staff at Long Beach. But, really, it is Dr. Dean Norman who has been responsible for this.

Dr. BENISHEK. That is the same person that has been there right along?

Dr. HEAD. Yes.

Dr. BENISHEK. Ms. Flanz, apparently, VA employees often confidentially provide patient information necessary to substantiate allegations of improper care to this subcommittee. This is not a HIPAA violation, so why are employees sometimes accused of privacy violations for this activity?

Ms. FLANZ. I think it is a function of confusion on the part of supervisors. VA is appropriately very protective of protected patient care information, and not all supervisors are aware of the right of employees to provide that information to this committee and to other oversight bodies.

Dr. BENISHEK. Ms. Lerner, what changes have occurred in the Office of Special Counsel since the last year's hearing? Is there anything that has substantially changed in the office?

Ms. LERNER. Well, we have had many more cases to investigate in the last year. We have been able to do a little bit of hiring. We have been able to hire someone to work full-time on VA cases in the expedited review system and hire additional staff to work the cases.

I mean, our process works. We have been getting relief for whistleblowers. We are getting people back to work. We are getting them stays of adverse personnel actions. You know, people, you know, I think, feel more comfortable and know about us, so we are getting more cases.

Dr. BENISHEK. All right. Thank you.

Dr. Hooker, I want to give you a chance to speak for a minute, because I don't think you have been heard from enough. Tell me what your response is today to the testimony of Ms. Flanz and Ms. Lerner.

Dr. HOOKER. Well, I can tell you by illustrating that we had a whistleblower who reported an inappropriate practice of giving Suboxone medication to help people who have addiction problems. And you are really technically not supposed to continue giving that medication if someone has an abnormal urine drug screen, so repetitive positive urine drug screens should be a cause for not giving that medication anymore.

We had a clinical nurse specialist who reported that practice going on, and rather than investigate, they investigated that nurse. He has been sitting in a clinical clerical position even though he is a clinical nurse specialist. He is essentially doing no functions. He is in a windowless office, reporting to clerks who need, you know, something moved or carried around, when he has a master's degree and is going for his Ph.D. And he is on Active Duty, just this past weekend, in the Reserves.

They have now proposed on Friday—he did contact the Office of Special Counsel back in August when he was first detailed. And they did propose discipline against him this Friday, a proposed suspension, on something that occurred in 2013 and a couple of other things that they allege occurred in 2014.

Dr. BENISHEK. Let me just interrupt you a minute, because I have heard of this before from the other members, other physicians, saying that they get a peer-reviewed gig against you, something that they can put against you without referencing the thing that you brought up.

Dr. HOOKER. Right.

Dr. BENISHEK. Is that your experience, as well?

Dr. HOOKER. Yes. My personal experience when I have been in the limelight for reporting things, I only had one time when I was called to a peer-review committee, and I have worked for the VA over 26 years.

And this particular instance, there was no peer in the room or on a telephone to be my peer. There was a dietician in the room, and there were, you know, a few other, like, you know, occupational therapists, in addition to a smattering of physicians. But there was no true peer for me to address my concern to. That was number one.

Number two is that the——

Dr. BENISHEK. So the peer-review process is flawed at your facility, it sounds like.

Dr. HOOKER. Yes, in certain circumstances, very flawed. Because people that they want to, you know, in a sense, harass—I had another colleague—well, several colleagues, who had no true peer in the room when they went before the peer-review committee.

Then we have people who are in the inner circle, who are the team players, who don't get peer-reviewed for cases that should be peer-reviewed and then others who get peer-reviewed for cases that really should not be peer-reviewed.

Dr. BENISHEK. Thank you, Dr. Hooker.

Thank you, Mr. Chairman.

Mr. COFFMAN. Miss Rice, you are now recognized for 5 minutes.

Ms RICE. Thank you, Mr. Chairman.

Ms. Flanz, I would just like to go back to the conversation we were having where you were talking about the burden of proof for retaliators.

What is the burden of proof that you apply when you are looking into allegations made by whistleblowers?

Ms. FLANZ. In any case, it depends on the tribunal that might hear an action.

Ms RICE. Say it is you.

Ms. FLANZ. I am not a tribunal.

Ms RICE. Well, I mean, say it is you making a recommendation to a DA's office or—who? The U.S. attorney? Who are the possible offices you could make——

Ms. FLANZ. In most cases, employee discipline is going to be subject to appeal to the Merit Systems Protection Board. The Merit Systems Protection Board in almost all cases applies a preponderance-of-the-evidence standard.

Ms RICE. Is that true for both retaliators and for whistleblowers?

Ms. FLANZ. If an action is going to be taken against an employee that is subject to appeal, if it is a suspension, a demotion, a removal, most actions—now, there are differences if we are talking about Title 38 doctors and nurses, who have their own disciplinary process.

But if we are talking about a government employee under Title 5, if the allegation is that that person did something wrong and should be disciplined and the appeal goes to MSPB, in most cases, the preponderance-of-the-evidence standard would apply.

Ms RICE. And in terms of any disciplinary action that is meant to be taken against a retaliator or a whistleblower, they both have built-in protections in the law, whether it is by their union representation or whomever—no? There is none?

Dr. Hooker. Not for pure Title 38. That is a little glitch in the system——

Ms RICE. Well, that is something——

Dr. HOOKER [continuing]. Pertaining to section 7422 of Title 38.

The Secretary of Veterans Affairs controls our clinical practice, our clinical competence. So what the Secretary says goes. And that is typically delegated to a chief of staff locally, who can be very, very, very retaliatory to physicians who do not play according to the party line or who are not team players.

Ms RICE. That is interesting.

Mr. Chairman, obviously, maybe that is something that we should, as a committee, look into trying to fix.

So, in my prior life as a prosecutor, there was a saying that is true not just in the world of criminal justice but, unfortunately, I see it here in the world of VA and specifically whistleblowers. And that term is, "Snitches get stitches." And while Dr. Head, Dr. Hooker, and Mr. Tremaine don't have the actual physical stitches, they surely are bearing the figurative ones.

Thank you, Mr. Chairman.

Mr. COFFMAN. Thank you, Miss Rice.

Dr. Huelskamp, you are recognized for 5 minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

I am still trying to figure out parts of the testimony. But I am looking at a document from November 2014, "Rebuilding Trust," from the VA Secretary.

At that time, he did note that there were over 100 investigations currently being undertaken. Do you have a rough figure of what those numbers are today?

Ms. FLANZ. I believe he was speaking to the IG's ongoing investigations into alleged misuse of scheduling and wait-list systems. The IG was, at its most active point, active at 98 sites. They have completed their work at several of them.

Let me just make sure I have the right data here.

They have completed their work at 43 of those sites. They have substantiated some scheduling impropriety at 14 of the 43. They found no particular impropriety at 29. And their investigations are ongoing at the balance.

Dr. HUELSKAMP. So that is, of the 100 from November, still haven't gotten to the second half of those? Are my numbers correct?

Ms. FLANZ. The IG has not yet delivered to the Department its report in the others. Yes.

Dr. HUELSKAMP. Okay. So 5 months later from this report to the public by the Secretary, and half these—I mean, these serious investigations have yet to be completed or be started or we don't know the status of those?

Ms. FLANZ. You would really have to ask the IG.

Dr. HUELSKAMP. Okay. Well, this is coming from the Secretary of the VA, and I appreciate you are representing the Department.

Ms. FLANZ. Yes.

Dr. HUELSKAMP. Can you ask them for me? This is from the Secretary. This says, "working diligently to cooperate with investigations by the inspector general, the Justice Department, and Office of Special Counsel." So this is all those together.

And so, do you know roughly a comparable figure today? More or less? But if I understand correctly, though, half of these have yet to be completed or even start the investigation.

Ms. FLANZ. I believe the IG has started them all and probably even finished quite a few but not yet delivered their reports.

Dr. HUELSKAMP. Okay. And this would be, presumably, where 3 individuals have been fired, out of 100 investigations? Is that what we are looking at here?

Ms. FLANZ. The question that you posed before about individuals, to which I gave you the answer three, had to do with whistleblower retaliation. The IG is looking at something different, and so that would be a different number.

Dr. HUELSKAMP. Okay. What is that number, then?

Ms. FLANZ. I am here today to talk about whistleblower retaliation. And I apologize, I don't have the number of actions taken as a result of the IG's findings.

Dr. HUELSKAMP. Okay.

Well, one thing I will ask about your testimony—and you were before this subcommittee last month. I am just curious, when you put together this testimony, who do you visit with above you to clear this testimony? I mean, do you visit with the Secretary himself and the Deputy Secretary and they clear this testimony before the committee?

Ms. FLANZ. There is a process that includes our leadership, yes.

Dr. HUELSKAMP. And so they approve everything in your testimony?

Ms. FLANZ. The front office approves all testimony, yes.

Dr. HUELSKAMP. So nobody in the front office knew that Mr. Head did not have an opportunity to visit with the Secretary, even though, reading this, I would suggest you assumed that he—you are suggesting everyone was talked to. So somebody looked at this and let you say that a visit might have been made? Am I understanding that correctly?

Ms. FLANZ. My testimony is that the Secretary makes a point of meeting with whistleblowers as he travels throughout the system. My testimony didn't specifically speak to any meeting with Dr. Head.

Dr. HUELSKAMP. What about the other two individuals testifying?

Dr. Hooker.

Dr. HOOKER. When the Secretary of Veterans Affairs came to our facility, he did not meet with any whistleblowers per se.

We asked for a private meeting with him, because we had sent a letter in November about a number of people under investigation that we felt were inappropriate, administrative investigation boards that appeared to be sham investigation boards. He had a strict schedule. We were allowed to go with another union for 15 minutes together jointly. I was unable to go because I had patient care duties, so my colleagues in the union went.

Dr. HUELSKAMP. Mr. Tremaine.

Mr. TREMAINE. The Secretary didn't visit our facilities. The Deputy Secretary did, but he did not meet with any of us.

Dr. HUELSKAMP. Okay.

I am just about out of time. If I might ask of Ms. Flanz, of the 15 corrective actions that were identified from the Office of Special Counsel, I would like to know how many of those actually had visits with senior VA officials.

Ms. FLANZ. I don't know.

Dr. HUELSKAMP. Would you please find out and report to the committee?

Ms. FLANZ. Yes, sir.

Dr. HUELSKAMP. I yield back, Mr. Chairman.

Mr. COFFMAN. Thank you, Dr. Huelskamp.

Mr. Walz, you are now recognized for 5 minutes.

Mr. WALZ. Thank you, Mr. Chairman.

Again, and I am going to follow along a little bit, I am going to venture out on a limb. I will bet you get a call from the Secretary now. Ms. Flanz might back me on that, I would bet.

But it goes to something bigger for me. I would argue and go back to this issue with Secretary Shinseki and others, I think many times they are let down by those around them. And it takes us back to that core issue of delegation of authority. In an organization this big, that has to happen. And so I want to get to this training, how we are going to change it, how we are going to make it better.

And I want to talk about OSC 2302(c). I would bet everybody in this room, at one time or another, has gone through some form of professional training, whether it was on a Friday afternoon or

there was a retreat or something like that. And I bet in our professional careers you can count and tell the ones that were highly effective and those that were forgettable. This is an important issue.

I am going to go to this. Have any of the three of you, Dr. Head, Dr. Hooker, and Mr. Tremaine, have any of you received OSC 2302(c) whistleblower certification training?

Dr. HOOKER. No, I have not.

Mr. TREMAINE. I have not.

Dr. HEAD. No.

Mr. WALZ. Don't you wish those three would have got it?

Ms. LERNER. Can I speak to that?

Mr. WALZ. Sure.

Ms. LERNER. I think what—what the 2302(c) certification training is is—it is not a specific training. There are five steps that agencies have to take to become certified. And one of them is—I mean, a lot of it is a training component, but it means putting posters at facilities, providing information to new employees about retaliation and their rights, providing information to current employees——

Mr. WALZ. Is there confusion on that?

Ms. LERNER. I am sorry?

Mr. WALZ. Is there confusion on that in the VA, that if someone tells you about a practice, isn't it widely known that you don't move them from their office without due process or anything? And, again, yes, facetiously, but I am fit to be tied here.

Ms. LERNER. I mean, I think the problem——

Mr. WALZ. Do you believe this is going to work?

Ms. LERNER. You know, I think the problem is that it has to filter down to the regions. I think that the message is good coming out of headquarters, but the folks who are actually implementing it need more training.

Mr. WALZ. Dr. Head, is this going to work?

Dr. HEAD. I think the current practices need a big change.

Mr. WALZ. So it is a step in the right direction.

I would venture to say this. I always think about this as training focuses on technique and content, development focuses on people. I would argue VA's issue is people, focusing on that, in these positions.

I would argue—and this is what always pains me, is the vast majority—and these hearing are very difficult for me, because there is a whole bunch of dedicated VA employees out there that are giving and sacrificing and doing great service, and their morale is hurting when they hear us do this. The problem is it tends to be some of those folks in that management chain that do that.

So my question to the three of you is, what would be the most effective thing we can do? And I don't want to belittle the training part of it. I should go on the record and be clear about that. I think you need to know that, and I think it is good to do a refresher course on what is appropriate, what is legal, what is there, and all that. So I am doing that. I just—it seemed to be a central focus of what we are going to do to change this.

I would ask the three of you, what should we be doing more of?

Mr. TREMAINE. Well, I think one of the—your definition, when you used the Webster's definition of a "whistleblower," I think that

in itself is really derogatory. You know, I don't think that—that in itself just, I think, kills a lot of people. When they think whistleblower, they think negativity. I think that, again, you have to embrace that. You have to embrace the whistleblower and acknowledge that and acknowledge that there are problems, and you have to resolve those problems.

And so I think that, you know, again, just that acknowledgment and that openness, the transparency, is critically important. And we just don't have that. We have the retaliation. That seems to be the first step anytime a whistleblower comes forward.

Mr. WALZ. Why the fear? Why not wanting to be better? Why not wanting to hear that? You can take everything with a grain of salt. Like, each one of us in our personal lives, when you get positive feedback, especially those you trust, those around you and other people. Why that resistance to hearing the truth?

Mr. TREMAINE. You know, I don't know. I think you hit the nail on the head when you said there are many VA employees. I mean, the majority of the VA employees, you know, 99.9 percent of the VA employees——

Mr. WALZ. Yes.

Mr. TREMAINE [continuing]. Are going to work every single day and love taking care of veterans and doing the right thing. And you just have that small minority that, you know, feel that they can utilize taxpayer money to do whatever they want and retaliate and call——

Mr. WALZ. Do you think Miss Rice is right, that there just needs to be some teeth in this thing, that folks need to know it is not going to be tolerated? Is there a patience to this?

And, again, I don't want to step on anybody's due process rights, but you hear the frustration across the spectrum up here that nobody is ever held accountable. And it is not a juvenile desire to see punishment for the sake of punishment. It is about making sure good people are served.

Dr. HOOKER. For professionals, we don't have due process rights in the traditional sense. So 7422 prevents us from having that due process right.

In the community, I would be held to the standards of my peers. In the VA, the Secretary tells me what I do and how I do it. So I can't argue, in a sense, the way I could with colleagues. I don't have the collegial oversight. I have clerks, in a sense, telling me how to practice medicine.

And then if I call the Office of Special Counsel and I report, because I did——

Mr. WALZ. That is a big problem.

Dr. HOOKER. Well, I did come across evidence that another veteran employee reported 2 years before I discovered it through a proposed termination of another employee who had brought up some issues. So she was put in another windowless office in the basement. She had two master's degrees and a counseling degree.

But where I am going with this is that when I reported to the IG—I'm sorry, the employees went to the Office of Special Counsel, I went to the inspector general. The report basically goes back to the VA. And, actually, I did call the OSC on all the nine people I currently have sitting home getting paid at high professional salary

levels for not doing their job, when they haven't really—they don't even know why they are home.

I have an ophthalmologist who is home. She was just removed one day, just threatened with—you know, so when we do report to those outside agencies, they turn it over to the VA for investigation. I am not a farmer, but I would have trouble asking the fox how many hens are left in the coop when the feathers are sticking out of the fox's mouth.

Mr. WALZ. Well, most of it boggles my mind, but the thing that keeps coming back to me is that this is how deep this is. What is the deal with this office thing and moving people to the basement? And it just boggles my mind. That isn't intimidation; that is your definition of violence in the workplace, in my opinion.

Dr. HOOKER. It is unacceptable.

Mr. WALZ. Okay.

I went over my time——

Dr. HEAD. One——

Mr. WALZ [continuing]. And I don't know if the chairman wants to follow up.

Dr. HEAD. One quick final point.

There has to be accountability. You know, moving me to, you know, a storage bin, you know, makes me feel bad. But they are trying to send a message not only to me, they are trying to send a message to everyone there saying, look at Dr. Head, he thinks he is great. He went and testified in front of Congress. They said they are going to protect him. But you know something? On my VA, no. They listen to me. And Congress can't do a thing about it.

And they are trying to intimidate all the other potential—I like to label whistleblowers as patriots. We should name them in the VA system, these patriots. They are trying to suppress their willingness to try to make a better life for these veterans, and it is just—it is shameful.

Mr. COFFMAN. Thank you, Dr. Head.

Let me just say also that the retaliation simply isn't limited to employees of the VA but also patients of the VA who step forward.

And in Colorado, we had a case last year where a patient gave a statement to an investigative reporter, and the reporter then called the VA and talked to the public affairs individual for that particular VISN. And the public affairs individual said, "Oh, you really don't want to talk to this person. He is a patient undergoing psychiatric care."

I sent a letter to the Secretary of the Veterans Affairs. I have never gotten a response to this date.

Our thanks to the witnesses. You are now excused.

Today, we have had a chance to hear about problems that exist within the Department of Veterans Affairs with regard to whistleblower retaliation. From the testimony provided and questions asked today, I am dismayed at the failure of the Department to adequately protect conscientious employees who seek to improve services provided to our veterans.

As such, this hearing was necessary to accomplish a number of items: to, number one, allow VA to highlight what efforts it has made to improve whistleblower protection, practices, and processes; two, address where improvements either have not been made or

where insufficient attempts give way to continued retaliation experienced by whistleblowers; and, three, assess next steps to be taken both by VA and by this committee to ensure that those employees who seek to correct problems within the Department are adequately protected.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

Mr. COFFMAN. I would like to once again thank all of our witnesses and audience members for joining us at today's hearing.

With that, this hearing is adjourned.

[Whereupon, at 5:56 p.m., the subcommittee was adjourned.]

PREPARED STATEMENT OF CHAIRMAN MIKE COFFMAN

Good afternoon. This hearing will come to order.

I want to welcome everyone to today's hearing titled, "Addressing Continued Whistleblower Retaliation Within VA." I would like to ask unanimous consent that the Hon. Martha Roby from the state of Alabama be allowed to join us on the dais, as she has been very active in the case of one of our witnesses here today. Additionally, I would like to ask unanimous consent that two statements be entered into the hearing record: one from a whistleblower and one from the Project on Government Oversight. Hearing no objection, so ordered.

This hearing will focus on the treatment of whistleblowers within the Department of Veterans Affairs, particularly the types and levels of retaliation they experience when reporting problems. This will serve as a follow-up to the hearing conducted by the Committee in July 2014, where we will address what progress the department has made since then to correct its retaliatory culture and where VA has failed to protect conscientious employees who seek to improve services for our nation's veterans.

The three whistleblowers we will hear from today come from VA facilities across the country. The hostility they receive for their conscientious behavior shows that the retaliatory culture, where whistleblowers are castigated for bringing problems to light, is still very much alive and well in the Department of Veterans Affairs. The truth of the matter is, the Congress needs whistleblowers within federal agencies to help identify problems on the ground in order to remain properly informed for the development of effective legislation.

For example, the national wait times scandal that this Committee revealed at a hearing just over one year ago, which resulted in the Secretary of the department resigning, simply would not have occurred without responsible VA employees stepping forward to fix problems. In the year since that scandal originally came to light, a new Secretary has come to the department, and he has stated that one of his primary missions is to end whistleblower retaliation within VA.

The Congress also passed legislation that makes it easier for the Secretary to fire poor performing and bad acting Senior Executive Service employees who in some cases perpetrate and encourage retaliatory behavior. Despite these efforts, retaliation is still a popular means used by certain unethical VA employees to prevent positive change and maintain the status quo within the department. In January, full committee Chairman Jeff Miller introduced legislation that would improve protections provided to whistleblowers within VA.

It will also discourage supervisors and other managerial employees from attempting to retaliate against whistleblowers by imposing more strenuous penalties for engaging in retaliation, including suspension, termination, and loss of bonuses. It is very simple, if you retaliate against or stifle employees who are trying to improve VA for our nation's veterans, you should not be working for VA, and you certainly should not receive a bonus for your despicable actions.

To that end, I encourage Members to join with numerous VSOs and whistleblower protection groups in support of H.R. 571, the Veterans Affairs Retaliation Prevention Act. Along with the whistleblowers here today, we will hear from the Office of Special Counsel regarding the efforts VA has made since our last hearing to improve its treatment of whistleblowers and where improvements remain absent and needed. A representative of VA will also be here to address why whistleblowers continue to

have their livelihoods jeopardized for attempting to make VA a better service provider for our nation's veterans. I look forward to the discussion we will have here today on this important issue.

With that, I now yield to Ranking Member Kuster for any opening remarks she may have.

PREPARED STATEMENT OF RANKING MEMBER ANN MCLANE KUSTER

Thank you Mr. Chairman.

This afternoon, the Subcommittee on Oversight and Investigations is holding a follow-up hearing to a hearing this Committee held last July. I believe that some of the most effective hearings this Subcommittee holds are follow-up hearings—they enable us to examine progress made and current problems that still exist at the VA. That is the core of our work here—to identify problems and work together to fix them and ensure the highest quality of care is being delivered to our veterans.

Today's hearing will focus on VA's treatment of whistleblowers, who play a crucial role in ensuring the VA is held accountable for providing quality care for our nation's veterans. Whistleblowers were instrumental in helping this Committee uncover wrongdoing at the Phoenix VA, which helped inform our drafting of the Veterans Choice Act. We must ensure that no one is afraid to come forward to report instances of mismanagement or wrongdoing that hinders our veterans' ability to receive care.

In terms of the Department of Veterans Affairs and its treatment of whistleblowers, a great deal of progress has been made. VA has established the Office of Accountability Review and has reorganized the Office of the Medical Inspector. The VA is also the first cabinet-level agency to satisfy the requirements for the Office of Special Counsel's whistleblower certification program. In addition, VA and the OSC have implemented and expedited the review process for whistleblower retaliation claims.

I am pleased to hear how the VA has taken these steps moving forward, however there are still many problems that still exist regarding how the VA treats and handles whistleblowers. OSC is responsible for whistleblower complaints from across the Federal government, yet it estimates that 40 percent, close to half of its incoming cases in 2015, will be filed by VA employees. OSC reports that the number of new whistleblower cases from VA employees "remains overwhelming" and that its monthly intake of new VA whistleblower cases remains high at a rate of nearly 150 percent over historical levels. According to OSC, these alarming cases include disclosures of "waste, fraud, abuse, and threats to the health and safety of our veterans."

The large number of complaints received from VA employees is, to some extent, a reflection of the size of the VA, but it also raises serious red flags as to the continuing problems that are systemic throughout the VA system and the treatment of VA employees.

The OSC testimony highlights some troubling concerns that the VA sometimes investigates the whistleblowers themselves, rather than investigating allegations raised by those whistleblowers. The OSC also references several cases where the medical records of whistleblowers were improperly and unlawfully accessed in what seems to be attempts to discredit some whistleblowers.

As a New York Times article last year outlined, there is a "culture of silence and intimidation" and a history of retaliation at the VA. According to the whistleblowers testifying before us this afternoon, this is still the case today. They will testify about this environment of intimidation and retaliation, and the use of sham peer reviews and investigations in order to silence whistleblowers.

As I stated before, I believe that VA has made some progress in this area, but clearly, more remains to be done. VA's culture of retaliation and intimidation did not happen overnight, but is a culmination of decades of problems that are deeply ingrained into the VA system. We must also not forget that the vast majority of VA employees are involved in healthcare, an industry that also has been seen by many to be intolerant of whistleblowers.

This culture of intimidation and fear for VA employees cannot be changed overnight. But for the sake of our veterans, and for the sake that ensuring the VA is providing the highest quality of care, this culture MUST be changed. Many of VA's problems that we will discuss today highlight VA's lack of accountability and the absence of a collaborative spirit between VA leadership and VA employees in order to seriously address whistleblowers complaints.

This afternoon let us begin the process of identifying what steps the VA needs to take going forward as the VA works toward the Secretary's goal of "sustainable accountability."

I am hopeful that this Subcommittee can continue to work in a bipartisan fashion to find ways to assist the VA in its monumental task of changing this long-standing culture and reform the manner in which whistleblowers are treated, and improve the process where all VA employees are working toward the common goal of helping and serving our veterans.

Mr. Chairman, again, I thank you for holding this follow-up hearing. Before I yield back I want to take a moment and thank our whistleblowers for appearing before us today—it takes real courage to put your careers at risk for coming forward and calling attention to problems and concerns. It is my hope that as we move forward we can create a culture at VA that welcomes whistleblowers and acknowledges their importance in better serving our veterans. I hope that in the months and years ahead VA will be known as an organization that welcomes and encourages all employees to work to solve problems.

I yield back the balance of my time.

PREPARED STATEMENT OF MEGHAN FLANZ

Good afternoon, Chairman Coffman, Ranking Member Kuster, and Members of the Committee. Thank you for inviting me here today to present an update on the Department's activities related to whistleblower protection.

VA exists to serve Veterans. That service takes place through interactions between Veterans and front-line VA employees—physicians, nurses, and other clinicians in VA hospitals, claims processing staff in regional benefits offices, cemetery workers and countless others—upon whom VA depends to serve Veterans with the dignity, compassion, and dedication they deserve. We depend on those same employees to have the moral courage to help us serve Veterans and taxpayers better by helping to make our processes and policies better, safer, and more effective and efficient. Within this context, the Department's responsibility to protect whistleblowers is an integral part of our obligation to provide safe, high-quality healthcare, and other benefits to Veterans in legally-compliant and fiscally-responsible ways. Protecting whistleblowers from retaliation is a key component of carrying out VA's core mission in accordance with its institutional values (I CARE—integrity, commitment, advocacy, respect, excellence). Veterans expect VA leadership to cultivate an environment that empowers our employees and demands accountability in service to our Veterans. We are making progress, and under Secretary McDonald's leadership, we will reach our goal of ensuring that every employee feels safe in raising concerns, and is protected from any retaliation when they choose to do so.

It is important to keep in mind that the underlying purpose of the whistleblower protection rules is to encourage the candid disclosure of information about problems with governmental programs and processes, so that deficiencies can be corrected and unsafe or unlawful behavior can be quickly corrected. Of necessity, there are teeth built into the law in terms of penalties for supervisors who retaliate against whistleblowers, but the penalties exist to support the primary focus on information flow and quality, safety, or process improvement.

VA is fully committed to correcting deficiencies in its processes and programs, and to ensuring fair treatment for whistleblowers who bring those deficiencies to light. Secretary McDonald talks frequently about his vision of "sustainable accountability," which he describes as a workplace culture in which VA leaders provide the guidance and resources employees need to successfully serve Veterans, and employees freely and safely inform leaders when challenges hinder their ability to succeed. We need a work environment in which all participants—from front-line staff through lower-level supervisors to senior managers and top VA officials—feel safe sharing what they know, whether good news or bad, for the benefit of Veterans and as good stewards of the taxpayers' money.

To reach these goals, the Department has taken several important steps to improve the way we address operational deficiencies, and to ensure that those who disclose such deficiencies are protected from retaliation:

- Reorganization and new leadership in the Office of the Medical Inspector (OMI), the component of the Veterans Health Administration that reviews whistleblower disclosures related to VA healthcare operations;
- Establishment of the Office of Accountability Review (OAR) to ensure leadership accountability;

•Completion of all requirements for certification under the Office of Special Counsel's (OSC) 2302(c) certification program;
•Improved collaboration with OSC, including negotiating an unprecedented expedited process to speed corrective action for employees who have been subjected to retaliation;
•Formal VA leadership communication to all employees regarding the importance of whistleblower protection, emphasizing that managers and supervisors bear a special responsibility for enforcing whistleblower protection laws; and
•Required annual training by all senior executives (Course title: "Whistleblower Rights and Protection and Prohibited Personnel Practices").

Last summer, the Secretary reorganized and assigned new leadership to the VA Office of the Medical Inspector (OMI). He also established the Office of Accountability Review, or OAR, to ensure leadership accountability for whistleblower retaliation and other serious misconduct. In addition to its ongoing work investigating allegations of retaliation and other misconduct by senior leaders, OAR is also working to improve the Department's ability to track whistleblower disclosures - and actions taken in response to those disclosures - across the entire VA system, whether the disclosure is referred to VA by OSC, comes in through the VA Office of Inspector General (OIG) Hotline, is brought to the Department's attention by this Committee or an individual Member of Congress, or is communicated by a VA employee directly to his or her supervisor .

VA has also improved its collaboration with OSC, especially with respect to whistleblower retaliation training and remedies. Last summer, VA requested and received certification under OSC's 2302(c) certification program. That certification reflects the Department's compliance with five requirements related to training employees and supervisors about whistleblower protection rules, and providing information about whistleblower rights and processes to current employees as well as new hires. Last summer, VA also negotiated with OSC, an expedited process to speed corrective action for employees who have been subjected to retaliation. That process, which is unprecedented and unparalleled in Federal government, allows OSC and VA to work as partners to protect whistleblowers from retaliation. More recently, we have asked OSC to help us expand that collaborative process to facilitate more efficient accountability actions for supervisors who engage in retaliatory conduct. We are also working with OSC's Training and Outreach staff to create a robust new face-to-face training program for VA supervisors, to ensure they understand their roles and responsibilities with respect to responding to whistleblower disclosures, and protecting employees who make those disclosures.

Since Secretary McDonald was confirmed last July, he and other VA leaders have made it their practice to meet with whistleblowers when they travel to VA facilities, and to engage with those who have raised their hands and their voices to identify problems and propose solutions. They do that both to acknowledge the critical role whistleblowers play in improving the quality, safety, and effectiveness of VA programs, and to model to supervisors throughout VA the engaged, open, accepting behavior they expect them to exhibit when subordinates step forward to express concerns. Secretary McDonald, Deputy Secretary Gibson, and other VA leaders have also initiated countless meetings, phone calls, and other communications with Members of this Committee, with committee staff, and with other Congressional committees and members to talk about particular whistleblowers for whom Members have expressed concern. The Department deeply appreciates the assistance of this Committee and others in identifying potential retaliation so we can stop it, and in ensuring that the problems whistleblowers disclose receive prompt, and fulsome attention.

Last month I had the opportunity to appear before this Subcommittee to provide the Department's views on several pending bills, including two related to whistleblowers. At that time I acknowledged, and I reiterate today, that the Department has had and continues to have problems ensuring that whistleblower disclosures receive prompt and effective attention, and that whistleblowers themselves are protected from retaliation. And I acknowledge today that, notwithstanding significant and ongoing efforts on our part, VA is still working toward the full culture change we must achieve to ensure all employees feel safe disclosing problems, or that all supervisors who engage in retaliatory behavior are held promptly and meaningfully accountable. At the subcommittee hearing last month, I articulated the Department's concerns that the proposed legislative approaches to improving VA's responses to whistleblower disclosures might have unintended consequences. At the same time, I committed, on behalf of the Department, to continue to work with OSC and with this Committee to get things right, and I reaffirm that commitment to you today. I am honored that Secretary McDonald and Deputy Secretary Gibson have asked me to assist them in this critical effort.

Mr. Chairman, this concludes my testimony. I look forward to answering the Committee's questions.

PREPARED STATEMENT OF CAROLYN LERNER

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

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

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

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

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

The current VA leadership has shown a high level of engagement with OSC and a genuine commitment to protecting whistleblowers. As many VA officials and Members of this Committee have repeatedly stated, culture change in an organization the size of the VA is difficult and will take time. But, if the current number of whistleblower cases is an indication of employees' willingness to speak out, then things are moving in the right direction.

I. Whistleblower Retaliation—Collaboration With the VA to Provide Expedited Relief to VA Employees

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

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

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

settlement included assignment to a new position that allows her to oversee the quality of patient care.

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

• Damian Reese, Phoenix VAMC—Mr. Reese is a Phoenix VAMC program analyst. He voiced concerns to Phoenix VAMC management about the amount of time veterans had to wait for primary-care provider appointments and management's efforts to characterize long wait times as a "success" by manipulating the patient records. After making this disclosure, Mr. Reese had his annual performance rating downgraded by a senior official with knowledge of his email. Mr. Reese agreed to settle his claims with the VA for mutually agreed upon relief.

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

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

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

• Charles Johnson, Columbia VAMC—Mr. Johnson, a technologist in the radiology department at the VA Medical Center in Columbia, South Carolina, disclosed that a doctor ordered him to hydrate a patient using a new, unfamiliar method in February 2014. Due to his concerns about the new hydration method, Mr. Johnson consulted with two physicians about the method, neither of whom would verify the method's safety. Mr. Johnson then contacted his union, which suggested he send an email seeking clarification of the method under the VA's "Stop The Line For Patient Safety" policy. In July 2014, Mr. Johnson was issued a proposed five-day suspension by the same doctor whose hydration method Mr. Johnson had questioned. In October 2014, at OSC's request, the VA agreed to stay Mr. Johnson's suspension. In February 2015, Mr. Johnson and the VA settled his case, under which the VA will, among other things, rescind the proposed suspension and evaluate the hydration method.

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

• Debora Casados, Denver, CO—Ms. Casados is a nurse in the VA Eastern Colorado healthcare 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 operation. Overall, we believe this review has resulted in positive change. A recent whistleblower case is demonstrative.

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

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

VA policy, and which could constitute a substantial and specific danger to public health and the safety of veterans.

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

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

III. Training Initiatives and Areas of Ongoing Concern

A. OSC's 2302(c) Certification Program

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

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

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

B. Investigation of Whistleblowers

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

There are two main problems with this approach. First, by focusing on the individual whistleblower, the systemic problem that has been raised may not receive the attention that it deserves. And second, instead of creating a welcoming environment for whistleblowers to come forward, it instills fear in potential whistleblowers that by reporting problems, their own actions will come under intense scrutiny.

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

C. Accessing Whistleblowers' Medical Records

A final, related issue of ongoing concern is the unlawful accessing of employee medical records in order to discredit whistleblowers. In many instances, VA employees are themselves veterans and receive care at VA hospitals. In several cases, the medical records of whistleblowers have been accessed and information in those

records has apparently been used to attempt to discredit the whistleblowers. We will aggressively pursue relief for whistleblowers in these and other cases where the facts and circumstances support corrective action, and we will also work with the VA to incorporate these additional forms of retaliation into our collaborative training programs.

IV. Conclusion

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

SPECIAL COUNSEL CAROLYN N. LERNER

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

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

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

PREPARED STATEMENT OF DR. CHRISTIAN HEAD

Introduction

Chairman, Hon. Mike Coffman

Ranking Member, Hon. Ann Kuster

Dr. Christian Head[1] comes before Congress to testify, not motivated by any political agenda, but based purely on a genuine interest in seeking solutions to address employee mistreatment, but most importantly, to improve the healthcare provided to our Country's heroes. Dr. Head submits this testimony in response to Congress's request to appear and testify on this issue.

Dr. Head is uniquely qualified to testify regarding issues within the VA system. Dr. Head is a world-renown, board certified Head and Neck Surgeon. Between 2002 through 2013, Dr. Head held dual appointments at the UCLA David Geffen School of Medicine becoming a tenured Associate Professor in Residence of Head and Neck Surgery, as well as an attending surgeon at the West Los Angeles Campus of the VA Greater Los Angeles Healthcare System ("GLAHS"). In 2007, Dr. Head was promoted to Associate Director, Chief of Staff, Legal and Quality Assurance within GLAHS.

Dr. Head's clinical and academic successes over the years have been numerous. However, despite Dr. Head's many accomplishments and contributions to the medical profession, Dr. Head has endured and witnessed, firsthand, illegal and inappropriate discrimination and retaliation of physicians, nurses, and staff members within GLAHS. Throughout this testimony, Dr. Head will speak on the growing number of complaints coming from VA employees, complaints ranging from discrimination and retaliation to complaints regarding substandard patient care and treatment.

Background

Dr. Christian Head is a prominent Head and Neck Surgeon who cares deeply about the veteran patients under his care. Dr. Head has been described as "one of our finest surgeons in Southern California. . . . [Who is] generous with his time and talent, helping Veterans and giving back to our community both locally and nationally. . . . [W]ho will make a difference in our world with his skills as a surgeon, his scientific research and laboratory." As his colleague Dr. James Andrews has said, Dr. Head "has tirelessly worked to improve the quality assurance of this insti-

[1] To avoid confusion, I will refer to myself in the third person throughout this testimony.

tution," "his tireless work ethic and cheerful attitude is highly admirable," "[h]e should be a role model for every physician employed by the VA," and "[t]he VA is very fortunate to have Dr. Christina Head as part of their team." (See Exhibit A.) Unfortunately, Dr. Head has been the victim of outrageous racial harassment, discrimination, and retaliation occurring within GLAHS.

Dr. Head obtained his Doctor of Medicine degree from Ohio State University, College of Medicine in 1993. Between 1992 and 1993, Dr. Head completed an Internship in Surgery at the University of Maryland at Baltimore. Between 1994 and 1996, Dr. Head commenced his employment with a Fellowship in Neuro-Otology Research at UCLA School of Medicine. Between 1996 and 1997, Dr. Head completed a Surgical Internship at UCLA School of Medicine. Between 1997 and 2002, Dr. Head worked as a Resident in the UCLA School of Medicine Head and Neck Surgery Department. In 2002, Dr. Head joined the faculty as a Visiting Professor in Head and Neck Surgery at UCLA. In 2002, Dr. Head also joined GLAHS. During his time with GLAHS, Dr. Head worked as a Head and Neck Surgeon, and in 2007, was promoted to Associate Director, Chief of Staff, Legal and Quality Assurance within GLAHA. In August 2003, Dr. Head joined the faculty of the UCLA Geffen School of Medicine as a full time Head and Neck Surgeon. Dr. Head left UCLA in 2013. Dr. Head has been board certified in Head and Neck Surgery since June 2003.

Over the years, Dr. Head's work has included clinical practice, surgery, academia, and research. Dr. Head has received accolades for his work, including the National Institute for Health–National Cancer Institute Faculty Development Award. In or around 2001 to 2002, Dr. Head was nominated for the UCLA Medical Center Physician of the Year award. In or around November 2003, Dr. Head launched the UCLA Jonsson Cancer Center Tumor Lab, which has been tremendously successful, yielding valuable research and benefitting many physicians and patients at UCLA and worldwide. In 2003, Dr. Head was one of a few surgeons nationwide to receive the Faculty Development Award from the National Institute of Health Comprehensive Minority Biomedical Branch, intended to increase the number of minority physicians in cancer research at major academic institutions.

Dr. Head's supervisors have included Marilene Wang, M.D. ("Dr. Wang"), UCLA/GLAHS Head and Neck Surgeon and Dr. Head's previous clinical supervisor at GLAHS; Dean Norman, M.D. ("Dr. Norman"), GLAHS Chief of Staff; Matthias Stelzner, M.D. ("Dr. Stelzner"), GLAHS Chief of Surgical Services; Donna Beiter, RN, MSN ("Ms. Beiter"), GLAHS Director, and Norman Ge, M.D. ("Dr. Ge"). Dr. Head's immediate supervisor at UCLA was Gerald Berke, M.D. ("Dr. Berke"), Chairman of the UCLA Department of Head and Neck Surgery, who has tremendous power and influence at GLAHS.

Retaliation Against Dr. Head Since His July 8, 2014 Testimony Before Congress

On or about July 8, 2014, at the request of Congress, Dr. Head testified before the House Committee on Veterans' Affairs regarding "VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability."2

During Dr. Head's testimony before Congress, he outlined exactly the pattern for retaliation within the VA system: isolate, defame, and attack professional competence. As the following facts will show, since Dr. Head's testimony before Congress, his supervisors, Director Donna Beiter and Chief of Staff Dr. Dean Norman, have done exactly this—they immediately attempted to defame his credibility, then they tried to revoke his operating room ("OR") privileges in an attempt to attack his professional competence, and then they isolated Dr. Head within the workplace.

Since July 8, 2014, based on information and belief, Director Beiter and Dr. Norman are making untrue and disparaging comments to other VA staff members about Dr. Head. Dr. Norman has claimed that Dr. Head is lying about Dr. Marilene Wang's timecard fraud, despite Dr. Wang and Dr. Norman previously testifying under oath that Dr. Wang was found to have committed timecard fraud and that the OIG recommended that Dr. Wang be terminated from her leadership position.

In or around late—July 2014, Dr. Head's patients started being taken away and reassigned to Dr. Wang. Around this time, Dr. Norman also stated to Dr. Head that "Dr. Wang is not going anywhere," and "If you don't like it, you're a whistleblower, take it to Congress."

On or about August 15, 2014, Dr. Head was prevented from entering the main operating room by the OR Nurse Director. The OR Nurse Director made a loud statement, "Dr. Head you have no surgical privileges, you cannot enter the operating room." Dr. Head asked her to call hospital privileging. The OR Nurse Director asked for the "white book" and next to Dr. Head's name in bold print was, "NO OR PRIVILEGES" with expiration in 5/2016. This event was witnessed by numerous hospital staff, nurses, and surgeons. The OR Nurse Director called hospital privi-

leging who confirmed that Dr. Head had full surgical privileges. The event was meant to humiliate and retaliate against Dr. Head and to further defame his good name and professional reputation. There were others on the list in the "white book" with expired credentials, but no bold print "NO OR PRIVILEGES" next to their name. This event could have also jeopardized patient care as there was a patient in the operating room waiting for surgery.

In or around Mid-August 2014, Dr. Head was notified that he would no longer be reporting to Dr. Norman, but instead to Dr. Norman Ge. Dr. Head was troubled by this information considering that Dr. Ge is extremely good friends with Dr. Norman, and Dr. Head felt that this reassignment would do nothing to decrease the retaliation.

Further, on or about August 22, 2014, Dr. Head was informed that the VA, at the direction of Director Beiter and Dr. Norman, would be transferring Dr. Head's office out of the Chief of Staff area, located in the nicely furnished/decorated 6th floor, into a tiny, dirty, poorly furnished closet-sized office on the 4th floor so that Dr. Head "could be by himself and not have to interact with others." The locks on the doors and computer passwords were changed so that Dr. Head would no longer have access to his office or computer.

On or about September 5, 2014 and September 24, 2014, Dr. Head attended two depositions (interviews under penalty of perjury) conducted by federal investigator Clara Trapnell. During one of these depositions, Investigator Clara Trapnell informed Dr. Head that the reason he was transferred and reassigned a new office, essentially demoting Dr. Head, was "because of his lawsuit."

On or about January 20, 2015, the VA filed court documents in which they admitted that the reason they retaliated against Dr. Head—by removing his Chief of Staff duties and transferring him out of the luxurious Chief of Staff suite on the 6th floor into a tiny, dirty, poorly furnished closet-sized office on the 4th floor—was "because of [Dr. Head's] statements to Congress." (For an excerpt of this document, see Exhibit B.)

On or about March 12, 2015 at approximately 10:00 a.m., Dr. Head was contacted by Jessica O'Connell M.D. by phone inquiring why Dr. Head was not in clinic at the West Los Angeles VA Hospital. Dr. O'Connell was told by Mark Harris—who is supervised by Christine Gonzales (*christine.gonzales@med.va.gov*) (VA cell 310–429–7090)—that Dr. Head was not in clinic seeing his patients. However, at that exact moment, Dr. Head was in fact seeing his second patient, Heath Johnson. Dr. Head immediately reported this incident to Dr. O'Connell and Dr. Stelzner in the Department of Surgery. Further, Robert Lopez, Dr. Stelzner's administrative assistant, also inquired by phone why Dr. Head was not in clinic seeing patients and also stated that Mr. Harris reported Dr. Head for not being at his duty station. Dr. Head asked Mr. Lopez to come to his clinic to confirm Dr. Head's presence so as not to disrupt patient care further. Dr. Head's presence in his clinic was subsequently confirmed. Personnel within the VA stated that Mr. Harris informed them that he had previously worked with Dr. Head at the Sepulveda VA Clinic and alleged that Dr. Head has a long history of "not seeing patients and being late," defamatorily implying that Dr. Head provides poor patient care. Dr. Head's patient, Mr. Johnson, described Mr. Harris as rude and disruptive and stated that it appeared Mr. Harris was trying to cause problems where none existed. Mr. Johnson also overheard the VA scheduler inform Mr. Harris that Dr. Head was in the hospital and would be seeing patients momentarily.

On or about March 19, 2015, Dr. Head was contacted by front desk personnel at the West Los Angeles VA Clinic that Dr. Head had a patient waiting to be seen at 12:45 p.m. The patient had arrived late and the front desk personnel were all out to lunch. Dr. Head was in the clinic theater until 12:20 p.m., but had left the VA at approximately 12:45 p.m. for medical reasons. Dr. Head asked the staff if one of Dr. Head's colleagues could see the patient, but the patient decided to reschedule. Dr. Head was informed that the patient was not upset.

On or about March 26, 2015, Dr. Head was told that Mr. Harris asked several employees to write points of contact stating that Dr. Head was late to clinic on that day. Dr. Head had a full day of clinic and, unknown to Mr. Harris, Dr. Head had notified his supervisors, Dr. Norman Ge; Dr. Jessica O'Connell, director of Surgery; Ms. Debbie Blaisdell, administrative assistant in the Chief of Staff office; and the Sepulveda Head and Neck Clinic scheduler that Dr. Head would be out on sick leave. Dr. Head received confirmatory emails from those individuals.

Dr. Head has been approached by several VA employees, along with a veteran patient who witnessed these events. Mr. Harris's behavior has been retaliatory and defamatory, making false statements to employees and patients about Dr. Head's professional and clinical competence, thereby creating a hostile work environment that is both confusing and inhospitable to the clinical care environment and seri-

ously jeopardizes patient care, all at a time veterans should be reassured that the health professionals are capable of providing them with the best medical care.

On or about April 6, 2015, the VA informed Dr. Head that he had formally been demoted from his position as Chief of Staff, further compounding the retaliation against Dr. Head for his truthful testimony before Congress in July 2014.

Retaliation Against Other Whistleblowers

Because of Dr. Head's leadership position within GLAHS and his willingness to stand up against wrongdoers within the system, Dr. Head has become aware of many other VA employees who are enduring their own retaliation. The following are just a few select instances of retaliation being faced by other VA employees.

Incident 1:

Dr. Tom Howard is another renowned physician within the Veterans' Affairs Greater Los Angeles Healthcare System who has been subjected to discrimination, harassment, and retaliation by management. Dr. Howard has occupied the position of a Staff Pathologist at GLAHS for approximately the last eight years. Dr. Howard has an exemplary record with the VA and has even received a Notice of Grant Award from the National Heart, Lung and Blood Institute (NHLBI). In addition to being a staff pathologist at GLAHS, Dr. Howard is a Principal Investigator currently conducting the largest hemophilia study of its kind ever funded in the United States as a result of the prestigious NHLBI grant he received.

Beginning in September 2009, Dr. Howard was subjected to an extremely hostile work environment created by his clinical service chief, Dr. Farhad Moatamed, as a result of the NHLBI grant that he received. This hostile work environment led Dr. Howard to develop a stress-related illness which required him to take time off to recover. Dr. Howard requested advanced sick leave from his second line supervisor, Dr. Jessica Wang-Rodriguez. Despite being aware of Dr. Howard's disability and the circumstances that caused it, Dr. Wang-Rodriguez repeatedly denied his advanced sick leave requests, forcing him to take leave without pay. Believing that he had been discriminated against due to his disability, Dr. Howard contacted an Equal Employment Opportunity (EEO) counselor on or about January 9, 2014.

In or around May 2014, Dr. Howard was forced to return to work, due to financial reasons, despite not having fully recovered from his work-related illness. Upon his return, Dr. Wang-Rodriguez moved him from the coagulation lab, which was his specialty, to a new lab supervised by Ms. Eva Archuleta, who had participated in harassing him in the past. On or about May 23, 2014, Dr. Howard became aware of the mishandling of patient specimens when a week's worth of patient samples were lost. He made complaints regarding the failure to transport patient samples properly by the Transportation Division under the VA Engineering Department. Dr. Howard believed that this was a serious problem that needed to be addressed immediately, as it was compromising patient care and safety.

On or about June 9, 2014, shortly after Dr. Howard made this complaint, he was suspended. However, before he was to serve his suspension, Dr. Wang-Rodriguez postponed it until further notice. Then, on or about October 10, 2014, Dr. Wang-Rodriguez purposefully held a meeting in Dr. Moatamed's former office which Dr. Howard was required to attend. This meeting was held in the office where his former supervisor subjected him to harassment, such as yelling, screaming, threats, and demeaning comments. This exacerbated his ongoing work-related illness to the point where he needed to seek leave; however, Dr. Wang-Rodriguez again denied his requests for advanced sick leave. In late November 2014, Dr. Wang-Rodriguez was removed as Dr. Howard's supervisor. She is now under investigation due to her actions against Dr. Howard and other issues within her department.

In or around January 2015, Dr. Howard became aware that a large number of blood and patient samples that were drawn from veterans over the last several years and sent out to Quest Diagnostics for analytical testing were not entered into the medical records of the veterans from the greater Los Angeles area. As such, the VA's clinical providers who were depending on these tests to guide the medical management of the veterans were apparently never informed of the results of these tests. Dr. Howard performed a preliminary investigation in which he reviewed a 21-page list comprised of unreported patient laboratory test results which showed all of the "esoteric tests" (i.e., those tests that cost the VA greater than $300.00 per assay performed by the contract referral laboratory) which were performed by Quest, but the results of which were never reported to the GLA Laboratory Information System, nor were the results ever relayed to the veteran patients. From this review, it appears that this specific lapse in reporting of lab test results has been going on since approximately January 2012, with the number of patients potentially affected being as high as 168. After making his complaints regarding this serious breakdown of care to veteran patients, Dr. Howard experienced retaliation in the

form of his office being searched and a greater interest and criticism from upper management in his day-to-day work activities. Recently, in or around April 2015, Dr. Howard was removed from his position as Medical Director of the Clinical Laboratories at Sepulveda Ambulatory Care Clinic.

Incident 2:

In another instance, Nafiseh Moghadam, P.A., a nurse practitioner within the VA, was discriminated and retaliated against by Dr. Marilene Wang, based in part on her national origin and Muslim faith. After seeing this employee working with Dr. Head, Dr. Wang also told this employee not to work with Dr. Head or provide him any assistance with patient care. Because of Dr. Wang's discriminatory animus towards this employee, as well as continued retaliation against Dr. Head, Dr. Wang had the employee terminated the day before her probationary period ended. This illegal behavior by Dr. Wang was supported by Donna Beiter and Dr. Dean Norman. (See Exhibit C.)

Incident 3:

One employee, who has been a surgical technician at West Los Angeles VA Medical Center for the last seven years, has experienced discrimination based on his national origin (Filipino) in the form of derogatory comments and retaliation for making complaints about unprofessional behavior and time card fraud. After making complaints, the employee has been placed on suspensions for minor infractions for which other employees receive no discipline. Additionally, bonuses have not been awarded to him when other subpar employees have been awarded bonuses.

Incident 4:

Christy Rodriguez is a medical instrument technician in anesthesia at West Los Angeles VA Medical Center for the past ten years. During Ms. Rodriguez's employment with the VA, she was subjected to a hostile work environment based on her national origin (Hispanic), age, and sexual orientation. Ms. Rodriguez has been passed over for promotion and has not been afforded opportunities for career development, despite repeatedly asking her supervisors. Additionally, Ms. Rodriguez's schedule has also been altered, negatively impacting her ability to take care of her ailing mother.

Incident 5:

Muriel Alford was a Case Manager for the Office of Resolution Management, Western Operations who has worked for the federal government for practically her entire career. During her employment with the VA, Ms. Alford was discriminated against due to her race (African-American) and sex (female), and has been retaliated against for engaging in prior Equal Employment Opportunity (EEO) activity. She experienced a constant stream of hostility from her Team Leader and was denied appropriate training by her managers as part of a plan to force her out, as she was an older African American female who had filed two prior EEO complaints. This pressure ultimately forced her to resign from federal service after 35 years.

Incident 6:

Deanna Anderson has been a Supervisory Medical Records Administrator Specialist with the Veterans' Affairs Greater Los Angeles Healthcare System since May 2006. During Ms. Anderson's employment with the VA, she has been subjected to discrimination based on her race (African-American) and retaliation for making protected complaints. She has been passed over for promotion and pay raises. Additionally, she has had to compete for her own position that she has rightfully held for many years.

Conclusion

Dr. Head provides this testimony with the hopes of finding solutions to address employee mistreatment and improve the quality of healthcare provided to our Country's veterans. As a long-time employee within the VA healthcare system, Dr. Head is optimistic that appropriate changes can be implemented, and he looks forward to being an integral part of that change and the bright future that is ahead.

By: Christian Head, M.D., April 26, 2016

For additional information, you may contact Dr. Christian Head through his attorneys:

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To access Dr. Head's previous written testimony to Congress, please visit: *https://veterans.house.gov/witness-testimony/christian-head-md*. To access Dr. Head's previous oral testimony to Congress, please visit: *http://www.c-span.org/video/?320316–1/hearing-whistleblowers-va.*

PREPARED STATEMENT OF DR. MARYANN HOOKER

Thank you, Mr. Chairman, and Members of the Committee for allowing me to address continued whistleblower retaliation within VA. My involvement with whistleblower retaliation dates to November, 2011, when my colleague, Dr. Michelle Washington, testified before the Senate Veterans Affairs Committee on the lack of access to mental health treatment. Not only was Dr. Washington retaliated against before and after her testimony, but other professional colleagues closely associated with her and with our professional union, AFGE Local 342, were retaliated against, as well. Methods of retaliation included denial of administrative leave, unsatisfactory performance rating, exclusion from department communications, removal of professional duties, enhanced scrutiny of clinical record charting, investigation by the OIG, and being the subject of a formal Administrative Investigation Board (AIB).

Since then, others who have spoken out against management practices or managers who have spoken in favor of their subordinates have been retaliated against, removed from their regular duties, or have left VA under pressure or unwillingly. In September, 2014, AFGE Local 342 members announced a no-confidence vote over management's sudden downgrading of surgical services and further reduction in clinical offerings, such as inpatient bed availability. Subsequent retaliation against AFGE Local 342 members included non-consideration for internal position vacancies, an extraordinary increase in workload, a noticeable reduction in workload, inaccurate labor mapping, loss of electroencephalography services for Veterans at the facility, and a number of staffing adjustments.

The following professionals remain detailed away from their regular duties to date:

Associate Chief Nurse (almost one year), Nurse Manager (almost one year), Registered Nurse (seven months), Nurse Manager (six months), Nurse Manager (two months), Radiologist (five months), Otorhinolaryngologist (five months), Ophthalmologist (one month), Quality Manager (two months), Nurse Executive (six months), and Senior Project Engineer (almost three years).

None were involved in scheduling, though all are involved in access to care. Many of the individuals made disclosures to senior management and would be considered whistleblowers if the information had been reported outside VA. Several AIBs have been convened reportedly examining different areas of practice, such as surgery services, pathology services, long-term care, inpatient care services, and non-VA care services. Two individuals reportedly had no alleged misconduct confirmed after investigations were completed, yet the individuals remain on detail. Almost all were not told the scope of any investigation or any reason for an investigation. None were given any forewarning of any concerns regarding their performance.

The disruptions from these personnel moves continue to have a very negative effect on staff. A GAO report on "VA Administrative Investigations" (GAO–12–483) found it critical for AIBs to be convened and conducted appropriately, as well as for information to be shared about improvements implemented in response to the results of AIB investigations. Compliance appears lacking in the aforementioned instances. Since the personnel moves do not appear to have been made to correct behavior or to have been made for the efficiency of public service, they appear to be a waste of medical talent and a waste of VA funding. Plans to realign VA services by addressing or right-sizing legacy programs, transitioning from a hospital bed-based system of care to an ambulatory/primary care model, and shifting resources from low-volume programs to other programs already were announced in 2011. There should be no underlying fear of discussing and planning for staffing adjustments driving these personnel moves. With no overt valid cause for their occurrence, constitutional rights appear maligned.

Psychological safety in a work setting has been defined as the extent to which employees feel able to ask questions or bring up team issues without being afraid of hurting their reputation, status or career. In a psychologically safe environment, employees have a shared belief that it is safe to take interpersonal risks, such as asking for help, admitting a mistake, questioning a procedure, or pointing out a mistake, and view these actions as "worth the trouble." (Adapted from Edmondson, A.C. [1999] Psychological safety and learning behavior in work teams. Administrative Science Quarterly, 44,350–383)

Workplace violence as defined by VA is any physical assault, threatening behavior, or verbal abuse that occurs while working or on duty. Lateral violence includes bullying, scapegoating, smearing someone's reputation, refusal to help, exclusionary behavior, intimidation, or other incivility. (Veterans Health Administration Workforce Succession Strategic Plan 2011) Bullying includes these behaviors familiar to VA employees: establishing impossible deadlines that will set up the individual to fail, undermining or deliberately impeding a person's work, removing areas of re-

sponsibilities without cause, constantly changing work guidelines, withholding necessary information or purposefully giving the wrong information, assigning unreasonable duties or workload which are unfavorable to one person, under work or creating a feeling of uselessness, unwarranted or undeserved punishment, and excluding or isolating someone socially.

Data from the Stress and Aggression study (VISNs 23 and 11) indicate that the predominant trigger of aggressive behavior in staff is related to frustrating systems and processes, while the main triggers of aggressive behavior in patients are frustrating interactions with staff and the ensuing sense of powerlessness. Enabling people to relate to one another with confidence and trust, and to root out suspicion and mistrust, is a way to strengthen democratic spirit and a sense of community. When officials and employees forget they are rendering a public service and behave in a manner to suit their own convenience rather than that of the public they are supposed to serve, a social institution can lose its humanity. (Jaques, Elliott [1976] General Theory of Bureaucracy) When money and resources available to government are diverted from the benefit of citizens, the seeds of conflict are sown.

Corruption, as defined by the United States Institute of Peace, is the abuse of entrusted power for private gain. Corruption creates a system whereby money and connection determines who has access to public services and who receives favorable treatment. (Governance, Corruption, and Conflict) Corruption undermines the trust and shared values that make a society work. Howard Wolpe, scholar and former US Representative, called corruption a symptom of divided societies, where success (or survival) comes at the expense of others. "To the extent that you can begin to alter that paradigm—to generate interdependence, and to recognize that collaboration can strengthen one's own self-interest, you begin to impact the drivers of corruption."

The story of VA is a story of two different organizations; there is the VA that takes care of Veterans, and there is the VA that takes care of itself. If VA is pictured as a diamond, Veterans are at one tip of the diamond, while the VA Secretary is at the other tip of the diamond. Between the Secretary and the Veteran is what whistleblowers perceive to be ever-expanding layers of management consuming the majority of funds earmarked for their task, and creating an increasingly challenging system denying them success in providing good care.

Whistleblowers tend to be those closest to Veterans in the diamond model. Whistleblowers tend to report on the VA-for-VA system when it appears to be operating at the expense of the VA-for-Veterans system. Concerns arise with regularity at the start of each fiscal year when medical center directors announce a 'zero budget increase' for operations. A knee-jerk response leads to consolidation of functions and hiring freezes. Salary dollars of professional staff typically are identified as the largest line item in the budget requiring trimming. New strategic goals and increased overhead costs also are givens. Since Veterans Equitable Resource Allocation (VERA) is driven by provider encounters and reportedly accounts for 75% of medical center budget allocations, flat-line budgets typically lead to the cutting of clinical personnel that further drop future VERA reimbursement and cause more cuts to staffing in the long run.

Along with ever-escalating demands to meet performance measures, unclear role relationships and inadequate channels of authority lead to constant personal manipulation at all levels. Licensed professionals subject to §7422 of Title 38 are constrained further by the Secretary's control over clinical practice and competence, leading to their experiencing additional inequalities and abuses. Reports to OIG, OMI, OSC, EEO, or JCAHO more often than not are sent for investigation to the very same VA reported for not following its own rules and regulations. This is in sharp contrast to The Washington Post report earlier this year on an Atlanta jury convicting 11 teachers of racketeering and other crimes in a standardized test-cheating scandal by teachers and administrators who felt under pressure to meet certain score goals at the risk of sanction if they failed. Why is VA not held to the same standard of correction?

Respectfully, Maryann Hooker, MD, President, AFGE Local 342

"If men were angels, no government would be necessary. If angels were to govern men, neither external nor internal controls on government would be necessary. In framing a government which is to be administered by men over men, the great difficulty lies in this: you must first enable the government to control the governed; and in the next place, oblige it to control itself." By: James Madison

PREPARED STATEMENT OF RICHARD TREMAINE

Dear Chairman Coffman

I am here with you today to testify about the unacceptable, vicious and ongoing retaliation against Dr. Sheila Meuse and myself for our whistleblower activity at the Central Alabama Veterans Healthcare System (CAVHCS), where the Director, James Talton, became the first SES (Senior Executive Service) member in history fired for neglect of duty. The Chief of Staff, also under investigation, was on paid leave for six months, and quietly retired in December 2014.

With disingenuous claims of improvements, there remains an atmosphere of exclusion and retaliation, against those who did not support Talton, or subsequently, the dangerously inexperienced leadership, and ineffectual management of Robin Jackson, the Deputy Network Director over Talton during his tenure, and who was immediately planted as interim director by Charles Sepich, the VISN 7 Director.

Dr. Meuse and I were two seasoned and experienced, yet idealistic newcomers to the leadership team of CAVHCS in March 2014. Although we both identified scheduling manipulations, illegal hiring practices, continued use of paper wait lists, severely delayed consults, critical levels of understaffing, fraud, and a complete breakdown of HR (Human Resources Management), directly to Talton, we quickly concluded he would not support our efforts to hold staff accountable.

In June 2014 we were forwarded an e-mail message sent to Talton in April of 2013, alerting him to critical scheduling manipulations from a staff physician. Since Talton was publicly claiming no prior knowledge of any scheduling manipulations, we became seriously concerned about his integrity, and on June 11, raised those concerns directly to Robin Jackson and Charles Sepich. We also informed them that we had been contacted by Representative Martha Roby on June 10, regarding her face to face meeting with Talton.

Immediately after our June 11 confidential disclosures to Sepich and Jackson, the severe retaliations from Talton escalated exponentially. We later learned it was because Sepich and Jackson had communicated every word of our confidential conversation about Talton, directly to Talton that very same day.

On June 24 I sent an emergency e-mail plea to Sepich, informing him of continued violent outbursts and mismanagement by Talton. The very next morning I was forced off the Montgomery VA campus by order of Robin Jackson. I was devastated to realize that I had been betrayed.

I was constructively removed from my leadership responsibilities, and prevented from acting in any leadership capacity by Talton and subsequently, by Jackson in humiliating all-employee e-mails.

Although Sepich had promised me that he would immediately begin a fact finding to help, in fact, four days earlier he had already chartered a fact finding to investigate fabricated allegations by Talton and Jackson against us. That FF was chaired by a subordinate of Sepich. As a result, Sepich and Jackson requested an AIB (Administrative Investigative Board) from VACO on us without any specific charges.

The AIB was conducted by the OAR (VA's Office of Accountability Review) the week of October 27, 2014, with results due on January 19, 2015. Instead, the AIB requested additional, on-site testimony, citing a new allegation put forward by a union president who was not selected for a promotion, thus extending the investigation, and its scope.

One of the AIB members, a sitting director, was a former subordinate, and friend of Charles Sepich.

Incredulously, during my first year at CAVHCS, I had been under the weight of investigations for 305 out of 365 days without a single charge, and beginning within my first 45 work days.

It is difficult to describe the level of disrespect, harassment, and retaliation we endured from Talton, Sepich, and Jackson as he removed hospital services from my authority, initiated major reorganizations and realignments adversely impacting my position, and without my input. My direct reports bypassed me, reporting to him at his request. I was excluded from key informational resources, blocked from critical administrative reports of major program assessments, and important site reviews.

In fact, when I asked for the complete administrative assessment done by Jackson himself, a month before I arrived, he told me, "If you want to see it, request the information under the Freedom of Information Act (FOIA)."

In an amazing failure of leadership, Sepich and Jackson actually detailed Dr. Meuse out of the state for 90 days, in the middle of our crisis!

I speak with you today with a heavy heart disgusted by continued cover-ups, a discrediting campaign through open-ended investigations, and the attempted destruction of my career, by the very VA I have always loved being part of.

So many VA employees are closely monitoring this issue, and hoping VA leadership at all levels will demonstrate a commitment to true excellence and transparency, by creating an environment free from Whistleblower Reprisal and Retaliation.

If the retaliatory actions from CAVHCS and VISN 7 against a dedicated veteran executive and brilliant career woman executive, both who have committed their lives to serving our Veterans, is tolerated in the least, it will most certainly have a chilling effect on any others considering stepping forward to protect the organization we all love serving Veterans through.

I have feared the loss of my job and career, and we both fear a further loss of our personal and professional reputations, but Dr. Meuse and I sat in disbelief a year ago, and agreed at that moment in time, we didn't have a choice, because it was more important to protect our Veterans, than protecting either one of our own careers.

We respectfully request that you immediately address the overt whistleblower retaliation that has become rampant in our VA.

We thank you for your commitment to our Veterans.

Sincerely,

Richard J. Tremaine, MBA, Associate Director, CAVHCS

With Acknowledgement and support, Dr. Sheila Meuse, Assistant Director, (retired 3.31.15)

STATEMENT FOR THE RECORD

PROJECT ON GOVERNMENT OVERSIGHT

Subcommittee on Oversight and Investigations Hearing on "Addressing Continued Whistleblower Retaliation Within VA"

Fear and Retaliation at the Department of Veterans Affairs

In the spring of 2014, the Project on Government Oversight (POGO) put out the call to whistleblowers within the Department of Veterans Affairs (VA) to provide an inside perspective on the issues the Department was facing.

In our 34-year history, POGO has never received as many submissions on a single issue. Nearly 800 current and former VA employees and veterans from 35 states and the District of Columbia contacted us. POGO reviewed each of the submissions, and found that concerns about the VA go far beyond long or falsified wait times for medical appointments; they extend to the quality of healthcare services veterans receive.

A recurring and fundamental theme became clear: VA employees across the country fear they will face repercussions if they dare to raise a dissenting voice.

POGO 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.[1]

In California, a VA inpatient pharmacy supervisor was placed on administrative leave and ordered not to speak out after protesting "inordinate delays" in delivering medication to patients and "refusal to comply with VHA regulations." In one case, he said, a veteran's epidural drip of pain control medication ran dry, and another veteran developed a high fever after he was administered a chemotherapy drug after its expiration point.

In Pennsylvania, a former VA doctor told POGO that he had been removed from clinical work and forced to spend his days in an office with nothing to do. This action occurred after he complained 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."[2]

In Appalachia, a former VA nurse told POGO she was intimidated by management and forced out of her job after she raised concerns that patients with serious injuries were being neglected. In one case she was reprimanded for referring a pa-

[1] 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.*

[2] 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.

tient 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 the larger problems, as the VA is currently experiencing. By now it is well known that employees who recently raised concerns about veteran wait times faced reprisal. But whistleblower retaliation in the VA is nothing new. In 1992 a congressional report detailed the experiences of VA employees who were harassed or fired after reporting problems.[3] Throughout the 1990s there were several congressional hearings conducted on the quality of care at VA hospitals and on reprisal against VA employees who exposed inadequate care.[4] Despite then-Secretary Togo D. West's declaration that such reprisals would not be tolerated, a House hearing in 1999 found that the reprisal problems still existed.[5] A Government Accountability Report from 2000 found that many VA employees were unaware of their rights to protections against retaliation for blowing the whistle on wrongdoing.[6] The report also found that the majority of employees feared retaliation and were therefore unwilling to report misconduct.

The Office of Special Counsel (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 25 whistleblowers.[7] But the OSC still has over 100 pending VA reprisal cases to investigate, among the highest of any government agency, according to Special Counsel Carolyn Lerner.[8] Although the VA has been cooperative with the OSC and their recommendations, merely addressing isolated incidents is not enough.[9] The VA has been struggling with a culture problem for decades and something more must be done.

Oversight at Its Worst

VA employees who have concerns about management or fear retaliation are supposed to be able to turn to the VA's Office of Inspector General (OIG). But whistleblowers have come to doubt the VA IG's willingness to hold wrongdoers accountable. Since 2014, the IG Office has not yet publically released any investigation into employee retaliation, making it difficult to assess how seriously the IG's office is taking this issue.

Furthermore, the VA IG's office issued an administrative subpoena to POGO in May 2014 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

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[3] Eric Lichtblau, "VA Punished Critics on Staff, Doctors Assert," The New York Times, June 15, 2014. *http://www.nytimes.com/2014/06/16/us/va-punished-critics-on-staff-doctors-assert.html.* (Downloaded April 10, 2015) (Hereinafter "VA Punished Critics on Staff, Doctors Assert").

[4] Government Accountability Office, Whistleblower Protection: VA Did Little Until Recently to Inform Employees About Their Rights, April 14, 2000. *http://www.gao.gov/archive/2000/gg00070.pdf* (Downloaded April 10, 2015) (Hereinafter Whistleblower Protection: VA Did Little Until Recently to Inform Employees About Their Rights).

[5] "VA Punished Critics on Staff, Doctors Assert."

[6] Whistleblower Protection: VA Did Little Until Recently to Inform Employees About Their Rights.

[7] Office of the Special Counsel, "OSC Obtains Relief for More VA Whistleblowers," January 20, 2015. *https://osc.gov/News/pr15–02.pdf* (Downloaded April 10, 2015).

[8] Joe Davidson, "Some VA whistleblowers get relief from retaliation," The Washington Post, January 20, 2015. *http://www.washingtonpost.com/politics/federal—government/some-va-whistleblowers-get-relief-from-retaliation/2015/01/20/067dcd14–9da8–11e4-bcfb-059ec7a93ddc—story.html* (Downloaded April 10, 2015).

[9] Matthew Daly, "VA settles more whistle-blower retaliation complaints," Associated Press, January 21, 2015. *http://www.azcentral.com/story/news/investigations/2015/01/21/va-settle-complaints-whistleblowers/22108555/* (Downloaded April 10, 2015); Chris Hubbuch, "VA to Investigate Overmedication, Retaliation Claims at Wisconsin VA," Military.com, January 16, 2015. *http://www.military.com/daily-news/2015/01/16/va-to-investigate-overmedication-retaliation-claims-at.html* (Downloaded April 10, 2015).

entities."[10] Though POGO did not comply with the subpoena, such an action was cause for concern for many of the whistleblowers who had shared information with us.

POGO remains concerned that there is not a permanent VA IG in place and that the position has been vacant for over a year.[11] Our own investigations have found that the absence of permanent leadership can have a serious impact on the effectiveness of an IG office.[12] 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.[13] 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.[14]

It appears the VA IG may be subject to this dangerous lack of independence. For example, the VA OIG has failed to release the results of 140 healthcare investigations since 2006.[15] Furthermore, the Department of Treasury IG sent a letter to this Committee just last month raising concerns about another VA IG investigation. After speaking to witnesses familiar with the situation, the Treasury IG concluded that their testimony, "calls into question the integrity of the VA OIG's actions in this particular manner." The Treasury IG's investigation also found that multiple witnesses stated a VA employee boasted about his ability to influence the VA OIG's investigations.[16]

Recommendations

In POGO's 2014 letter, we recommended concrete steps for incoming VA Secretary McDonald to take in order to demonstrate an agency-wide commitment to changing the VA's culture of fear, bullying, and retaliation. Neither Acting Secretary Sloan Gibson nor Secretary McDonald have 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 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 bonuses that have been provided to wrongdoers in the past. Retaliation against whistleblowers is already a prohibited personnel practice, but it will be up to the senior-most VA leadership to ensure that this rule is enforced by the agency. 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.

But it's not just the VA Secretary who can work to fix this problem. Congress should enact legislation that codifies accountability for those who retaliate against

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[10] Letter from the Project On Government Oversight to Richard J. Griffin, Acting Inspector General for the Department of Veterans Affairs, about the IG's subpoena for POGO records, June 9, 2014. *http://www.pogo.org/our-work/letters/2014/va-inspector-general-issues-subpoena-for-pogo.html*.

[11] 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*.

[12] "Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs? Addressing Inspector General Vacancies," May 10, 2012. *http://www.pogo.org/our-work/testimony/2012/go-ig-20120510-inspector-general-testimony.html* (Hereinafter Testimony of POGO's Jake Wiens on "Where Are All the Watchdogs?).

[13] Testimony of POGO"s Jake Wiens on "Where Are All the Watchdogs?"

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

[15] Donovan Slack, "VA doesn't release 140 vet healthcare probe findings," USA Today, March 8, 2015. *http://www.usatoday.com/story/news/politics/2015/03/08/probes-of-veterans-health-care-often-not-released-to-public/24525109/* (Downloaded April 10, 2015).

[16] Letter from Eric M. Thorson, Department of the Treasury Inspector General, to the Hon. Jeff Miller and the Hon. Corrine Brown, Chairman and Ranking Member of the House Committee on Veterans Affairs, regarding the VA IG investigation, March 11, 2015. *https://veterans.house.gov/sites/republicans.veterans.house.gov/files/Letter%20from%20Treasury%20Dept.%20IG—0.pdf* (Downloaded April 10, 2015).

whistleblowers. The definition of "wrongdoing" must include retaliation. The cultural shift that is required inside the Department of Veterans Affairs must be accompanied by statutory mandates that protect whistleblowers and witnesses inside the agency from retaliation. Legislation should ensure that whistleblowers are able to be confident that stepping forward to expose wrongdoing will 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 that prevents them from coming forward.

While federal employees working at the VA enjoy whistleblower protections, contractors do not. Congress should extend the same protections to contractors in order to promote internal oversight in an increasingly contractor-heavy landscape.

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. Congress should extend whistleblower protections to veteran whistleblowers.

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.

STATEMENT OF KIMBERLY HUGHES STATEMENT

Thank you for the opportunity to submit testimony for the record to the Veterans Affairs' Subcommittee on Oversight and Investigations. I would especially like to thank Chairman Mike Coffman and Ranking Member Ann Kuster for providing a hearing Addressing Continued Whistleblower Retaliation within the Department of Veterans Affairs and a platform for whistleblowers to tell their stories.

My name was first mentioned in the VA Whistleblower Hearing before the full committee on July 8, 2014 regarding Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability, by Scott Davis, a fellow whistleblower at the Veterans Health Administration (VHA) Health Eligibility Center (HEC) in Atlanta, GA. The Atlanta Journal Constitution followed up with an article that told some of my story on August 15, 2014 and I applied for whistleblower protection from the Office of Special Counsel (OSC) in September 2014. My case is currently under review.

The scandal is a year old and the news out of VA still has the power to stun average people. Some employees have committed suicide due to retaliation on top of the 22 Veterans a day that take their own lives.

A Little About Me

For the record, I was hired by VA in 2004 as a GS–9 Presidential Management Fellow and promoted every year that I was eligible to the GS–14 level. My reputation was stellar and I was often sought after by other offices to either work for them or consult with them due to my knowledge, skills and abilities. I loved working for Veterans and during my career was given the opportunity to help formulate the healthcare budget in the VHA Office of Finance. My experience in that office was one of true admiration and respect for my chain of command. I would not trade that experience for any other inside or outside of VA.

In 2005, I was the first VA employee ever allowed to work (via detail) at the Office of Management and Budget on a VA Congressional Justification (2007 Budget Request) with the President's budget examiners. I have been nominated for multiple awards related to my work including Employee of the Year in the VHA Office of Finance and a President's Quality Award while I was a Presidential Management Fellow. I was given outstanding performance ratings year after year and was honored to be selected as a participant in the prestigious Leadership VA Program in 2012—shortly after which my life and career were forever altered by retaliation.

Doing My Job

I am the person that blew the whistle on the backlog of 900,000 pending healthcare applications in the enrollment system to my chain of command in April 2012. I was the Associate Director for Informatics at HEC for three years and supervised a staff of analysts whose jobs included monitoring and reporting the status of many administrative data sets related to healthcare enrollment. In March 2012, it became clear to my staff and me that there was an alarming increase in the number of healthcare applications that were ending up in a pending status—both income

and eligibility related—rather than being processed to a final enrollment determination. This is a kind of administrative limbo where the application can sit until someone acts upon it and applicants were never notified that their application was in this status which meant they could linger in it for days to years. We also identified 48,000 applicants as being deceased and in a pending status.

As we dived into the data to find an explanation, it became clear that there was a relationship between the increase in long-term pending (>70 days) and the online healthcare application process which had been advertised since 2009 both by VA senior leaders and via VA website as "the fastest and easiest way to apply for healthcare." The enrollment data did not support this claim.

In April 2012, this observation was elevated in a meeting with the Deputy Chief Business Officer for Member Services (DCBO, Senior Executive), Lynne Harbin, as well as HEC Director, Tony Guagliardo and HEC Deputy Director, Floretta Hardmon, and via an Excel table to the levels above DCBO including the VHA Chief Business Officer, Katie Shebesh and the VHA Deputy Assistant Secretary for Operations/Management, Philip Matkovsky (who abruptly resigned in December 2014).

The monthly meetings continued regarding pending applications beginning in April, 2012 until June, 2012. During the meetings, my staff and I received a great deal of push back from HEC management and DCBO including a "negotiation" where at first those in pending status for a year or less would be notified; then a second "negotiation" occurred where they would agree to go back two years and notify those applicants of their pending status; and a final "negotiation" was offered in that they would agree to go back three years and notify those applicants of their pending status—all three times we said that all applicants should be treated the same. The concern was then raised that if all pending applicants were notified that it would embarrass the Department and become public knowledge that they had been building up for years and Veterans would notify their Congressional representatives, creating a "scandal" for HEC management. The notification of applicants in a pending status was left unresolved.

In the June 2012 meeting, it was determined that this project would be taken away from Informatics (me), and assigned to Floretta Hardmon, HEC Deputy Director by Tony Guagliardo, the HEC Director. To my knowledge, Ms. Hardmon never held another meeting or asked for any follow-up analysis or data related to her "taskforce". I continued to raise the issue in weekly Director's meetings but they were abruptly cancelled until further notice beginning in August 2012. The Director and Deputy Director continued to meet with other Associate Directors on a regular basis but I was "frozen out" of the front office. In October 2012, I was handed a memo by the HEC Director backdated to September 28, 2012 (a falsified document), notifying me that I was being detailed with no discussion or prior notice to a non-supervisory analyst position, working directly for the DCBO, Lynne Harbin. In December 2012, I was permanently demoted to the analyst position. Although I was becoming increasingly worried about management's actions towards me, I went to work in my new job and embraced my new duties. I was still analyzing data from the enrollment system but for the first time, also providing analysis of additional data sets in the organization which revealed more problems.

In November 2012, during some routine analysis of the Veteran's Transportation Program data, I determined that the information being reported using the data set was so flawed that it could not be used for official reporting and notified my chain of command, Ms. Harbin and via a monthly report that was disseminated up to the Deputy Assistant Secretary for Operations/Management. At the time, the data was being used to justify funding for a program to transport Veterans to medical centers and clinics and was touted as saving the Department money as opposed to reimbursement for mileage. However, it was clear that savings could not be determined on a national level and the program did not have valid data to support such a claim. I was yelled at by Ms. Harbin that "there has to be data to support the program!" There was not.

In January 2013, I was still monitoring pending applications and was stunned to learn from my former Informatics staff about a meeting with the Director, Tony Guagliardo and the Deputy Director, Floretta Hardmon where they were instructed to wholesale reject 600,000 pending healthcare applications in the enrollment system without concern for their true eligibility. They stated that the Director told them that he "didn't have the staff to work them" and "wanted to start fresh for Fiscal Year 2013." The Informatics staff refused to follow the orders and one person actually had to leave the meeting and find a subject matter expert on enrollment to tell the Director and Deputy Director that they did not have the authority for such action. I was horrified as this may be the most brazen and largest single attempt at fraud in VHA history. I now understood why I had been moved out of

Informatics and promptly told Ms. Harbin about the meeting. She did not share my concern.

Additionally, in January 2013, as I was analyzing data in the internal workload system at HEC—called WRAP—I came across a confusing set of three dates. The first column was the date the application was received (or uploaded via scanner). There was a second interim date in a second column and a closed date in a third column. This data was being used to compute the turnaround time for applications that were assigned to HEC employees to process. From what I could tell, the turnaround time was based on the second interim column and the closed column. I met with a subject matter expert on the WRAP system and asked him how the different dates were being used. He confirmed my suspicions that the interim date and the closed date were being used to calculate the official turnaround time for all of the applications. This meant that an application could be received in October 2012, "opened" by a HEC employee on December 12, 2012 and then closed on December 15, 2012 and the turnaround time would be reported as three days. The received date was ignored in the calculation. Although the HEC Director was officially reporting a turnaround time of four days, I found nearly 40,000 unprocessed applications in the workload system and some were nearly a year old. The majority category belonged to combat Veterans. I was again horrified and reported this to Ms. Harbin. She did not share my concern.

As my analysis of the different data sets kept uncovering problems and it appeared that the healthcare application process was in at least a partial meltdown from the online application process to the internal processing of applications by HEC staff, I was told that the Office of Inspector General (OIG) was in the building so I put together a file for them assuming they would eventually meet with me. In the meantime, the retaliation was well under way.

The Cover-up and Retaliation

Beginning in May 2012, I was subjected to "pervasive and severe" (VA's description) retaliation by Ms. Hardmon, Mr. Guagliardo and Ms. Harbin. The retaliation included false allegations of threats, being portrayed as "difficult," "disgruntled," "inflexible," and "erratic" (logically, the last two actually cancel each other out); told that I was "too fact-based and relationships are what matter;" detailed on the last day of the fiscal year (falsified) so that my supervisor, Ms. Hardmon would not have to provide an annual performance rating to me; eventually being demoted in December 2012; and put under surveillance with both a camera and microphone just outside of my office door and (I learned later) a wiretap on my personal cell phone. The environment became so hostile I was often "baited" by management and shunned by other employees who refused to speak to me or come into my office, left out of meetings and important e-mail strings related to my job duties and physically isolated in a suite of offices with one other person and Ms. Harbin.

As I mentioned before, during the final months of my employment at HEC, OIG officials were in the building and, to the best of my knowledge, there to examine pending healthcare applications. It appears as though the backlog may have been reported to OIG sometime around August or September 2012 and the notification was sent to the HEC Director, Tony Guagliardo. This timeline also coincides with the escalation of the retaliation that I was subjected to and it is pretty clear that I was used as a scapegoat to deflect the accountability from his office to me.

I was never interviewed by an OIG official regarding the healthcare applications although I should have been at the top of the list—both as the former Associate Director for Informatics and a current analyst. As it turns out, I was at the top of a "hit list." Instead of meeting with me, I was subjected to hostility by the agents in the building. For example, when I entered the building, the security guard would pick up his phone and announce my arrival to someone else on the end of the line. I was warned by employees I didn't know from other offices while outside the building and near the elevators that "loose lips sink ships" and similar warnings. When I printed e-mails they now had a tag of "Martinsburg" in them which meant my computer was being monitored. I was lied to repeatedly by the HEC Director and HEC Deputy Director regarding the status of my 2012 performance evaluation which I did not receive until January 2013 (the standard is by the end of October 2012). Withholding my evaluation meant that I would have difficulty in applying for a new position outside of HEC which essentially held me captive.

Finally, after more than eight and a half years of service to VA, I resigned under extreme mental and emotional distress on January 24, 2013. I have filed claims regarding my experiences of retaliation with VA and have yet to come to reconciliation although I have heard many promises of settlement and reinstatement over the last two years. VA did agree to mediation three times and backed out each time with no explanation.

What Has Happened at HEC?

I was informed approximately three months after my resignation (and six months into OIG's "investigation") that my previous position had been reclassified by Ms. Harbin to a GS–15 (from a GS–14) specifically to reassign Mr. Guagliardo away from the Director of HEC. He was also reportedly given a slot at the Army War College and provided a Master's Degree in Strategic Studies by the taxpayers who paid him to attend college. Ironically, he had previously been caught including "Master's Degree" as a credential in a conference bio in September 2011 when he did not have one. Ms. Hardmon was promoted to a GS–15 by Ms.Harbin to a new position she created in her office shortly after his reassignment. Ms. Harbin has retained her position as Deputy Chief Business Officer although her defense of the healthcare application backlog has been completely discredited.

VA is a "Bafflefield"

Although OIG has been investigating disclosures made by multiple HEC employees for years, they have yet to issue a public report. According to news sources OIG was finalizing a report in October 2014, which includes at least five additional whistleblowers who applied to OSC for protection. A possible reason for the delay? One person reported in the media that OIG interviewed her eight times and she told them the same story eight times including what to look for and where to find it but they had not followed up on her disclosure.

The Way Forward

I don't see how any of this costly drama—what I and scores of others have been subjected to—improves the culture of VA, attracts talent to federal service, or serves Veterans and taxpayers in any way. My wish is that the current fear-based management will no longer be an albatross around the necks of conscientious employees who are doing their best to fulfill the mission of the Department. Perhaps Bob McDonald is the right person for the job of Secretary; for the sake of the Veterans and employees, I hope he is.

As to OIG, President Obama must nominate a permanent Inspector General to help ease the fear and retaliation of those whose life's work is to care for Veterans. The fact that this hearing is being held speaks volumes as to the importance of filling the vacancy. This will send a message to the Veterans and employees that the salad days of cover-up and retaliation are over.

LETTER FROM: MIKE COFFMAN

To: Hon. Robert A. McDonald, Secretary,

U.S. Department of Veterans Affairs,

810 Vermont Avenue, NW., Washington, DC 20420

Dear Secretary McDonald,

Please provide written responses to the attached questions for the record regarding the Oversight and Investigations Subcommittee hearing "Addressing Continued Whistleblower Retaliation Within VA" that took place on April 13, 2015.

In responding to these questions for the record, please answer each question in order using single space formatting. Please also restate each question in its entirety before each answer. Your submission is expected by the close of business on Thursday, May 21, 2015, and should be sent to Ms. *Bernadine Dotson at bernadine.dotson@mail.house.gov*.

If you have any questions, please call Mr. Eric Hannel, Majority Staff Director of the Oversight & Investigations Subcommittee, at 202–225–3527. Sincerely,

Mike Coffman, Chairman, Subcommittee on Oversight and Investigations

Questions for the Record From: Chairman Mike Coffman

1. VA does not currently have a tracking system to determine the magnitude of or trends in employee misconduct cases and identify problem areas across the VA system. The only method for tracking disciplinary actions that may have occurred is by querying the Personnel and Accounting Integrated Data system, which only provides actions that resulted in loss of pay but does not provide details as to what the infraction was. So, VA lacks the resources to identify trends in misconduct across the VA system and prevent identified problems from recurring. Does the VA have a centralized database to track cases of misconduct, and what solutions has the VA implemented to identify systemic problems and prevent them from recurring?

2. The Office of Special Counsel (OSC) has expressed disappointment that despite the numerous complaints it forwards to VA, the Office of Medical Inspector (OMI)

seems to consistently take the position that patient health was never at risk. This approach hides the severity of systemic and longstanding problems, and has prevented VA from taking the steps necessary to improve quality of care for veterans. How has VA ensured organizational accountability for cases investigated by the OMI?

3. VA does not collect and analyze aggregate data on the results of Administrative Investigation Board (AIB) investigations, which it uses to determine the facts surrounding alleged employee misconduct related to VA policies or procedures. AIBs do not determine disciplinary actions, but their results may be used to inform such actions. Having aggregate data could provide VA with valuable information to systematically gauge the extent to which matters investigated by AIBs may be occurring throughout the agency. What processes has VA adopted for collecting and analyzing aggregate data from AIB investigations?

4. Have whistleblowers at the Health Eligibility Center (HEC) in Atlanta, who reported a backlog of 900,000 health care applications, experienced any retaliation for their disclosures?

5. Whistleblowers at the HEC have provided the Committee with evidence that appears to show SES employees in the Chief Business Office misled veteran organizations about the pending problem, which may have been caused in part by an inability to upload DD–2 l 4s with an online application. Please explain if VA leadership and/or the OIG have looked into these allegations at the HEC and if so, what results and accountability measures have been or will be pursued?

6. There is significant confusion among VA staff regarding how to deal with whistleblower disclosures. Managers need additional training to distinguish between insubordination and legitimate protected disclosures. What training does VA provide to managers on supervising whistleblowers, and how does VA measure the impact of any training that is provided?

7. Regional counsels throughout VA handle the vast majority of the whistleblower retaliation caseloads internally. Because of the large and decentralized nature of VA, whistleblower complaints are often handled by these regional counsel offices. OSC staff have stated that regional counsels sometimes do not understand how to adequately defend their case against facility managers. What training does VA provide to regional counsels mediating whistleblower cases, and how does VA measure the impact of any training that is provided?

QUESTIONS FOR THE RECORD FROM: CHAIRMAN MIKE COFFMAN

1. VA does not currently have a tracking system to determine the magnitude of or trends in employee misconduct cases and identify problem areas across the VA system. The only method for tracking disciplinary actions that may have occurred is by querying the Personnel and Accounting Integrated Data system, which only provides actions that resulted in loss of pay but does not provide details as to what the infraction was. So, VA lacks the resources to identify trends in misconduct across the VA system and prevent identified problems from recurring. Does the VA have a centralized database to track cases of misconduct, and what solutions has the VA implemented to identify systemic problems and prevent them from recurring?

VA Response: VA agrees that it is important to identify and track issues to determine how systematic they are, and identify trends that may help VA better address problems.

VA has a centralized database that tracks disciplinary actions proposed and decided across the VA system. The system, which was created shortly after Secretary McDonald's confirmation, allows the Department to identify trends in the types of employee misconduct. Systemic problems may be mitigated through training to improve employees' awareness of rules and expectations, through clarifications in VA's Table of Penalties, or through other appropriate mitigation strategies.

2. The Office of Special Counsel (OSC) has expressed disappointment that despite the numerous complaints it forwards to VA, the Office of Medical Inspector (OMI) seems to consistently take the position that patient health was never at risk. This approach hides the severity of systemic and longstanding problems, and has prevented VA from taking the steps necessary to improve quality of care for veterans. How has VA ensured organizational accountability for cases investigated by the OMI?

VA Response: In Summer 2014, VHA's Office of Medical Inspector (OMI) was restructured to expand and intensify its focus on healthcare quality and patient safety. The Office of Special Counsel's (OSC) Carolyn Lerner recently expressed ap-

proval of this transformation, stating in her April 13, 2015, testimony to Chairman Coffman's Subcommittee, ". . . in response to OSC's findings, VA overhauled the Office of Medical Inspector (OMI), and has taken steps to better respond to the patient care concerns identified by whistleblowers." Concerning a recent investigation led by OMI, she observed, "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." This positive view is confirmed by the fact that OMI continues to receive OSC cases for investigation. Since the restructuring, OMI has either completed or continues work on over twenty cases.

All OMI investigations have adopted a more comprehensive approach that calls for this office to assemble and lead teams of persons from appropriate Program Offices and subject matter experts (SME) from across the Department of Veterans Affairs. These teams routinely include experts on human resources policies and procedures from the Office of Accountability Review (OAR) to address potential findings of individual wrongdoing, and to provide advice on personnel matters. Our joint efforts produce VA reports, vetted by VA's Office of General Counsel (OGC) for legal ramifications, OAR for employee accountability, and by other VA and VHA Program Offices, before being approved by leadership.

OMI now meets regularly with OSC to review the status of investigations and discuss findings, schedules for reports, and progress. These meetings have improved communication between OSC and VA on investigations, ensuring complaints are thoroughly examined and that whistleblowers receive the protections to which they are entitled. The Department is committed to taking the steps necessary to ensure complaints are thoroughly examined and that whistleblowers receive the protections to which they are entitled.

It is our hope and belief that OMI's restructuring has helped to ensure integrity and accountability across VHA's healthcare system. This improved cooperation is helping to overcome challenges in providing effective healthcare oversight, and is supporting efforts to restore the trust of Veterans and the general public.

3. VA does not collect and analyze aggregate data on the results of Administrative Investigation Board (AIB) investigations, which it uses to determine the facts surrounding alleged employee misconduct related to VA policies or procedures. AIBs do not determine disciplinary actions, but their results may be used to inform such actions. Having aggregate data could provide VA with valuable information to systematically gauge the extent to which matters investigated by AIBs may be occurring throughout the agency. What processes has VA adopted for collecting and analyzing aggregate data from AIB investigations?

VA Response: VA agrees that data-collection might be a helpful tool in learning from past investigations, and also assessing whether certain issues are systematic versus isolated. The Risk Analysis and Compliance Oversight Division of VA's Office of Accountability Review is exploring strategies to collect and analyze aggregate data from AIB investigations.

4. Have whistleblowers at the Health Eligibility Center (HEC) in Atlanta, who reported a backlog of 900,000 healthcare applications, experienced any retaliation for their disclosures?

VA Response: VA is dedicated to ensuring that all protected whistleblowers are treated fairly and in accordance with 5 U.S.C. Section 2302(b)(8), which prohibits retaliation against whistleblowers. VA will not tolerate retaliation or reprisal against whistleblowers, and we will continue to assess whistleblower activity to ensure no punitive actions occur. VA is aware of several whistleblower retaliation complaints filed with the Office of Special Counsel by Health Eligibility Center (HEC) employees. These complaints are currently under investigation.

5. Whistleblowers at the HEC have provided the Committee with evidence that appears to show SES employees in the Chief Business Office misled veteran organizations about the pending problem, which may have been caused in part by an inability to upload DD–214s with an online application. Please explain if VA leadership and/or the OIG have looked into these allegations at the HEC and if so, what results and accountability measures have been or will be pursued?

VA Response: The Department has been informed that the Office of Inspector General is reviewing these allegations.

6. There is significant confusion among VA staff regarding how to deal with whistleblower disclosures. Managers need additional training to distinguish between insubordination and legitimate protected disclosures. What training does VA provide to managers on supervising whistleblowers, and how does VA measure the impact of any training that is provided?

VA Response: Last summer, VA worked cooperatively with OSC to develop electronic training for supervisors on whistleblower rights and protections. All VA supervisors must complete this mandatory training on a biennial basis. The Department is also working with OSC to develop face-to-face training for VA supervisors that will cover, among other things, guidance on managing whistleblowers within the workforce.

7. Regional counsels throughout VA handle the vast majority of the whistleblower retaliation caseloads internally. Because of the large and decentralized nature of VA, whistleblower complaints are often handled by these regional counsel offices. OSC staff have stated that regional counsels sometimes do not understand how to adequately defend their case against facility managers. What training does VA provide to regional counsels mediating whistleblower cases, and how does VA measure the impact of any training that is provided?

VA Response: OSC recently met with VA OGC's senior leaders, including all Regional Counsel and Assistant Regional Counsel, to talk about the whistleblower retaliation complaint process and to clarify the parties' respective roles in mediating or adjudicating those complaints. The Department is working with OSC to develop additional training for Regional Counsel attorneys who handle these cases.