

**Written Testimony of Dr. Katherine L. Mitchell**

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**for Oversight Hearing**

**“Learning from Whistleblowers at the Department of Veterans Affairs”**

**Subcommittee on Oversight and Investigations**

**House Committee on Veterans’ Affairs**

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## Section I: Introduction

My name is Dr. Katherine L. Mitchell. I am a board-certified internist who is currently employed at the Veterans Integrated Service Network (VISN) 22 office in Arizona as a Specialty Care Medicine consultant. My VA professional career has spanned 21 years in various roles including staff nurse, emergency department staff physician, emergency department director, and post-deployment clinic medical director. In 2017 I also completed the 2 year VA Quality Scholars program wherein I learned the fundamental basics of quality management, research design, project implementation, and change theory.

I became a nationally known VA whistleblower in May 2014 because I was the first, actively-employed VA front-line staff member to speak publicly regarding the Phoenix VA waiting list manipulation, lack of timely Phoenix VA primary care appointments, substandard Phoenix VA triage nursing care, and other health and safety issues which were potentially applicable to the entire VA system.

I initially testified in front of the House Committee on Veterans' Affairs (HVAC) in a ground-breaking July 2014 hearing regarding VA whistleblower retaliation. I subsequently testified three additional times in front of congressional committees regarding various topics including my analysis of Phoenix VA patient care deaths on the waiting list, national VA health care and oversight issues, and subsequent improvements at the Phoenix VA Medical Center.

Since the VA access crisis was identified, I have seen great strides made in VA access and patient care. Although remaining cracks in the VA system must be addressed, I strongly believe the VA currently provides millions of high quality patient care episodes every year in a manner that in many ways is superior to private care.

I had hoped my July 2014 HVAC testimony would help jumpstart a fundamental shift in VA culture wherein all employees would be encouraged by VA leadership to identify problems without fear of retaliation. Unfortunately, I believe VA leadership at all levels still continue to perpetuate a culture of whistleblower retaliation even as the VA publicly decries such tactics and rolls out new initiatives to encourage more employees to speak up about VA problems.

Specifically, in my case the VA whistleblower retaliation against me has continued for most of the last 5 years despite signing a September 2014 settlement agreement intended to resolve such unjust treatment. Although I have made multiple direct and indirect attempts to fight the retaliation, I have not yet found any successful method to stop it.

Available avenues to formally address VA whistleblower retaliation have been exceptionally slow and thus not able to provide any prompt relief.

In October 2018, after the Office of Special Counsel's preliminary investigation found credible evidence of the ongoing whistleblower retaliation against me, I entered into mediation with the VA via the OSC alternative dispute resolution process (ADR). That mediation is still ongoing because the VA no longer has an expedited mediation process in place.

In the remainder of this written testimony I will outline examples of ongoing VA whistleblower retaliation against me since signing a September 2014 settlement agreement, briefly describe my attempts to stop such retaliation, and discuss my concerns regarding the VA Office of Accountability and Whistleblower Protection (OAWP). I will also propose potential remedies for assisting VA whistleblowers, positively influencing VA culture, and strengthening federal whistleblower safety-nets.

Please note that I am not the only nationally prominent whistleblower experiencing persistent retaliation after congressional testimony. Dr. Christian Head who testified with me in the July 2014 whistleblower hearing has had ongoing, severe VA retaliation against him since appearing in front of the HVAC and other congressional committees.

If the VA has no qualms about subjecting prominent national whistleblowers to further retaliation, it stands to reason that the VA could target lesser known local whistleblowers with even more enthusiasm. Since Dr. Head and I have been unable to get relief from retaliation in the last 5 years, I believe most other whistleblowers will not fare any better.

## Section II: Whistleblower Retaliation against Dr. Mitchell – Examples from 9/2014 to present

### Pertinent Background:

- In September 2014 I signed a settlement agreement with the VA in order to resolve the whistleblower retaliation against me. As part of the settlement agreement process, I was offered a new position/training as Specialty Care Medicine consultant at a VA Veterans Integrated Service Network (VISN) office in Arizona and allowed to enter the 2-year VA Quality Scholars program.
- As per the job description given to me as part of the settlement, the Specialty Care Medicine consultant position/associated on-the-job training would allow me to directly influence the quality of patient care by participating in the oversight of quality assurance, risk management issues related to poor quality care, and utilization review at multiple facilities within a 3 state region. The VA Quality Scholars program would enable me to learn the basics of quality management, research design, quality project implementation, and change theory.
- The VISN office has 3 main divisions: medicine/CMO (Chief Medical Officer), quality/QMO (Quality Management Officer), and business/DND (Deputy Network Director). My Specialty Care Medicine position fell under the VISN medical/CMO division. Although the VA Quality Scholar position was unique in that it was not assigned a division, it clearly aligned with VISN quality/QMO division activities.
- When I started working at the VISN office, I hoped I could resume my VA professional career trajectory without the institutional stigma of being a whistleblower. I immediately observed that staff were very distant and rarely spoke to me. Although several communicated privately to tell me they were glad I brought attention to VA issues, I believed my whistleblower status was causing most staff to be inappropriately apprehensive. I decided the best course of action was to consistently demonstrate my professional expertise, work ethic, and interpersonal skills. By doing so, I hoped I could develop effective collegial relationships and reassure staff that I was a trustworthy, reliable individual who would be a valuable asset to the VISN office.
- By early 2015, after realizing VISN leadership was not enthusiastic about my presence in the VISN office, I was not surprised by their subsequent retaliatory behaviors towards me. In 2016, when VISN-level retaliation against me never abated, I tried to obtain an alternative VA position outside the VISN office. In the process of searching for a new position in 2017, it became evident that the retaliatory actions against me were also occurring at the level of VA Central Office (VACO).

## **Examples of Ongoing VA Retaliation against Me:**

For purposes of brevity, I have summarized only a few episodes of the countless episodes of whistleblower retaliation I experienced from late 2014 through March 2019. These examples are provided in rough chronological order, not in order of severity.

- 1. From 2015 through the date of this testimony VISN leadership has prohibited me from performing the primary duties of my Specialty Care Medicine job description which was provided to me as part of the September 2014 settlement agreement with the VA.**

I signed the settlement agreement and specifically accepted the position based on the official duties contained in formal "position description". However, VISN leadership has never allowed me to officially perform any of primary duties listed on the job description that was provided as part of the legally-binding 2014 settlement agreement.\* Those primary duties included coordination of and involvement in quality assurance, risk management, utilization review, and clinical cost analysis.

**\*Note:** Since 2014, even though I have been prohibited from officially performing risk management activities, I have nonetheless addressed reports of patient care problems that have been brought to my attention privately by hospital employees who felt confident I would not disclose their names. Those employees contacted me because they did not feel comfortable reporting their concerns using facility chains-of-command or the OIG because the employees feared whistleblower retaliation.

Responding to such informal reports clearly fell within my Specialty Care Medicine duties even though leadership would not officially allow me to officially perform those duties. Each time I received an employee's report, I maintained employee confidentiality, remotely researched the patient care chart to gather data, analyzed the data to determine if the employee's concerns were valid, and wrote a formal summary listing concerns/conclusions about patient quality. I electronically provided each summary to the VISN leadership for further follow-up. Though leadership almost never provided me any updates and were not always pleased with my activities, I believe my findings did receive VISN attention. I am aware from subsequent conversations with involved hospital employees that my efforts have resulted in significant changes in policy, consult processes, and even the removal of a grossly substandard physician.

- 2. In December 2014 after I found gross factual errors in a facility's response to an Office of Inspector General (OIG) inquiry, VISN leadership never allowed staff to share OIG inquiries/facility responses with me again.**

In December 2014 a VISN QMO staff member need the assistance of a physician to review the accuracy of a small batch of facilities' responses that appeared to be problematic. Because I was the only physician on-duty that day, the VISN staff member asked for and subsequently received my assistance. Although the majority of responses to each OIG inquiry were accurate, I found one facility response which was clearly contrary to facts documented in the patient's chart. I

summarized my findings in writing and forwarded them to the QMO division and QMO staff member.

Since that time I have never been allowed to review any facility OIG responses even though review of such responses falls within the Specialty Care Medicine consultant position description I received when I signed the settlement agreement. The QMO employee was told not to share OIG hotline responses with me again.

**3. From 9/2014 through 2018, various VISN leadership actively discouraged staff from associating with me.**

From conversations with VISN co-workers I learned VISN division supervisors would tell each other which VISN staff were seen speaking with me. Two division supervisors openly instructed staff not to provide any information of any type to me, even if that information was just routine, common knowledge. One staff member who persisted in speaking with me was moved to an office far away from my cubicle.

**4. In FY17 now-former VISN 22 leadership significantly prevented me from obtaining the full benefit of my VA Quality Scholar (VAQS) training program for 17+ consecutive weeks.**

Although other VISN staff did not have to have prior approval for projects, I was not allowed to start VAQS projects examining the quality of patient care without submitting a project proposal and obtaining approval from senior VISN leadership. In a VISN office where leadership routinely made decisions within a matter of days on any subject, 2 senior leaders deliberately impeded my progress in the VAQS program by taking an extraordinarily long time (11+ weeks) to consider one of my VAQS project proposals before rejecting it. It was not until 1/25/17, 11+ weeks after my proposal submission, I was told my project proposal was rejected because "it was not a VISN priority" even though the project was based on a high priority VA directives to address women's health care in VA emergency departments.

At any time during that 11+ weeks those senior leaders easily could have informed me that my VAQS project was denied and allowed me the opportunity to present another project. However, they inexplicably chose to ignore my email requests for follow-up on my project proposal. Because I could not get approval for my VAQS project from VISN leadership, I missed 11+ consecutive weeks of opportunity to be working on a patient care project or projects that would have allowed me to work at my full potential as a VAQS and Specialty Care Medicine consultant.

On the date I was told my project was rejected, I was also told I was being removed from the VAQS program because I had not provided my confidential settlement agreement to VISN senior leaders. It would take another 6 weeks to be reinstated to the VAQS program through the intervention of the Office of Special Counsel.

**5. In violation of the 2014 settlement agreement, in January 2017 now-former VISN leadership suddenly removed me from the VAQS program because I declined to provide a confidential**

**copy of my 2014 VA settlement agreement which the VISN Director had inappropriately requested.**

On 1/25/17 now-former VISN leadership informed me that I was being removed from the VAQS program by VISN leadership because I refused to provide a copy of my confidential 2014 settlement agreement wherein the VAQS program eligibility was discussed. I was told by the VISN director that since I had refused to provide the settlement agreement, she had no “proof” that I was still eligible to be in the VAQS program.

I immediately stated I could ask the Office of Special Counsel (OSC) to contact her immediately to verify my eligibility, but she declined and stated again that I was prohibited from further participation in the VAQS program. As a VISN director, she should have known the process to get verification of my VAQS status from VA Central Office/VA legal counsel and the restrictions on demanding a copy of a confidential OSC settlement agreement.

The VISN director never told me prior to 1/25/17 that she required me to establish my eligibility. If she had communicated that to me prior to 1/25/17 I would have contacted the OSC to intervene to provide the appropriate verification of my VAQS eligibility.

**6. A now-former direct supervisor gave me impossible performance goals in January 2017. Although I formally voiced objections, he still did not provide timely revisions to those impossible goals for 2 months. Unfortunately, many of the revisions were inadequate and rendered most goals essentially impossible for me to achieve within the remaining FY17.**

I was first notified of the FY17 performance goal criteria by my supervisor on 1/20/17. The deadline for completing all criteria was 9/30/17. The fiscal year 2017 (FY17) performance goals I was initially given were completely unrealistic/unachievable. (Note: Performance goals are different than the annual proficiency criteria on which I am rated.)

Among the mandatory requirements to which I would be held in order to be viewed as fully meeting performance goals included publishing a minimum of 5 peer reviewed journal articles in the timespan between 1/20/16-9/30/17 (a standard to which no other VISN staff in the nation is held to and which would not be possible even for a full time academic researcher working alone), improving the access SAIL scores by a full quintile in 5 VISN facilities (an achievement that the entire VA using all available resources for the past 2 years had not been able to do in any VISN in the entire country), and improving the healthcare associated infection SAIL metrics a full quintile simultaneously in all 8 VISN facilities (an equivalent achievement never done in any VISN in the whole country since SAIL began).

The VISN management repeatedly insisted in the 1/25/17 meeting that the performance goals were reasonable even though anyone with basic knowledge of SAIL data/publications would know that the performance goals grossly violated VA Handbook 5013, Performance Management Systems. Although VISN management eventually stated I could submit suggestions for alternative performance goals, the CMO quickly sent me new performance goals which were only minimally changed. I sent an informal grievance on 1/31/17 to VISN leadership. Subsequent performance goals were eventually modified in approximately March 2017 but still were not achievable before the deadline of 9/30/17.



- 7. During FY17, VISN 22 administration refused to assign me to relevant committees/workgroups pertinent to my quality activities or my role as VISN 22 Specialty Care Medicine consultant.**

My job title is VISN 22 Specialty Care Medicine consultant. However, when VISN 22 reorganized its committees in mid-2017, VISN 22 management did not inform me that it had restarted the Specialty Care Committee. Management chose not to appoint me to this committee. I only learned of the committee's existence in January 2018 when I was doing research on starting a VISN-level committee for specialty care.

Although my physician experience includes 9.5 years in a VA Emergency Department, in 2017 and 2018 I have been excluded by VISN 22 administration from any membership on the VISN 22 workgroup to improve Emergency Department flow throughout VISN 22 facilities. (It was not until 2019 that I would be assigned to an Emergency Department project to improve such flow.)

After completing a self-developed project that identified VISN 22 facilities' interfacility specialty care consult (IFC) processes and points of contact (POC) for each step, I inexplicably was excluded from membership on the workgroup looking at these processes even though they were relying on my self-developed project materials to address IFC problems.

- 8. At the end of FY17 I was told by my now-former direct supervisor that she was not authorized to rate me any higher than "fully satisfactory" on my end-of-year appraisal rating. Her statement was illogical because, based on the definitions printed on the appraisal rating form, I met the all the criteria contained in the definition for "excellent" and my VA Quality Scholar work supported a rating of "outstanding".**

Not only did I meet all the criteria listed by the form for the category of "excellent", my supervisor was also aware that I had received an "outstanding" performance rating from my VA mentor in my 0.75 FTE VA position as VA Quality Scholar. My now-former supervisor inexplicably stated she was not allowed to consider such outstanding performance when providing a summary rating me as a full time VA employee even though I occupied a 0.75 full-time VA position as VA Quality Scholar and only 0.25 full-time VA position as Specialty Care Medicine consultant. She stated I would have to submit a reconsideration (formal complaint) of her summary rating of "fully satisfactory". Although she was the primary rating official, she inexplicably told me that she did not "have the power" to change my rating. (*I do not think she was retaliating against me but rather was following retaliatory orders from more senior VISN leadership who did not want me to be rated higher.*)

I filed a formal complaint within the VISN office and eventually was granted a rating of "Excellent".

- 9. In October 2017, shortly after a Washington Post reporter submitted to VACO my statements about ongoing VA whistleblower retaliation, the VA suddenly withdrew its offer of a short-term assignment to the Office of Accountability & Whistleblower Protection (OAWP) without providing any explanation.**

In an August 2017 telephone meeting for 1.5-2 hours with a now-former OAWP Executive Director I was informed that the VA Deputy Undersecretary of Healthcare Operations and Management (DUSHOM) had recommended an OAWP assignment for me because the OAWP had no physicians assigned to it and was in great need of such medical expertise to investigate cases involving physicians. During that meeting I was offered me a 4-month assignment to the OAWP with the ability to extend the detail. I accepted.

Because the OAWP Executive Director stated he wasn't sure how to initiate the necessary paperwork for me to have the assignment, I told him I would do the research to find out how to expedite it. Within 3 days on 8/25/17 I sent him an email telling him I was excited about the opportunity to work with the OAWP and that I created the necessary HR documents (attached to the email) in order to expedite the detail. He replied on 8/25/17 "Thank you for getting the process started. Since this will be a unique detail, I'll work it with [VA Deputy Undersecretary of Healthcare Operations and Management]".

In September 2017, a Washington Post reporter was working on a story regarding increasing VA whistleblower retaliation. When he interviewed me, I told him VA retaliation was worsening. The reporter subsequently submitted my comments about ongoing/worsening VA whistleblower retaliation to VA Central Office (VACO) as part of routine investigative process in order to get a response from VACO. (The reporter's final article appeared on 10/30/2017.)

Shortly after the timeframe that the VA would have received notification of my specific comments by the reporter, I received a curt 2 sentence email dated 10/25/17 from that same OAWP Executive Director stating that he would "not be moving forward" with the OAWP detail. This OAWP Executive Director never responded to my subsequent email requesting an explanation of why the detail was suddenly cancelled.

Because the OAWP had ongoing significant need for medical expertise in investigations, I believe the assignment offer was withdrawn because VACO was displeased with my comments about VA retaliation. Since the VA DUSHOM had recommended me for the position and since the VA DUSHOM never again contacted me, it would have taken a senior VACO leader to reverse the DUSHOM's recommendation for an OAWP assignment, stop DUSHOM interactions with me.

**10. In a January 2018 news article the VA falsely portrayed itself as continuing to work on my case even though it has persistently ignored my genuine attempts since 2016 to resolve its breach of settlement agreement and had broken off all contact with me since October 2017.**

In a USA Today article published 1/16/18, the VA falsely contended it was "still working" on my case. In fact, from October 2017 through the time the VA entered mediation with me in October 2018 the VA Central Office had no direct or indirect contact with me.

The VA has persistently ignored my attempts to resolve the breach of settlement agreement. After it became evident that the VA materially breached the 2014 settlement agreement, I tried to resolve the issues informally via the Office of Special Counsel starting in approximately mid-2016. After the VA stopped responding to the OSC in Spring 2017, on 6/23/17 I sent (via email delivery) a 6/23/17 formal "Notice of Breach of Settlement Agreement" with a 30 day deadline

for response to the VA DUSHOM. The DUSHOM informally acknowledged receipt of this document in an email dated 6/27/17. In the formal notice I requested a new position to resolve the breach.

The follow-up communication I received was a brief email dated 7/19/17 from the DUSHOM asking for my resume and indicating he was “pursuing a couple possibilities” for me. I promptly provided my resume via email. Although I subsequently was offered a short-term OAWP assignment with a potential for a longer position, that assignment offer was later withdrawn.

Because I received no formal response from the VA to the initial Notice of Breach of Settlement Agreement and because the material breach continued/worsened, on 11/15/17 I subsequently submitted (via email delivery) a second document entitled “Second Formal Notice of Breach of Settlement Agreement” to the VA DUSHOM. This notice was read by the DUSHOM on 11/15/17. This document gave a 30 day deadline for VA response. The 30 day deadline passed on 12/15/17 with no formal or informal response from the VA. As of June 2019, the VA has never provided any informal or formal response of any kind to my “Second Formal Notice of Breach of Settlement Agreement”.

**11. In January 2018, after I publicly stated I had been offered an Office of Accountability and Whistleblower Protection (OAWP) short-term assignment which had inexplicably been withdrawn, VACO countered with an inaccurate public statement claiming that I had never been officially offered a position with the OAWP.**

In a nationally circulated January 17, 2018 USA Today article wherein I stated I had been offered an OAWP position which was subsequently withdrawn, the VACO inexplicably contended that I had not ever been officially offered any type of position with the OAWP. VACO’s statement was not consistent with the conversation or emails from the OAWP Executive Director with whom I had arranged the short-term assignment.

**12. From 2017 through 2018, even though I was assigned responsibility for the Healthcare Associated Infections (HAI) at all VISN 22 facilities, various VISN leadership would not include me in the HAI communication loop between the facilities and VISN 22, provide access to the facilities’ HAI improvement action plans, or actively involve me in ongoing HAI projects.**

In early 2017 I was specifically assigned by the VISN 22 CMO division to monitor the prevention of HAI in VISN facilities by tracking trends and following up with front-line staff who would be most familiar with root causes and interventions. However, in February 2018 I learned via emails that I had not been included the communication loop between the VISN 22 DND and the facilities regarding HAI. I learned of the communication loop only after receiving an email wherein a facility questioned why it was being asked to do “double-work” by providing HAI action plans to VISN 22 DND and separate documents to me. Although I sent multiple emails to my chain-of-command to be included in the activities/information flow, I was never allowed to participate. HAI responsibility was removed from my responsibilities in FY19.

**13. Contrary to multiple OPM regulations, VISN operating procedures, and VISN business needs, in late 2018 VA Central Office (VACO) reportedly was able to deny me the ability to participate in medical review of local VISN-level consult issues even though it is highly irregular for VACO to be involved in such matters.**

In 2018 I was struggling to fill my 40 hour workweek with activities because the duties I was allowed to perform did not consume all my duty time. In late 2018 I learned the business division of my VISN was experiencing consult problems which could be resolved by physician review. After briefly speaking to my supervisor, I subsequently submitted an email to that supervisor formally requesting the ability to have some of my work time assigned to the business office to assist with these consult problems. Several months later I learned my request had been inexplicably denied even though such duties would clearly fall under the Specialty Care Medicine role and were within my scope of practice as a board-certified internist.

In 2019 I inadvertently learned from an extremely reliable source that my request had been forwarded to VACO for review and that VACO had denied the request. Because it is extremely irregular for VACO to have any input on the routine local assignment of a temporary job duty for a local VISN-level employee, I believe I was being treated differently because of my whistleblower status. I am extremely concerned that VACO has been surreptitiously dictating my VISN job duties, or lack thereof, since beginning my VISN position in 2014.

### **Section III: Lack of Timely Avenues to Stop Whistleblower Retaliation against Dr. Mitchell**

During these last 5 years, I have not been silent about the retaliation against me. Although I have made multiple direct and indirect attempts to fight the retaliation, I have not yet found any successful method to stop this unjust treatment.

Since 2015, I have notified my immediate chain-of-command several times in an attempt to obtain relief. Although 2 of my immediate supervisors were blatantly retaliatory against me, I could not elevate the existence of the retaliation to the chain-of-command because the VISN Network Director, the top supervisor in the VISN chain-of-command, had also taken retaliatory actions against me. I spoke with 2 of my subsequent supervisors about VISN-level retaliation. However, although they were sympathetic to my plight, they informed me that they could not overcome VISN-level “politics” that were successfully blocking me from performing any of the duties of the Specialty Care Medicine consultant position or participating in VISN-level projects that were in the scope of Specialty Care Medicine duties.

In late 2016 I contacted the Office of Special Counsel or OSC, explained the retaliation, and asked if it could help me obtain a new VA position. The OSC tried to resolve the problem by informally engaging the VA, but the VA declined to participate. Because the OSC was so backlogged, I was told the only way to receive further OSC help was to file another whistleblower retaliation complaint and wait my turn in line, a line that ultimately was about 15 months long.

In 2017 I also contacted several congressional offices and was told they were referring all VA whistleblower matters to the new VA Office of Accountability and Whistleblower Protection (OAWP). I contacted the OAWP twice in 2017. When I submitted my request for OAWP assistance, I even cc'd the now-former Secretary of the VA, an individual with whom I had exchanged several patient care-related emails. I waited again – it was a wait that would last 16 months to get a follow-up response from the OAWP. The now-former Secretary of the VA never responded.

In June 2017 I also sent the now-former VA Deputy Undersecretary for Healthcare Operations and Management (DUSHOM) a formal legal notice citing settlement agreement breach and clearly outlined the whistleblower retaliation against me. In the document I requested assistance with obtaining a new position. I was elated when the DUSHOM asked for my resume. As a result of his actions, I subsequently received and accepted an offer of a new short term VA assignment with the OAWP with the potential for a permanent position. Unfortunately, the VA suddenly withdrew the offer after I gave a national newspaper interview about ongoing VA retaliation. In November 2017 I sent the DUSHOM a second formal legal notice of breach. Although the email read receipt confirmed the DUSHOM read the notice, I never received any type of VA response to my formal legal notice.

In October 2018, after the OSC's preliminary investigation found credible evidence of ongoing whistleblower retaliation against me, I readily entered mediation with the VA. That mediation is still ongoing as of June 2019 because the VA no longer has an expedited mediation process in place.

*Please note: In 2014 the VA had an expedited mediation process for OSC cases wherein credible retaliation was found. Although I am not privy to the details of that confidential process or the rationale for discontinuing it, that 2014 VA expedited mediation process was successfully used to address the whistleblower retaliation against me and other VA employees.*

#### **Section IV: Whistleblower Vulnerabilities when Interacting with OAWP - General concerns & specific examples based on Dr. Mitchell's 2017 & 2019 experiences**

In this section I describe my Office of Accountability and Whistleblower Protection (OAWP) interactions in 2017 and 2019 and explain how those interactions reveal weaknesses in OAWP processes. Although the OAWP has recently come under new leadership, I remain concerned the OAWP does not yet seem to have any effective processes in place to ensure the complainants are not subjected to further retaliation for using OAWP services. Further development and transparency of OAWP processes would help address the concerns discussed below.

**1) Prior to the filing of an OAWP complaint, the OAWP triage intake staff fails to communicate key information to complainants about the potential for the complainant's supervisor and facility leadership to obtain unredacted complaints/associated unredacted documents.**

Based on my OAWP experiences described below and intermittent conversations with other whistleblowers who have contacted the OAWP, the OAWP intake staff routinely do not disclose to whistleblowers that any documents submitted can potentially end up in the hands of the whistleblowers' supervisors/facility leadership if A) the OAWP initially deems the complaint not to meet the criteria for whistleblower retaliation, B) the OAWP directly does an investigation, or C) the investigation is referred by the OAWP to the VISN/VISN facility associated with the whistleblower.

***My OAWP experiences:** On 9/8/17 I sent an email to the OAWP notifying it that I was experiencing whistleblower retaliation. In the 9/13/17 email response the OAWP triage specialist wrote "To ensure your whistleblower disclosure and subsequent retaliation is addressed appropriately, please respond to this email with information..." She then listed the information to include events, witnesses, and documented evidence such as emails. She did not inform me whether or not those documents could be shared with my supervisor/leadership.*

*Because the 9/13/17 OAWP email did not disclose the OAWP processes for handling my complaint, I sent a follow-up email dated 9/13/19 seeking more information/explanation about those processes. I asked if my supervisor, VISN office, or general VA leadership would have access. I also inquired as to whom would be investigating the retaliation.*

*I received the OAWP triage specialist's partial response to those questions on 9/15/17, but the triage specialist did not state who would have access to my complaint and supporting documents. Because the triage specialist did not answer that question, I replied on 9/15/17 asking her to confirm who would have access. In a 9/18/17 email, the triage specialist sent me her phone number and subsequently spoke off the record with me. In our conversation she vaguely indicated the documents might be shared, but she would not officially confirm it.*

*In 2019 I received written confirmation from an OAWP staff member that all whistleblower evidence documents could be shared with a complainant's*

*supervisors/facility leadership and that even previously redacted information could be unredacted/given to VISN leadership (and to the facility if the VISN requests that the facility investigate). In a 2/5/19 email to the OAWP I wrote "Can you verify that my chain of command within VISN 22 (supervisor/VISN 22 leadership) would not have access to the documents I submit to you?" In a 2/5/19 email response an OAWP staff member informed me in writing that "[she] cannot confirm that they will not see the documents ...documents can be shared as the investigation proceeds" in retaliation cases.*

*I was also informed via the same 2/5/19 email response that redacted information could also be given to the VISN when there were disclosures of violations, gross mismanagement, waste of funds, abuse of authority, or specific danger to public health or safety. OAWP staff member wrote in such cases "...the investigative party (OAWP or VISN) may be provided with copies of the redacted information".*

- 2) Prior to the filing of an OAWP complaint, the OAWP triage intake staff apparently fail to communicate key information to complainants about the investigative process and the potential to have the investigation conducted by the VISN or by the complainant's facility if the OAWP declines to conduct the investigation using its own staff.**

Based upon my OAWP experiences described below and intermittent conversations with other whistleblowers, the OAWP intake staff do not fully explain the process of investigation and do not routinely disclose to whistleblowers that any complaints not meeting the initial definition of whistleblower retaliation are forwarded to the employee's VISN for subsequent investigation and/or subsequent delivery to the complainant's facility to investigate.

***My OAWP experiences:*** *In a 9/15/17 I was informed by an OAWP triage specialist that the OAWP investigates matters involving "all VA Senior Leaders" and refers any other matters not involving senior leadership "to the appropriate entity to investigate". The triage specialist did not specify which entities would be involved.*

*In 2019 an OAWP case manager wrote that the investigative party for allegations other than retaliation would be the "OAWP or VISN". However, she did not offer any specific information on what might happen if a retaliation complaint was deemed not to rise to the level of whistleblower retaliation.*

*Because it took 17+ months for the OAWP to respond to my 2017 initial intake disclosure, I asked the same case manager about the timeliness of any future investigative processes. The OAWP triage case manager told me she could not "clarify the OAWP timeframe for taking action or the investigation process. Each case is will be [sic] handled on a case by case basis." I was surprised because I assumed the OAWP would have processes defining the average/desired timeframes for investigations.*

- 3) The OAWP does not appear to have any processes in place to ensure that the content of any referred complaint is handled by a neutral party at the complainant's VISN office or facility.**

**Anecdotal OAWP information:** *I have been told by VA staff who wish to remain anonymous that the OAWP will forward those complaints deemed not to be retaliation to the regional VISN with only general instructions to address the complaint. The OAWP does not appear to take any steps to ensure the content of the complaint is handled by a neutral party at the VISN.*

*I have been told that OAWP complaints are often forwarded by the VISN to the complainant's facility (enabling the facility to investigate itself) because the VISN does not have the staffing to investigate. (This is similar to how the VISNs commonly handle OIG hotline complaints that are referred to VISNs.)*

*I do not have any information on whether or not the OAWP does follow-up of forwarded complaints to determine if resolution is achieved.*

**4) The OAWP intake processes appear to be extremely slow with gaps of up to 1+ years for initial intake.**

*When talking to another VA whistleblower (Dr. Christian Head) who also testified at the 2014 HVAC hearing, I learned that he never received any contact from the OAWP despite having filed a complaint more than 1+ year earlier.*

**My OAWP experience:** *In 2017 I was told by several congressional offices that they refer all potential VA whistleblower retaliation cases to the OAWP. After learning that I could not receive congressional help unless I first went through the OAWP process, I contacted the OAWP to file an initial complaint. In September 2017 I sent the initial email to make a disclosure and ask if the OAWP could help. I subsequently sent a December 2017 email to the VA Accountability Team and the now-former Secretary of the VA wherein I stated "I would like to file a case with the OAWP" and provided a succinct synopsis of the retaliation I experienced. Unfortunately, I did not receive any OAWP response until January 2019 (1+ year later) asking me if I "still wish to file a disclosure".*

**5) The OAWP appears to be subject to internal pressure from VA Central Office (VACO) senior leadership.**

**My OAWP experience:** *In late August 2017, after I had notified the now-former VA Deputy Undersecretary of Healthcare Operations and Management (DUSHOM) in June 2017 about ongoing whistleblower retaliation against me, the now-former OAWP Executive Director contacted me at the request of the DUSHOM regarding a short-term detail position to the OAWP as a physician investigator with the potential for a longer assignment. I accepted the detail. Because that OAWP Executive Director was uncertain how to initiate the detail paperwork, I drew up the appropriate paperwork and forwarded it to him. He sent me an email 8/25/17 which thanked me "for getting the processes started" and stated he would "work it with [the DUSHOM]". In late September/early October 2017 I gave an interview to the Washington Post wherein I*



*stated that the VA retaliation against whistleblowers like myself had worsened. Although the article did not appear until 10/30/17, the VA was notified of my comments in advance as part of the standard procedure for journalists. Shortly after the time the VA was initially notified, I sent an inquiry to that OAWP Executive Director asking for an update on the detail position because I had not heard from him after waiting the expected 4-5 weeks it takes to get detail approval. In a 2 sentence email he replied he was not moving forward with the detail for me. He did not respond to my subsequent email politely asking for an explanation.*

*In January 2018 VACO publicly denied in a 1/17/18 USA Today article that I was offered an OAWP position despite those emails to/from the now-former OAWP Executive Director which are described above. Although I do not have direct evidence of VACO's interference with my detail, it seems logical that only VACO senior leadership would have the power to not only cancel the detail that had been arranged by the DUSHOM but also deny such a detail position offer ever existed.*

**6) The OAWP is inappropriately asking for complaint details/documentation which could logically interfere with a potential/pending OSC investigation.**

**My OAWP experience:** *On 1/25/19 I was contacted via email by an OAWP triage case manager to determine if I still wanted to file a complaint based on my 2017 correspondence with the OAWP. At the time of contact I was already in the OSC's Alternative Dispute Resolution (ADR) process with the VA because a Fall 2018 preliminary OSC investigation found credible evidence of whistleblower retaliation against me. I explained this and asked "would there be any purpose in engaging the OAWP now?"*

*Per a 1/30/19 email, the OAWP case manager responded that the "OAWP would still conduct their investigation despite OSC involvement (provided we have all supporting documentation)." This statement is extremely concerning to me. Because the VA has no expedited mediation process in place, my ADR with the VA has been ongoing since October 2018. If the mediation process ultimately is not successful, then it will terminate.*

*If the current ADR process fails, then the OSC would conduct a full investigation of the VA retaliation against me. In the event of a full OSC investigation, if the VA were to be given advance access by the OAWP to my complaint and all my supporting documents, I fear there would be a significant risk intimidation of/retaliation against my witnesses or other interference with the OSC investigation of my case.*

## **Section V: Potential Remedies to Assist VA Whistleblowers, Positively Influence VA Culture, & Strengthen Federal Whistleblower Safety-Nets**

Because many ingrained root causes contribute to VA whistleblower retaliation, I do not know of any single method which could effectively obliterate retaliation in the VA system overnight. However, I believe there are potential remedies which, if done concurrently, realistically could address immediate whistleblower concerns, facilitate reductions in VA retaliation events, positively influence VA culture so all VA employees could identify safety issues without fear of retaliation, and systematically strengthen federal whistleblower safety-net resources. I have listed a few of those remedies in this section.

Note: Some of the recommendations listed below include references to 3 VA initiatives: High Reliability Organization (HRO), Just Culture, and Servant Leadership. In theory, each of these initiatives can positively influence VA culture. However, 2 initiatives (Just Culture & Servant Leadership) have not been consistently operationalized in a manner conducive to substantially influencing the sprawling VA culture. The remaining initiative (HRO) has not yet been implemented though its eventual success will be extremely limited if Just Culture & Servant Leadership are not already strategically in place.

The HRO initiative is a 3-pronged approach to achieve organizational healthcare excellence by fostering a workplace culture of safety, dedication to continuous improvement, and leadership support. The “culture of safety” has techniques/guidance that empower every employee to verbalize safety concerns and potential solutions without fear of retaliation. As part of that culture, every level of leadership expects/actively encourages employees to verbalize legitimate concerns and take action to prevent patient harm. The emphasis on a culture of safety and continuous improvement are tantamount.

The Just Culture initiative must be present to have an effective roll-out of HRO. “Just Culture” involves implementing an institutional culture wherein there is balanced assignment of accountability for designing safe processes/systems and for addressing any occurrence of negative healthcare/safety outcomes. That accountability is shared by both the individual employee and the institution. If a problem/negative outcome occurs, the event is analyzed to assign individual and institutional accountability. This analysis also determine how the problem/negative outcome can be prevented in the future by addressing employee-level issues as well institutional-level issues that contributed to the event. Just Culture also effectively reverses the present VA “culture of blame” wherein staff are penalized for admitting mistakes.

The Servant Leadership initiative essentially encourages leaders to promote collaboration/teamwork, trust, and ethical behaviors among themselves and employees to meet the needs of the organization and its staff. In its simplest form, Servant Leadership is the ethical use of leadership power.

### **Recommendations for the Department of Veterans Affairs**

- **Reinstate a VA expedited mediation process (similar to what was present in 2014) for OSC cases wherein credible whistleblower is found and there are no confounding factors.**

Although it may be unintentional, the current extreme delays in VA mediation responses imply the VA devalues whistleblowers to the point that it is not even willing to provide adequate resources or expedited processes to ensure those suffering credible retaliation are treated promptly and fairly.

If the Office of Special Counsel (OSC) has determined credible evidence of retaliation exists and there are no confounding employment factors, there is no reason for the VA to delay implementing the remedies to reverse the unfair/unjust personnel actions and appropriately

address the effects the whistleblower retaliation has had on the employee. (I am defining “confounding factors” as substandard employee performance/conduct that normally would justify a major adverse personnel action as defined by as defined by VA Directive 5021/17, Employee/Management Relations. Per that VA Directive, major adverse actions are “suspension, transfer, reduction in grade, reduction in basic pay, and discharge based on conduct or performance”.)

In 2014 the VA had an expedited mediation process for OSC cases wherein credible retaliation was found. Although I am not privy to the details of that confidential process or the rationale for discontinuing it, that 2014 VA expedited mediation process was successfully used to address the whistleblower retaliation against me and other VA employees.

- **Discard the practice of removing/firing probationary employees who have become whistleblowers and who have displayed good work performance/competence during their VA probationary employment.**

The purpose of the probationary period is to determine if an employee is a good fit for the VA position and can function appropriately with other VA team members. If an employee has displayed good work performance/interpersonal skills at his or her position, that employee should be welcomed into the VA system because the VA workforce would benefit from the employee’s presence.

In the past, the VA has fired probationary employees after they become whistleblowers even though there were reportedly no red flags in the employees’ VA work performance. While technically any employee can be fired without cause in the probationary period, the spirit of the applicable regulation/law is to help weed out poor performers including those with poor interpersonal skills and NOT to weed out those with the integrity to speak up about VA problems jeopardizing Veterans’ care or agency mission. In addition, while there are legitimate red flags in probationary period performance that would necessitate firing a probationary employee whether or not the employee was a whistleblower, the VA should not use very minor issues that can be easily corrected with training or instruction as a trumped up excuse to fire a whistleblower when the VA would not use those same issues to fire a non-whistleblower in the probationary period.

- **Ensure that all VA facility Administrative Investigative Boards (AIBs) and Professional Standard Boards (PSBs) are no longer weaponized as tools of retaliation.**

In the VA system, AIBs and PSBs have been weaponized to retaliate against whistleblowers. Unethical use of AIBs and PSBs involve deviating from prescribed regulations for committee set-up and functioning, providing the whistleblower with only limited information/time to address allegations, stacking AIB/PSB committee membership in favor of the retaliator, and drawing conclusions that are not based on the objective evidence. There appears to be almost no accountability for AIB/PSB committee members who act in bad faith.

The VA must ensure that all AIBs/PSBs are conducted in a standardized fashion according to appropriate regulations. However, AIB/PSB regulations can be complex and not all facility HR

personnel are familiar with requirements. While there are several approaches to ensuring AIB/PSB standardization, some measures include 1) creating a system-wide universal standard operating procedure for all AIB/PSB phases that includes rules of procedure, 2) developing a mandatory AIB/PSB checklist that must be completed/signed by committee members and verified by Human Resource staff as being accurate, and 3) holding any AIB/PSB committee member (as well as facility HR personnel) immediately accountable for deviating from the SOP/checklist.

- **Revise VA leadership/supervisor training on whistleblower retaliation to ensure the content is comprehensive, impactful, and reflects real-world concerns of whistleblowers.**

Although I do not recall the exact date, sometime in the last 2 years I was listening to a virtual presentation wherein leadership was receiving training on whistleblower retaliation. Although the training content was technically accurate, it fell far short of discouraging retaliation. The emphasis appeared to be on improving documentation of poor employee performance so that substandard employees could not hide behind “whistleblower” status to avoid accountability for poor performance. While I agree that employees should have appropriately applied accountability for their poor performance, I vehemently disagree with the inference that the vast majority of whistleblowers are just poor performers who became whistleblowers to shirk responsibility for their otherwise substandard performance.

The training would have been much more useful if it had identified examples of the commonly used HR tools surreptitiously used as retaliation, the reasons why those uses violated VA policy/OPM regulations/federal law, and how misuse of those HR tools would not be tolerated within the VA system. The training certainly would have been more impactful if it identified 1) actual examples of consequences for leadership who deliberately misused such HR tools and 2) actual examples of the manner by which VA whistleblowers positively impacted agency operations/mission. The training should have also highlighted 1) ways in which to encourage all employees to identify VA problems without fear of retaliation and 2) methods for leaders to respond to reports of VA problems.

In addition to seeking HR specialist/VA leadership perspectives on content development, VA whistleblower input on/evaluation of training content would help ensure the training addresses whistleblower concerns and is truly tailored to preventing whistleblower retaliation.

- **Incorporate more effective means to encourage leadership to routinely recognize VA employees/whistleblowers who have alerted the chain-of-command about problems jeopardizing Veterans’ care or agency mission.**

Recognizing employees who identify problems and/or solutions to VA operations and safety issues should be incorporated into standard VA workflow. Providing such recognition should be a substantially weighted expectation included in leadership’s annual performance evaluation. In addition, the weekly national VHA call, monthly VISN Executive Leadership Council meetings, and other similar calls/meetings should have a recurring segment in which there is informal & formal recognition of leaders who have encouraged employees to speak up about problems

negatively impacting VA operations and how identification of those problems will positively impact agency operations/goals.

Unfortunately, VA leadership in many places do not routinely offer formal/informal recognition if an employee identifies problems and/or solutions to issues negatively impacting VA operations in any setting. Leadership do not follow the guidelines which are published Handbook 5017/1, Employee Recognition and Awards.

Although the current VA initiatives of “Servant Leadership”, “Just Culture”, and “High Reliability Organization” theoretically would encourage positive leadership behavior and incorporation of employee recognition into standard VA workflow, those initiatives’ principles have not been effectively operationalized.

- **Revise Just Culture training/forms and then roll out “Just Culture” to more VA facilities so that all VA employees will be encouraged to proactively identify and report patient health and safety concerns.**

If effectively implemented, the Just Culture initiative replaces a “culture of blame” with balanced accountability for staff and the institution whenever negative outcomes occur. The Just Culture approach should significantly alleviate fear of retaliation/unjust treatment for identifying and reporting issues that negatively impact a facility’s operations and safety.

I recently reviewed some forms used by large VA facility to promote “Just Culture” when assigning accountability to adverse patient safety events. I was appalled to see the forms neglected to formally evaluate/document whether institutional factors (e.g., short staffing, lack of proper process, lack of resources, etc.) contributed to the negative outcome. While the form did list some employee factors that would mitigate the type of accountability attributed to the employee, the document essentially still resulted in unilaterally assigning blame and instituting a punitive approach to address employee behavior.

That punitive approach is not consistent with Just Culture principles. I am concerned that employees will not readily identify health and safety issues in such a punitive environment. If the Just Culture principles are being incorrectly applied in one large VA facility, I am concerned that Just Culture is being incorrectly operationalized at other VA facilities.

- **Emphasize proper execution of Peer Review/Root Cause Analysis (RCA) to include the need to formally consider/document/report all institutional factors contributing to negative outcomes.**

While processes for Peer Review and RCA theoretically should include institutional factors/accountability for negative outcomes, in the VA such consideration is not consistently/objectively performed or documented. For each case/event being reviewed, there should be an enforced requirement for every Peer Review committee and Root Cause Analysis committee to formally solicit/document information on whether there were institutional processes that failed and/or otherwise contributed to the negative case/event outcomes. There should be a standard operating procedure in place for the Peer Review committee/RCA

committee to ensure that institutional accountability is assigned and institutional deficiencies are proactively addressed so the risk of future negative outcomes can be reduced.

While there are many ways to emphasize such institutional analysis, one potential way would be to develop a standardized reporting form which each involved employee would be required to complete and every committee would be required to consider. In addition to filling out a “blank” section describing his or her account of the event/case, the employee would also be given the option to complete the pre-printed form questions including, but not limited to, 1) “Are there pertinent facility factors (e.g., lack of resources/inadequate standard operating procedures/understaffing or other issues) that you believe contributed to the outcomes in this incident? If so, please explain.”; 2) “Have you previously reported institutional factors you believe contributed to this negative outcome or could have prevented this negative outcome? If so, please explain.”; 3) “Can you identify any facility process improvements or potential equipment/resources that could prevent this incident from re-occurring in the future? If so, please explain.”

Emphasis on analyzing institutional/facility factors and appropriately assigning institutional accountability is consistent with the VA initiative of “Just Culture” and “High Reliability Organization”.

### **Recommendations for the Office of Accountability & Whistleblower Protection**

*Note: I only have very limited recommendations for the OAWP because its processes are not transparent to me. I am proposing the following remedies based on my experiences detailed in Section IV of this written testimony.*

- **Speed up the time for triage intake/follow-up of OAWP complaints.**
- **Foster transparency in OAWP procedures so that complainants filing with the OAWP are aware exactly where their documentation/complaint will be forwarded at each step of the OAWP process and are informed of the approximate timelines for each OAWP process step.**
- **If referral of a complaint is necessary, establish processes to ensure the content of any referred complaint is handled by a neutral party at the complainant’s VISN office or facility.** (Ideally no referrals of whistleblower complaints would occur.)
- **If not already doing so, based on the nature of the whistleblower retaliation allegations that are received, make ongoing content recommendations for real-time field updates and training pertaining to the prevention of VA whistleblower retaliation.**
- **If not already doing so, if the OAWP has inadequate resources, consider narrowing the scope of investigations conducted directly by OAWP staff to emphasize its current strengths (speed and agility) to address major adverse actions against whistleblowers.**

Although I do not have official data, I have anecdotally been told that a number of claims submitted to the OAWP are either for allegations completely unrelated to whistleblower retaliation or allegations in which the retaliation is not classified as a major adverse action by VA

Directive 5021/17. (Per that VA Directive major adverse actions are “suspension, transfer, reduction in grade, reduction in basic pay, and discharge based on conduct or performance.)

While any type of credible whistleblower retaliation is unacceptable, the OAWP likely does not have the manpower resources or processes to personally investigate every allegation of whistleblower retaliation.

If not already doing so, assuming OAWP resources are so limited that it must prioritize its activities, the OAWP should consider concentrating its available OAWP manpower on 4 activities 1) determining whether SES executives are facilitating retaliation, 2) determining if there are credible allegations of whistleblower retaliation in situations where the whistleblowers are facing unjust major adverse actions, 3) quickly reversing major adverse actions that reasonably appear to be stemming from whistleblower retaliation on investigation, and 4) monitoring/tracking data pertinent VA whistleblower retaliation.

(Note: If the OAWP is not already doing so, the minimum pertinent OAWP data to monitor would include frequency of allegations of VA whistleblower retaliation, types of personnel actions that are reported in allegations of whistleblower retaliation, facility/service line implicated in allegations of whistleblower retaliation, and number/facility/service line/major adverse action in substantiated whistleblower retaliation cases. That data could help the VA monitor whistleblower retaliation, identify trends, and proactively address areas where there are concerns about retaliation and/or indications of a need for facility/service line cultural change.)

When conducting OAWP investigations involving SES executives or major adverse actions, the OAWP may choose to use its own employees for the investigation or obtain the assistance of non-OAWP VA subject matter experts. However, to avoid bias and potentially increasing the risk of further retaliation against the whistleblower, the OAWP should never delegate the primary investigative process back to the facility or the facility’s VISN office if the case involves SES executives or major adverse actions against complainants.

If the OAWP is referring any retaliation complaints to the VISN/facilities, then it must establish standardized processes to ensure the content of any referred complaint is handled by a neutral party at the complainant’s VISN office or facility.

- **Take appropriate steps to ensure OAWP decisions are not influenced by internal pressure from VA Central Office.**
- **Do not solicit case documents when a potential complainant is already in the OSC investigative stage or mediation process.**

## **Recommendations for Congress**

- **Consult with the Office of Special Counsel (OSC) to determine what additional budget allocation would enable the OSC to effectively manage its entire caseload and backlog in a timely manner and meet projected caseload needs.**

In general, the largest portion of OSC claims are filed by VA employees. At the end of 2018, the OSC had a backlog of over 2,600 cases while still receiving new claims at historic levels. The general budget request for the OSC is 1% lower than last year. The OSC recently was able to hire 11 additional staff due by lowering its financial lease obligations, which will improve its ability to handle its caseload. However, additional budgetary monies may still be required to enable it to address all new and backlogged claims in a timely fashion and proactively address projections on the numbers of claims which will be filed in the coming fiscal year.

- **Use bipartisan influence to ensure that a 3 member Merit Systems Protection Board quorum is immediately established.**

The MSPB is the safety net for all federal employees who have legitimate claims of adverse/unfair personnel actions including those who are VA whistleblowers. The MSPB has not had a quorum for over 2 years. Without a quorum no MSPB appeals can be decided. As a result there is a backlog of over 2,000 petitions and other cases – each day of delay for each case has potentially significant negative impact on an employee’s career, livelihood, and psychosocial well-being.

Although 2 MSPB nominees have been approved in committee, they have not been submitted for full vote because there is a wait for select a 3<sup>rd</sup> nominee. (Of the 3 nominees originally selected, 1 nominee withdrew his name from consideration.)

(An employee can choose to bypass the MSPB delays by filing directly in federal circuit court. However, this option is out-of-reach for many federal employees because it is extremely cost-prohibitive and lengthy.)

- **Allocate sufficient budgetary monies for the Merit Systems Protection Board (MSPB) to fulfill its mission requirements in a timely manner and recruit additional staff to replace pending retirements.**

The budget request for the MSPB is 10% lower than last year. The MSPB had stated the budget cut will significantly impact multiple operations and also affect its ability to address staffing needs for pending retirements. The MSPB is a major safety net for federal employees and should not be jeopardized.