

Sworn Written Statement by Mr. Kuauhtemoc Rodriguez M.A, M.S, Iraq War Veteran, US Army Infantry Officer, USAF Security Forces, Former Chief of Specialty Care Clinics at the Phoenix VA 2015 to June 2018

Submitted for the Record for June 25, 2019 Hearing

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS OVERSIGHT HEARING: LEARNING FROM WHISTLEBLOWERS AT THE DEPARTMENT OF VETERANS AFFAIRS

Sworn Written Statement

Dear HVAC Committee,

My name is Kuauhtemoc Rodriguez and I am writing this sworn written statement so that it may be included as a sworn written statement for the HVAC Committee on Whistleblowers held on June 25, 2019. I am writing to provide you a very brief overview of the disclosures I have made since 2014 through 2018 while at the Phoenix VA. I first reported in 2014 that the Phoenix VA was paying an Arizona tribe reimbursement payment for Native American ceremonies using a made-up ICD-9 code that was not designated for the purpose as it was being utilized by the facility. The Phoenix VA executives were using congressionally appropriated funds for Veterans Health Care, to pay out payments to a tribe without that money being designated by congress for that purpose. I provided the OIG one binder with payments made, names, socials, etc. The OIG stated that someone in the VA Central Office did not want to pursue this case that showed that over \$500,000.00 had been paid out without congressional authorization. There are 4 binders that contain a running record of these payments still at the Phoenix VA and are located in the Scheduling Operations Office. The OIG did not send this to the Department of Justice for further inquiry even though federal law states that only congress can appropriate money for a specific purpose, not executives at the Phoenix VA.

In April 2015 I found Veterans who had died waiting for specialty care on an internal database at the Phoenix VA. I reported this to the executives at the Phoenix VA, who assured me they would look into it. I never heard anything back from these executives, and by the Fall of 2015 I determined that over 35k Veterans had been waiting for care. In a 2016 OIG report that came out of my 2015 disclosure, it was determined that on an average day, the Phoenix VA has 1,100 patients waiting longer than 30 days for appointments. There are especially significant wait times for psychotherapy appointments, with patients waiting an average of 75 days. Out of a sample of 215 veterans with 295 consults who died while waiting for care, 62 of their consults (21 percent) were delayed. However, according to VA Office of Inspector General, the delayed consults did not relate to their cause of death. In another case, a veteran “waited in excess of 300 days for vascular care.” Ironically in the fall of 2017, and again in April 2018 I filed additional OIG complaints alleging that the Phoenix VA Mental Health department continued to block out Psychotherapy appointment slots that resulted in long delays for Veterans in excess of 200 days,

and cushy schedules for doctors within this department. No one has brought accountability to this Mental Health department despite repeated OIG complaints I filed, with evidence included. The Phoenix VA executives were more interested in retaliating against me for bringing up mismanagement, corruption, at the Phoenix VA by encouraging corrupt employees at the Phoenix to file false allegations of harassment, and discrimination against me in order to shut me up. When the media contacted the Phoenix VA in 2017 for an article that was being done on the Phoenix VA, the Public Affairs officer of the Phoenix VA referred to me as a “media whore” to the reporter on record. When I reported this to the facility director, human resources, and OWAP, nothing was done to this Public Affairs Officer, but instead this gentleman has since been promoted at the Phoenix VA. The VA states that it does not tolerate harassment, discrimination, or retaliation against whistleblowers in public, but in private it utilizes all its available resources to go after whistleblowers like an organized criminal organization.

The Phoenix VA executives punished me repeatedly for my verified disclosures and attempted to mentally break me with their consistent bullying, mobbing, harassment, discrimination, and removal of my duties throughout the years in my former position. I was banished to a storage closet that had holes in the walls, was dirty, and which had no air conditioning. I was also placed in a linen closet after I filed 2 OSHA complaints, but I was still in a mediocre office in comparison to other Chiefs of departments that actually had full working office’s. In 2017 the Phoenix VA executives attempted to cover up the conditions of this closet, they painted it, covered up the holes, and brought in air conditioning. When OWAP did their site visit to the Phoenix VA they promptly determined that there was never any harassment against me, clearly ignoring the pattern of covering up malfeasance by the Phoenix VA executives. OWAP clearly was on a mission not to seek out impartial evidence to make an unbiased determination of whistleblower retaliation. OWAP ignored a death threat I received, threats of violence I received, my car vandalized, even though there were sworn statements made by witnesses, and did not seek testimony from witnesses to the alleged transgressions. OWAP only interviewed the people that I had alleged harassed me, bullied me, retaliated, and discriminated against me. Of course, these latter people were going to say that they never had committed these latter acts against me. What OWAP did to me was enable the Phoenix VA to continue their malfeasance without any consequences.

In April 2018 I filed a national OIG disclosure alleging that the VA facilities across the nation were cancelling patient appointments in a process called “cancelled by clinic” before a patient actually has his/her appointment. This latter process is an ongoing issue that partially gets reported in the VA’s monthly public data. The VA has between 6% and 8% clinic cancellations, in which Veterans mostly do not get notified in time that their appointment has been cancelled, causing a delay of care. In May 2018 the Office of Special Counsel asked the VA to initiate an investigation and OMI began to examine the data I provided. The act of asking the VA to investigate itself should be of great concern to anyone seeking impartial investigative results and should prompt congress to establish a law that removes investigative processes out of the hands of any agency involved in alleged transgressions. I say this because this latter report has been held for almost 1 year without publication, but in the draft that I was recently sent it provides contradictory explanations for delays in care for our nations Veterans. I am therefore asking this committee to seek out the GAO to redo this investigation related to nationwide clinic cancellations, so that an impartial organization can adequately do justice in this daily occurrence that continues to delay the care of Veterans.

In closing I would like to ask this committee to be more vigilant at the Department of Veterans Affairs and how it continues to maintain toxic leaders at the highest levels of the organization, who are merely shifted from VA to VA in order to hide their continued mismanagement. VA facilities and VISN networks operate like private fiefdoms that answer to no one, to include congress. VA facility executives and VISN network leaders actively monitor whistleblower complaints and seem more interested in either kicking the can down the road, or going after the whistleblower, like has been done to me. My career was destroyed, and I remain black balled within the VA system, to the point that I had a promotion rescinded, and will never be promoted again unless there is intervention from the MSPB. I honorably served in the United States Army Infantry and in the United States Air Force Security Forces, and also deployed to Iraq. When I saw the VA hurting my fellow Veterans by delaying their care, and in some cases contributing to their deaths I blew the whistle. When I saw Veterans having their mental health care delayed to the point, they were committing suicide at the Phoenix VA, I continued to blow the whistle, except no one came to help them or me. The men and women who honorably served their country were let down at the Phoenix VA and continue to be let down, a facility that is still a 1-star facility today. Why would congress allow the Phoenix VA and other facilities like this to

maintain an executive roster full of underperforming managers? Veterans deserve quality managers like me who care about the well-being of their fellow Veterans who at one point in their lives took an oath to defend the constitution of the United States against enemies foreign and or domestic. Congress has a responsibility to ensure that organizations utilize funding for what it is intended for, and the management officials the VA employs should be an extension of that oversight. The media has repeatedly documented the bad actors employed throughout the nation at VA facilities, and if congress truly wants to help Veterans then it will demand that all 1-2star facilities that have been 1-2star facilities year after year, remove their managers. No private hospital would maintain failing executives year after year on its payroll, why should the Department of Veterans Affairs be allowed to maintain their failed leaders in critical healthcare positions? In addition I would like to ask the committee to look into my case as a whistleblower so that I can get my career back, and to ask why the VA has a very well-funded legal team at the Phoenix VA doing their best to derail what little I have left of my career. I thank you for your time and should you request my testimony in person I would be glad to appear before HVAC.

Kuauhtemoc I. Rodriguez, M.A, M.S, US Army Veteran, US Air Force Veteran, Iraq War Veteran, Former Chief of Specialty Care Clinics at the Phoenix VA

Electronically Signed