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

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

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

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

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

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

I. The Office of Special Counsel

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

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

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

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

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

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

II. Whistleblower Disclosures

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

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

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

1. Ft. Collins, CO

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

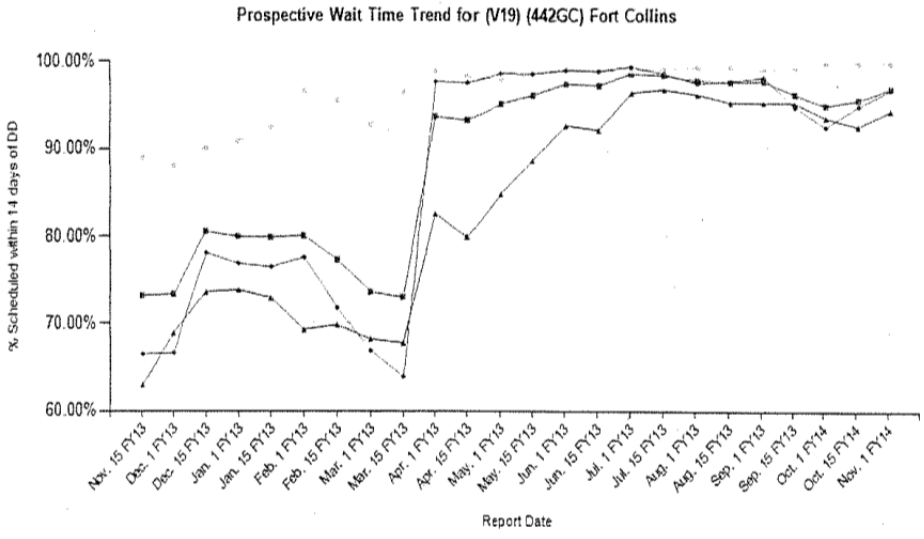
- A shortage of providers caused the facility to frequently cancel appointments for veterans. After cancellations, providers did not conduct required follow-up, resulting in situations where "routine primary care needs were not addressed."

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

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

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

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



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

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

2. Brockton, MA

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

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

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

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

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

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

3. Montgomery, AL

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

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

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

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

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

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

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

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

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

III. Whistleblower Retaliation

1. Overview and scope of the problem

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

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

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

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

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

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

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

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

3. Examples of relief obtained

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. A New and Better Approach from the VA

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

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

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

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

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

V. Conclusion

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

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

U.S. OFFICE OF SPECIAL COUNSEL
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Washington, D.C. 20036-4505

The Special Counsel

June 23, 2014

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

Re: Continued Deficiencies at Department of Veterans Affairs' Facilities

Dear Mr. President:

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

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

Jackson VAMC

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

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

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

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

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

Ongoing Deficiencies in VA Responses to Whistleblower Disclosures

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Next Steps

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

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

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

Respectfully,

Carolyn N. Lerner

Enclosures

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Special Counsel Carolyn N. Lerner

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

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

Deputy Special Counsel for Litigation and Legal Affairs Eric Bachman

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