S. Hrg. 114–586

NOMINATIONS OF MICHAEL J. MISSAL AND HON. CAROLYN N. LERNER

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

NOMINATIONS OF MICHAEL J. MISSAL TO BE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND HON. CAROLYN N. LERNER TO BE SPECIAL COUNSEL, U.S. OFFICE OF SPECIAL COUNSEL

January 12, 2016

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Committee on Homeland Security and Governmental Affairs

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NOMINATIONS OF MICHAEL J. MISSAL AND HON. CAROLYN N. LERNER

TUESDAY, JANUARY 12, 2016

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senators Johnson, Portman, Lankford, Ayotte, Ernst, Sasse, Carper, McCaskill, Tester, Baldwin, Heitkamp, and Peters.

Chairman JOHNSON. This hearing will come to order. I want to welcome everybody. Good morning.

Today the Committee is considering two nominations: Mr. Michael Missal to be the Inspector General (IG) for the Department of Veterans Affairs (VA), and Ms. Carolyn Lerner, renominated for a second term as United States Special Counsel of the Office of Special Counsel (OSC). I understand that Senator Tester has a tight schedule this morning, so I thought we would get going right away because I know Senator Tester would like to introduce Mr. Missal.

OPENING STATEMENT OF THE HONORABLE JON TESTER, A UNITED STATES SENATOR FROM THE STATE OF MONTANA

Senator TESTER. Yes, thank you, Mr. Chairman. Interestingly enough, I have a meeting with the Secretary of the VA at 10 o'clock, so I appreciate your allowing me to go first.

I want to thank you, Mr. Chairman, and Ranking Member Carper for holding this hearing today. Today we are going to consider the names of two individuals who can bring forth stronger oversight and accountability to the Federal Government while also ensuring that we are better supporting and empowering Federal whistleblowers.

I want to take this opportunity to introduce Michael J. Missal, who has been nominated to serve as the Inspector General of the Department of Veterans Affairs. This nomination should not be in doubt. Mike has extensive investigative and management experience. He has gained this through a number of high-profile investigations, audits, and inspections over the years. And, Michael, I want to thank you for being here, and thank you for your willingness to serve. And I also want to thank the members of your family for being here today.

At no fault of your own, this nomination has been a very long time in coming, and I certainly share the frustration of the Chair-

man, Ranking Member, and Members of this Committee who have been waiting impatiently for 2 long years. Particularly given the turbulence of the last couple of years, it is unacceptable that the VA has been without a permanent Inspector General to provide the kind of leadership and independent oversight necessary to hold the VA accountable and to guide the Office of Inspector General (OIG) through its increasing workload. Now at long last the ball is in this Committee's court.

I personally met with Mike late last year to discuss his credentials and his experience and to ensure that he was fully aware of the task, a very difficult task, that is at hand. I believe that he is superbly qualified for this nomination. His skill set, his experience, and his temperament are right for the job, and he is certainly ready to go to work.

During our discussion it was clear that Mike and I shared the belief that the public's confidence and trust in the VA have been greatly undermined, and it will take a long time, I might add, before that trust and confidence will be restored. If confirmed, Mike will play a critical role in this process.

It is clear that the VA needs to operate in a more transparent manner, and it needs to be held accountable when it is not doing right by the veterans of this country. The omnibus appropriation bill that we passed late last year makes historic investments in the VA health care. I fought for every dollar that is in that bill. But while I am pleased with these significant new investments in our veterans, we have the responsibility to make sure that the money is properly spent. If confirmed, we will expect Mike to do the same. We cannot afford to make these investments without knowing they are producing real results for the veterans who have earned it. We also cannot afford to allow systematic failures to continue, failures that deny or delay care for veterans or in any way compromise their well-being.

For instance, it was just reported in Montana that the private information of hundreds of veterans may have been compromised by the VA. We need increased accountability, and we need it today.

Later today, the Senate Veterans' Affairs Committee, of which I am also a member, will vote to move Mr. Missal's nomination forward. I am confident that his support will be overwhelming and probably unanimous. But now is the time for this Committee to act. I am hoping we can move forward on this nomination in the coming days to ensure that the VA's Office of Inspector General can finally have the permanent leadership and oversight that we have been demanding for the past 2 years. It is a critical step if we are to rebuild the trust of the public and particularly of our veterans in the agency that was created to ensure that we properly honor and care for those who have sacrificed so greatly for this country.

Mike, I just once again want to thank you for your willingness to serve. It is truly appreciated. Chairman Johnson, Ranking Member Carper, thank you again for holding this hearing today. This is an important step forward for the VA. It is an important step forward for our veterans. Like I said earlier, I hope we can move on Mike Missal's nomination as IG as soon as possible.

Thank you.

Chairman JOHNSON. Thank you, Senator Tester. Again, I think we all share your frustration that we have not had a nomination for a permanent Inspector General at the VA, and we are very pleased that Mr. Missal is willing to serve.

I know when I met with you in my office, I was very grateful that you are willing to serve. This is a troubled Inspector General's office. It just is. And we will talk about that later.

I know you both have family members. We are waiting for Senator Cardin to introduce Ms. Lerner. Maybe you would like to just quickly introduce your family members, whom we also welcome. Mr. Missal.

Mr. MISSAL. Sure. I have my wife, Deborah, here and son, Jordan, who is a senior at Washington and Lee University.

Chairman JOHNSON. Welcome.

Senator CARPER. Is Jordan the one wearing the green tie?

Mr. MISSAL. Green tie.

Senator CARPER. Thank you.

Ms. LERNER. My husband, Dwight Bostwick, is here with me. Our two children, Ben and Anna, would be here if they could be, but they are back at college. But they sat through the first hearing, so I cannot really hold it against them.

OPENING STATEMENT OF SENATOR JOHNSON

Chairman JOHNSON. We certainly welcome you and your family members, and we truly appreciate the fact you are willing to serve your Nation in these capacities. These are not easy jobs.

I do have an opening statement which I would ask consent to have entered in the record.[1]

But let me just talk about why this is in many respects so personal to me. Ms. Lerner, when I had you in my office yesterday, I told you that I came here because we have some enormous problems. And I have to admit, when I first contemplated running for the U.S. Senate, I was not thinking about really delving into the Office of Inspector General and taking a look at all the details there. Well, actually we have Senator Cardin here. Senator Cardin, are you ready to introduce Ms. Lerner right off the bat?

Senator CARDIN. I apologize.

Chairman JOHNSON. No. That is fine. To be respectful of your time, if you are ready to go, why don't you make your introduction of Ms. Lerner? Then I will continue with my opening statement.

OPENING STATEMENT OF THE HONORABLE BENJAMIN L. CARDIN, A UNITED STATES SENATOR FROM THE STATE OF MARYLAND

Senator CARDIN. Thank you, Mr. Chairman. I appreciate the courtesy of allowing me to introduce Ms. Lerner, and, Ranking Member Carper and Members of the Committee, it really is a pleasure to be here today to introduce to the Committee Carolyn Lerner, who happens to be a Marylander, who has been nominated to another term as Special Counsel of the United States Office of Special Counsel, and I am pleased to support her nomination.

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[1] The prepared statement of Chairman Johnson appears in the Appendix on page 31.

Ms. Lerner received her undergraduate degree from the University of Michigan and her law degree from New York University (NYU) School of Law, and after clerking, she made the extremely wise decision to move to the State of Maryland. She has been a Maryland resident for 25 years and now lives in Montgomery County, Maryland.

OSC, I think you all know, is an extremely important agency. The work that is done by OSC is critically important to our Federal workforce and to our laws. They are basically responsible for the implementation of the Civil Service Reform Act, the Whistleblower Protection Act (WPA), the Hatch Act, and the Uniformed Services Employment and Reemployment Rights Act (USERRA). They safeguard the merit system.

Mr. Chairman, I am very proud of our Federal workforce. I think we have the best Federal workforce in the world, dedicated public servants. But it depends upon individuals who are willing to step forward to make sure that system continues.

It is not easy to be a whistleblower. It takes courage. And this position that Ms. Lerner has been renominated for guarantees that these laws work properly. And I must tell you it does take some courage for people to participate in the system. Ms. Lerner has brought needed stability, continuity, and professionalism to the office. Ms. Lerner has reduced OSC's costs to resolve a case by 45 percent, leading to record levels of productivity. In 2015, OSC resolved over 6,000 cases, which is an over-50-percent increase from the year that Ms. Lerner took office. She overhauled the alternative dispute resolution program, as mediation can often save time and money in producing better outcomes, and has earned praise from the Government Accountability Project (GAP) for setting new global gold standards for alternate dispute resolution (ADR).

When it comes to results, the number of favorable actions on behalf of whistleblowers and the merit system, she has consistently set records. In 2015, her office secured 268 favorable actions from whistleblowers and other employees, up from 201 favorable actions in 2014. The results speak for themselves. She has saved us money, and she has resolved cases, and has resolved them in a favorable manner.

I am very proud to support her nomination. Let me just cite a couple examples because this is what this is about. It is about the credibility of our system.

One involved the Air Force Port Mortuary in Dover, Delaware. They discovered misconduct regarding the improper handling of human remains of fallen servicemembers, which ultimately led to corrective action by the Air Force. That is the type of matters that we are talking about which her professionalism has helped to resolve.

Her work with whistleblowers at the Department of Homeland Security (DHS) revealed improper management of annual overtime payments, resulting in millions in cost savings to taxpayers, saving taxpayer dollars.

And OSC's work with Veterans Affairs whistleblowers has helped to improve the quality of health care of our veterans.

She has received numerous endorsements, and many of them I will just put into the record, but let me just end with Congressman Jeff Miller. The Chairman of the House Committee on Veterans' Affairs wrote to the Committee to express his "enthusiastic support for the confirmation of Ms. Carolyn Lerner for reappointment to lead the Office of Special Counsel. Ms. Lerner has been an outstanding Special Counsel who marshaled her office resources admirably to respond to the unexpected wave of VA complaints. She has worked tirelessly to promote accountability and restore confidence in the VA. Therefore, I offer my wholehearted support for her confirmation for another term as Special Counsel."

I agree with Congressman Miller, and I urge the Committee to consider her nomination and to report it favorably to the floor in a timely manner so that she can continue the great work she is doing on behalf of the American people.

Chairman JOHNSON. Thank you, Senator Cardin.

It is interesting that in the introductions by both Senator Tester and Senator Cardin—I made a couple notes. Senator Tester talked about the importance of the Inspector General and, quite honestly, of the Special Counsel to be transparent and accountable, which is really what we need all of government to be—transparent and accountable. And I completely agree with you, Senator Cardin, coming from the private sector, where I have seen excellence because of our free market competitive system, very impressed with the quality of the Federal workforce. I realize, people with the skill level that are engaged in these agencies could make more in the private sector, but they do, as patriots, as committed Americans, serve our government, have less pay, and they do a really good job.

And you are also right that it is very difficult to step forward, and it is difficult to step forward because this is the shock that I have experienced, coming from the private sector, is the level and pervasiveness of retaliation against those individuals, those whistleblowers, which is why this hearing and these nominations and these positions that we will be voting on your confirmation for are so incredibly important.

I asked for my opening statement to be entered into the record, and, by the way, those letters of recommendation[1] will be also.

I just want to take a couple minutes to talk about the story of why this is so important. Again, I said I did not come here to delve into Inspectors General. I mean, I did not know much about it until I landed on this Committee. It really began with the events in Cartagena and a hearing we had with the Director of the Secret Service really denying the reality of the problems occurring within that agency. And as we continued to delve, my staff continued to delve into the problems involved in the report from the Office of Inspector General on the events in Cartagena, we realized that the report had been doctored. There was not integrity, there was not independence, there was not accountability from the Office of Inspector General.

Now, that was the Office of Inspector General within the Department of Homeland Security, and that was an Acting Inspector General that I think was corrupted by that individual's desire to be ap-

[1] The letters of recommendation appear in the Appendix on page 307.

pointed the permanent Inspector General. It is a really bad idea. So that was my first foray into understanding how an Office of Inspector General, whose sole purpose is to be the watchdog of these agencies, to be independent and transparent and accountable, how that office can be corrupted.

Fast forward to January 8, 2015. Aaron Glantz of the Center for Investigative Reporting breaks a story about Candy Land and Candy Man at the Tomah VA. The story publicized the existence of a then-secret—I want that word to seep in—a "secret" report from the VA Office of Inspector General that examined and whitewashed Dr. Houlihan's questionable prescription practices. That was on January 8, 2015, the first time I heard that there were problems at the Tomah VA.

On January 12, Candace Delis of Wisconsin took her father, Thomas Baer, a veteran of this country, to the Tomah VA Urgent Care Center with stroke symptoms. Mr. Baer sat in the waiting room—this is somewhat disputed—2 to 3 hours, probably suffered a couple strokes, died a couple days later. They finally transported him to Gunderson Lutheran to try to get adequate care, but he could not be saved.

Here is the point I want to make. A few days later, when I was talking to Candace Delis, she told me, "Senator, had I only known"—"had I only known the problems at the Tomah VA Health Care Center, I never would have taken my father to that center." She came from Marshfield, Wisconsin, a Medical Center of Excellence. I have to believe her father, Thomas Baer, would be alive today had she only known.

Now, upon hearing this, a new Chairman of this Committee, I assigned my staff the job of investigating the Tomah health care facility. In 3 months, I think we uncovered more problems in that facility than the VA Office of Inspector General uncovered in a 3-year investigation. They first had an allegation, a complaint, in March 2011, a 3-year investigation, finally issued a report in March 2014, which they did not make public. By the way, that was one of 140 other reports on investigations and inspections that they did not make public.

I have asked other Inspectors General about how many reports they have kept private, away from the public, and they look at me like I am from another universe. It is just basically unheard of unless there are issues of national security.

So there is a real problem, Mr. Missal, in the Office of Inspector General within the VA system, and that is why I said, God bless you for taking on this task. You have a very large task at hand.

We will talk a little bit later about this White Paper. Again, it took 3 years for the Office of Inspector General to investigate and then issue a non-public report on the problems within Tomah. It only took them a couple months to write and make public a report that retaliated—the Office of Inspector General wrote a report that retaliated against the whistleblowers of the problems at the Tomah VA system. That is why these positions are so incredibly important. That is why we need people of integrity that will be independent, that will be transparent, so that the agencies within this Federal Government are held accountable.

So, again, I am looking forward to the hearing. I think that certainly underscores why this is so important, this hearing, and I look forward to it. With that, I will turn it over to my Ranking Member, Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Thanks, Mr. Chairman. Thanks for calling this hearing today and bringing us together. It is good to see all my colleagues again. And it is very nice to see both of you and to have a chance to see your spouses and at least a child or two. I want to thank your spouses for their willingness to share you, each of you, with the people of our country and to allow you to do this service. We know from our own experience that these are tough and demanding jobs, and so we are especially grateful for the family members, the sacrifices that you make to allow them to serve.

I want to begin by welcoming back Carolyn Lerner. It is nice to see you. But she is no stranger to this Committee, and Carolyn is not a stranger either to the position to which she has been nominated. And as we heard, the Office of Special Counsel has a number of very important functions. Around here, it is probably best known as the primary office for enforcing whistleblower protections.

We all know that whistleblowers play an important role, I think an increasingly important role, in rooting out waste, fraud, and abuse in government. They are often the first to raise concerns and highlight instances where we can better serve the American people. The Special Counsel's Office also plays an important role in ensuring that whistleblowers are heard and that they are protected after they speak up.

I have seen firsthand—and it has been alluded to—the good work that the Office of Special Counsel has done at the Dover Air Force Base, especially with the Port Mortuary there where the remains of our fallen heroes are brought from all over the world. Several years ago, we learned that, thanks to some whistleblowers there, that some of the behaviors, some of the actions taken within that mortuary were inappropriate—maybe not illegal but inappropriate and just wrong-headed and wrong. And the folks who raised these concerns were retaliated against. They were retaliated against to the extent of losing their jobs.

I remember one of them, whose name was "Mr. Z," showing up at our doorstep in our Dover office, my Dover Senate office, and laying out what was going on. And we ended up talking with him and other whistleblowers. The Office of Special Counsel got involved, and lo and behold, a year later, when I visited the Port Mortuary—I try to go by there every year or two, and I visited to see how things were going, and the people who greeted me at the entrance there were the whistleblowers. And the people who did not greet me during that tour were the colonel who had run the place. He was gone. And the other person who did not welcome me for that tour was a senior civilian employee there who was gone. And I just want to thank you, not just on behalf of those people who had the courage to raise their heads and raise their hands and say something is wrong here, but on behalf of all the people and

all the families who will rest easier because of the work that you have done.

It is also my understanding—and Senator Cardin has alluded to this—that under your leadership, Carolyn, these positive outcomes that I have just referred to have become more frequent and that your agency has markedly improved as a resource for whistleblowers. We look forward to hearing from you about what you and your team have accomplished, as well as to learn of your plans for continued improvement going forward.

I also want to welcome this morning Michael Missal and thank him for his willingness to be considered for this very important position of Inspector General at the VA.

As we all know and have heard already, IGs play an extremely important role in our government. Their work helps us save money, reveal and prosecute wrongdoing, promote the integrity and efficiency of government, and, hopefully, increase the confidence of the American people in their government.

Unfortunately, we have seen far too many IG positions, including the one Mr. Missal has been nominated to fill, sit vacant for far too long. In fact, the VA has been without a permanent Senate-confirmed Inspector General, as we heard, for more than 2 years.

In the past couple of years, in fact, in the last Congress and in this Congress, Dr. Coburn and I and now Senator Johnson and I have sent letters to the President from every member of this Committee in two Congresses now saying to the President we know you are busy, and we know there is a lot going on in the White House, but these IG vacancies, these positions have been vacant for too long, you need to do something about it.

To his credit, and his staff over there, they have done something about it, and your presence here today is further evidence of that. We keep having IGs step down, so there are new vacancies to fill. But we are getting, I think, much better support out of the White House, and our job is now to do our job.

I will close with that. I just ask that the rest of my statement be entered for the record,[1] if I could, and, again, welcome one and all. We look forward to hearing from you. Thank you.

Chairman JOHNSON. Without objection, it will be.

It is the tradition of this Committee to swear in witnesses, so if you will both rise and raise your right hand. Do you swear the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. MISSAL. I do.

Ms. LERNER. I do.

Chairman JOHNSON. Our first nominee is Mr. Michael Missal. Mr. Missal is the nominee to be Inspector General at the Department of Veterans Affairs. He is currently a partner at the law firm K&L Gates, where he leads the firm's policy and regulatory practice groups. Mr. Missal holds a B.A. from Washington and Lee University and a J.D. from the Catholic University of America. Mr. Missal.

[1] The prepared statement of Senator Carper appears in the Appendix on page 33.

TESTIMONY OF MICHAEL J. MISSAL,[1] NOMINEE TO BE INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. MISSAL. Thank you. Chairman Johnson, Ranking Member Carper, distinguished Members of the Committee on Homeland Security and Governmental Affairs (HSGAC), and veterans who have served our great Nation. It is an honor and privilege to testify before you today as the nominee to be the Inspector General of the Department of Veterans Affairs.

This would have been an incredibly proud day for my parents, Harold and Rose Missal, but unfortunately both passed away a number of years ago. Aside from family, the most important things in my father's life were his military service and his public service. My father was a World War II veteran who fought in Europe with the Army's 286th Engineer Combat Battalion. He was a proud veteran and truly one of the "Greatest Generation."

My father was also a State judge in Connecticut for more than 30 years. He instilled in me the importance of public service and the concept of "giving back." He believed that there was no higher calling than being in public service and working hard to make a difference in people's lives. I started my legal career in public service and have always desired to return to it. I cannot imagine a more meaningful or important role than the Inspector General of the Department of Veterans Affairs.

The Mission Statement of VA is to fulfill President Lincoln's promise: "To care for him who shall have borne the battle and for his widow, and his orphan" by serving and honoring the men and women who are America's veterans. VA provides essential services and benefits to our veterans, but it has more work to do to live up fully to President Lincoln's promise.

This is a particularly critical time for VA as it attempts to rebuild the trust and confidence it has lost from our veterans, Congress, Veterans Service Organizations (VSOs), and the American public. The VA Inspector General plays a crucial and independent role in assisting VA meet its mission and identifying the instances where it falls short. The need to eliminate waste, fraud, and abuse and to promote efficiency and integrity at VA may never have been greater. Recent public reports from the Office of Inspector General and elsewhere underscore the need for significant and prompt improvements in the way VA is servicing our veterans. If confirmed, I look forward to playing a role in strengthening the programs, policies, and culture of VA.

I have had the opportunity recently to meet with many of you and to hear your thoughts and views about VA and the workings of the Office of Inspector General. The discussions have been extremely constructive and valuable. I recognize your bipartisan approach to these issues and the great frustration in VA not fully meeting its mission.

Many of you discussed the important role that whistleblowers play in identifying potential issues. I also believe that whistleblowers are immensely important to the work of the VA Office of Inspector General. If confirmed, one of my goals will be to promote an improved environment in which whistleblowers have confidence

[1] The prepared statement of Mr. Missal appears in the Appendix on page 35.

that their concerns will be fairly and effectively considered by the Office of Inspector General and that their identities will be protected from disclosure. I will also take the necessary steps to ensure that whistleblowers are fully aware of their right to be free from reprisal for making protected disclosures and how to seek redress from appropriate authorities if reprisal occurs.

I believe that I have the experience, skills, judgment, and temperament to be a highly effective Inspector General. My professional career has provided me with valuable and extensive experience in investigations, audits, and inspections, three of the primary functions of an Inspector General. I have successfully conducted a number of complex and high-profile investigations. With respect to audits, I have routinely dealt with accounting principles and auditing standards. Finally, I have been involved in the inspections of various entities.

My service on the Management Committee of K&L Gates and my role as the co-practice area leader of the policy and regulatory practices have provided me with significant management experience. As a co-practice area leader, I am responsible for the performance of more than 200 policy and regulatory lawyers and professionals. The Management Committee is also responsible for the overall business and operations of the firm, including developing a budget for a firm with over $1 billion in revenues.

If confirmed, I pledge to work tirelessly and independently on behalf of our veterans and the American public. I also pledge to work collaboratively with this Committee and other Members of Congress and their staff. Thank you for the opportunity to testify before you today, and I look forward to your questions.

Chairman JOHNSON. Thank you, Mr. Missal.

Our second nominee is Ms. Carolyn Lerner, who has been renominated to serve a second 5-year term as United States Special Counsel of the Office of Special Counsel. She holds a Bachelor's degree from the University of Michigan and a law degree from New York University Law School. Ms. Lerner.

TESTIMONY OF THE HONORABLE CAROLYN N. LERNER,[1] NOMINEE TO BE SPECIAL COUNSEL, U.S. OFFICE OF SPECIAL COUNSEL

Ms. LERNER. Thank you. Chairman Johnson, Ranking Member Carper, Members of the Committee, thank you for the opportunity to testify today. I also want to thank Senator Cardin for his kind words.

I want to thank my family for their support and encouragement over the last 4½ years since I have taken on the new challenge of heading up the Office of Special Counsel. I am honored that the President renominated me to serve a second term.

I want to acknowledge the OSC leaders that are here today. I am very proud to serve with these exemplary public servants.

Senator CARPER. Could we ask them to raise their hands?

[Hands raised.]

All right. Thank you all.

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[1] The prepared statement of Ms. Lerner appears in the Appendix on page 80.

Ms. LERNER. I can say, without hesitation, that the Office of Special Counsel is engaged in the most productive period in its history, and this productivity is due to the hard work of all of OSC's employees—the folks who are here today, the people in the field offices, in Washington, D.C., Oakland, Dallas, and Detroit. I am very proud to serve with all of them.

Our strong results in whistleblower retaliation, whistleblower disclosure, Hatch Act, and USERRA cases demonstrate this office's ability to promote better and more efficient government. For example, our work with whistleblowers has prompted improvements in the quality of care for veterans at VA centers across the country. We have protected Customs and Border Protection (CBP) whistleblowers who reported widespread waste and improper overtime payments at the Department of Homeland Security. And by working with this Committee in oversight hearings, Congress passed bipartisan legislation that will save $100 million a year. That is about four times OSC's annual budget.

And we vigorously enforced the Hatch Act and worked with this Committee, particularly then-Senator Akaka and Senator Mike Lee, to modernize the act by limiting the Federal Government's unnecessary interference with State and local elections.

When I was first nominated as Special Counsel, I often remarked that OSC was the best kept secret in the Federal Government. I wanted this to change so that more employees and taxpayers could benefit from the work of this small but effective agency. And change it has.

In 2015, for the first time in the agency's history, we received and resolved over 6,000 new matters, a 50-percent increase from 2011, when I first took office. This dramatic increase in filings indicates that whistleblowers believe they can make a difference by coming to OSC. Studies have shown that the No. 1 reason that employees do not report waste, fraud, or abuse is not because they fear retaliation. It is because they do not believe any good will come from their taking the risk. If the number of cases filed is any indication of employees' willingness to raise concerns—and I think it is—then we are moving in the right direction.

Given that the demand for OSC's services has far exceeded our small agency's resources, we have needed to find new and more efficient ways to approach increasing caseloads, and we have. OSC's cost to resolve a case is down by 45 percent, leading to record levels of productivity, and I have focused on being a careful steward of the taxpayer dollars.

I have also found better ways to manage cases. For example, I reinvigorated our alternative dispute resolution program because we know that mediation saves time and money for both agencies and employees alike, and it often results in better outcomes. And we are currently experimenting with an innovative approach to managing whistleblower cases. The new approach consolidates four OSC positions into one. This is proving to be both efficient and effective. By taking these smart approaches to our growing caseload, we are generating efficiencies without compromising the quality of OSC's work. Indeed, when evaluating the most important statistic—the number of favorable outcomes for whistleblowers and the merit system—we are consistently setting records. For exam-

ple, in 2015, we secured 278 favorable actions for whistleblowers and other employees. Prior to my tenure, the number of favorable actions had dropped to 29 and was consistently below 100 per year.

But statistics cannot capture OSC's true impact. Our work with whistleblowers often saves lives and sparks reforms that prevent wasteful, inefficient, or unsafe practices.

In summary, I am very grateful for the opportunity to have served as Special Counsel. But there is still much to be accomplished. If confirmed for a second term, I hope to build on current successes. I will continue to protect VA and all other Federal employees from retaliation, and we will strive to find new ways to use our limited resources to improve government.

I thank this Committee for 4½ years of a productive relationship. I look forward to answering your questions.

Chairman JOHNSON. Thank you, Ms. Lerner. I want to thank all my colleagues that have come here. It just underscores really how important we all feel these positions are and what these positions have to do and what they offer to government. Because we have so many members, we are going to limit questions to 5 minutes.

Let me start out. I have some questions I am going to ask both of you, and I would like both of you to answer in series.

The first one: Is there anything you are aware of in your background that might present a conflict of interest with the duties of the office to which you have been nominated? Mr. Missal

Mr. MISSAL. I do not.

Chairman JOHNSON. Ms. Lerner.

Ms. LERNER. I do not.

Chairman JOHNSON. Do you know of anything personal or otherwise that would in any way prevent you from fully and honorably discharging the responsibilities of the office to which you have been nominated? Mr. Missal.

Mr. MISSAL. I do not.

Chairman JOHNSON. Ms. Lerner.

Ms. LERNER. No, I do not.

Chairman JOHNSON. Do you agree without reservation to comply with any request or summons to appear and testify before any duly constituted Committee of Congress if you are confirmed? Mr. Missal.

Mr. MISSAL. I do, Mr. Chairman.

Ms. LERNER. Yes, I do.

Chairman JOHNSON. OK. Thank you.

Let me go back to the White Paper. Again, not to beat a dead horse, but I think it is just such a powerful example of why these positions are important and really to get your commitment, both of your commitments, to make sure that we rectify the problems within particularly the Office of Inspector General.

There was a whistleblower, Dr. Chris Kirkpatrick. He came forward. He was trying to get the attention of the management within the VA about the overprescription of opiate drugs. Because he came forward, he was terminated. The day of his termination he committed suicide.

If that is not tragic enough, on June 4, 2015, after spending 3 years investigating and then not publishing a report on the problems of the VA health care system, the Office of Inspector General

issued and made public a White Paper that included this statement: "I strongly recommend a thorough review of the in-depth sheriff's report, a publicly available document that is included in the documents produced, records produced, pages 5795 to 5851, with specific attention to the pages detailing the voluminous amounts and types of marijuana and what appears to be other illegal substances found in Dr. Kirkpatrick's residence as well as other items including a scale and used devices containing marijuana residue. The evidence indicates that Dr. Kirkpatrick was likely not only to have been using but also distributing the marijuana or other illegal substances."[1]

I have no idea what any of this had to do with the issue at hand in terms of the overprescription of opiates that resulted in veterans' deaths and the lack of care that resulted in the death by lack of care to Thomas Baer. This is the Office of Inspector General writing a report that is retaliating against a dead whistleblower.

Now, I asked Ms. Linda Halliday, when she testified before us, I wanted to know who was involved in this within the office. There is a problem within the office. I have not gotten that answer, and that is my first question to you, Mr. Missal. Are you disturbed by this?

Mr. MISSAL. I am disturbed by the language in the White Paper, yes.

Chairman JOHNSON. Are you disturbed that the White Paper was ever issued?

Mr. MISSAL. I just do not know enough about the facts and circumstances as to why it would, but that is certainly one of my first priorities would be to look at that.

Chairman JOHNSON. Will you cooperate with this Committee and me to find out who was involved in the writing of this White Paper in the office?

Mr. MISSAL. Mr. Chairman, I will provide you the information you need to get the answers to your questions.

Chairman JOHNSON. Also, this Committee was forced, because of the lack of cooperation by the Acting Inspector General, to issue a subpoena on April 29. That subpoena has yet to be complied with.

Now, we are getting many excuses for not complying with it, privacy issues. We do not want to reveal any private information. Obviously, the Office of Inspector General had no problem revealing private information publicly. We certainly have no interest in that. Will you commit yourself to making sure that our subpoena is complied with so we can get to the bottom of not only the problems within the Tomah VA system but within other health care systems within the VA, but also to get to the bottom of the problems within the Office of Inspector General? Will you comply with that subpoena?

Mr. MISSAL. Mr. Chairman, I have not seen the subpoena, but I certainly will look at it. My goal is to have a cooperative and collaborative relationship with this Committee. I hope in the future we do not need any more subpoenas. But I commit that I will look at the subpoena and will address all the issues in it.

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[1] The White Paper referenced by Senator Johnson can be found in the Appendix on page 333.

Chairman JOHNSON. OK. I will be rather tenacious in looking for cooperation on that.

Ms. Lerner, I just want to get your assessment. We talked yesterday a little bit about this White Paper. I realize this is probably not going to be within your office's jurisdiction, but can you just talk about how corrosive something like that is coming from the Office of Inspector General?

Ms. LERNER. One of the primary roles of an IG office is to inspire confidence in employees because you need them to do your work as an IG. I think it is similar to the Office of Special Counsel. Employees need to feel comfortable coming to you and reporting waste, fraud, abuse, and other misconduct. It is the lifeblood of what we do. And my concern with that White Paper is that it sends a message to the wider VA community that if you do come forward, your reputation may become an issue. And that I think has a very chilling effect potentially on the workforce, and so it concerns me from that perspective.

Chairman JOHNSON. OK. Thank you. I want to be respectful of time. I will go to Senator Carper.

Senator CARPER. Thanks again very much.

Mr. Missal, the IG launched investigations over a year ago, I think maybe close to 100 investigations, at facilities across the country. I am told there are about 25 that are still outstanding and incomplete. I am told that the workload that the IG's office carries is enormous, and the other challenges and problems are far greater than the workforce allows them to address. What should be done about that? And I might say the VA facility in Wilmington, Delaware, including South Jersey and all of Delaware, we are very proud of, but we have been waiting for a long time for that report.

Mr. MISSAL. Well, Senator, one of the first priorities, if confirmed, will be to immerse myself into the work, the priorities, the plans of the office to make sure that things are properly staffed. If I come to the conclusion that additional resources are needed, I certainly would bring it to the attention of this Committee.

Senator CARPER. All right. Thank you. Let me just talk about cross-agency collaboration between the VA IG's office and the Office of Special Counsel. We have heard that it is not the best, and I always like to say if it is not perfect, make it better. That is one of my guiding principles in life. What do you think you all might do, each of you just very briefly, what might you do to improve the relationship between your agencies and to better protect whistleblowers? Do you want to go first, Ms. Lerner?

Ms. LERNER. I guess it is better to be forward-looking than backward, but—and I am very optimistic that we will be able to work with the new VA IG leadership. The primary problem that we have had in the past has been basically the lack of a collaborative and cooperative relationship, and in particular with regards to information sharing, which is really important so that we are not duplicating efforts, and using our resources wisely, and we should be sharing information with each other. I am very hopeful that with new leadership that will happen. Mr. Missal and I have spoken a couple of times. I am sure that we will have further conversations about the ways that our offices can work together in a productive way.

Senator CARPER. Good. Thank you.

Mr. Missal, just very briefly.

Mr. MISSAL. Sure. I believe that the Office of Special Counsel plays a really important role, that the mission of the Office of Inspector General is very similar in some respects to what the Office of Special Counsel does. And they should work very closely together, share resources, share information, work collaboratively.

Senator CARPER. OK. Let us talk about whistleblower protection. As I think others have mentioned, maybe the Chairman, our Committee held a hearing where VA employees recounted their experiences blowing the whistle on misconduct. Some of these whistleblowers expressed the view that we also heard from others that the IG's office does not maintain whistleblower confidentiality when investigating complaints. I do not know if you are aware of these concerns. I would like to ask you if you are. What would you do to find out if they are valid? And if they are, what would you do about it?

Mr. MISSAL. Well, I am generally aware of it from what I have read in publicly available information. This is something that I have zero tolerance for in terms of any mistreatment of whistleblowers. I share Ms. Lerner's belief that whistleblowers are very critical to the workings of better government, and one of my goals would be to increase the environment for whistleblowers so that they feel comfortable coming forward and to treat them with respect and dignity.

Senator CARPER. All right. Ms. Lerner, Senator Cardin in his introduction of you went through some metrics, interesting metrics—you mentioned them as well—in terms of measuring the performance, good performance, by you and the team that you lead. What could other agency heads, what could other managers in the Federal Government learn from you and from your team that might be transferable to them?

Ms. LERNER. Thank you for the question. It is an interesting one. I think necessity is the mother of invention—I think that is the——

Senator CARPER. I have heard that before.

Ms. LERNER. And we really needed to come up with more efficient, creative ways of doing business because of the influx of cases. Our staff has seen their caseloads double and triple. We are inundated with cases. And we are a small agency. We have about 140 employees. We have jurisdiction for the entire civil workforce. With the new VA cases that make up about 30 or 40 percent of our cases, our caseload increased by 1,000 in just over one year. So we have had to look really carefully at the way we do business and see if there are more efficient ways of doing it.

One thing that I have really emphasized is mediation. It gets cases resolved more quickly, often with better results, and without a full investigation. We do not have to spend a year investigating a case that we think has merit. If we think that we can get it solved early, that is what we do, and that has been my instruction to the case examiners as well. We do not even have to get to the point where it goes to mediation or to a full investigation. If the case examiners can resolve a case early on, let us do it.

We have come up with a pilot project that consolidates four different positions into one to try and see if that can lead to more effi-

ciencies and be more effective, and I am very optimistic that that project is going to work out.

So I guess the short answer is look for new ways of doing business. Old models may work, but sometimes you have to be flexible and come up with more efficient ways.

Senator CARPER. My time has expired. I just want to add one last thing. If there are things that we need to be doing, we, this Committee, or the Senate, the House, the Administration, to enable you and your folks to do an even better job going forward and continue these kind of results, please let us know. Thank you.

Ms. LERNER. Thank you.

Senator CARPER. And I thank you both for a great job.

Chairman JOHNSON. Thank you, Senator Carper.

Before I move on to Senator Portman, I just want to ask consent to enter into the record the White Paper issued by the Office of Inspector General,[1] my July 8 response to the White Paper, my September 29 letter to Ms. Linda Halliday asking her to find out who wrote the White Paper, and then her October 6 response saying she would not give me those names.[2] So we will just enter that in the record.

Senator Portman.

OPENING STATEMENT OF SENATOR PORTMAN

Senator PORTMAN. Thank you, Mr. Chairman. And for both of you, thank you for your continued interest in serving your country.

I am going to focus my comments, Mr. Missal, on your important role. The men and women in uniform who have put their lives at risk for all of us deserve the best, and as you know, they have not always received that in terms of their health care. This is an issue that has had a lot of focus in general. I do think that Secretary McDonald appreciates the need for us to reform the way veterans are getting their health care. Back home, I have held a bunch of town meetings on this and gotten some good input. We have a long list of concerns. The long waiting lists you know about, the adjudication of claims, some of the eligibility requirements. Things like Agent Orange eligibility is a big concern back in Ohio.

But let me focus on one that is a little different, and it builds on something the Chairman just talked about, and that is the issue of mental health treatment and the overprescription of painkillers, particularly opiates, that have led too often to the use of heroin and to some tragic circumstances.

I have been focusing on this issue for a number of years, and I think, although there has been some progress made, there is a lot more that needs to be done. So I would just ask you in your role as Inspector General—where, as you know, you have a responsibility to look at health care issues, review medical center operations, evaluate the health care programs, provide oversight really on the critical role that the VA plays in health care—what you plan to do about that.

One common theme that I have found as I talk to veterans is that too often it is just too easy for doctors in the VA system to

[1] The White Paper submitted by Senator Johnson appears in the Appendix on page 333.
[2] The letters submitted by Senator Johnson appears in the Appendix on page 316.

prescribe painkillers that are narcotics, that are opiates, that, again, lead to a similar high to heroin but a more expensive one. This, of course, has devastated families, torn communities apart, robbed individuals of their dreams.

I recently met with a veteran in Columbus, Ohio, who lost a family member who started on prescription drugs that were given to him by the VA to deal with pain, and then moved to heroin and eventually overdosed on heroin. The Chairman talked about the whistleblower who helped to reveal some of these cases and eventually committed suicide.

This VA Inspector General report from 2012 and 2013 found that VA providers often inadequately assessed patients who were prescribed opiates, inadequately monitored patients on opiates, were asked by facility managers to write opiate prescriptions for patients they had not even assessed. There is a more recent concern I have, which is the use of opiates for post traumatic stress disorder (PTSD) and traumatic brain injury. This report was just issued last week. This is a report by the Government Accountability Office (GAO) with regard to the Department of Defense (DOD) and VA health care actions needed to help ensure appropriate medication and continuation in prescribing practices. I brought two copies today because, Ms. Lerner, I think you also will be indirectly involved in this issue. I would like to hand these to you today and also enter this, Mr. Chairman, into the record.[1] It is fresh off the presses, and it has some very disturbing information in it, including the following:

VA's new policy to ensure continuation of mental health medications lacks clarity on the types of medications considered mental health medications. As a result, the providers may be inappropriately changing or discontinuing mental health medications due to formulary differences, potentially increasing the risk of adverse health effects for transitioning servicemembers. And, again, if you look on pages 14, 15, 16, and page 23, you will see the reference to opiate use even for traumatic brain injury.

So my question to you is: If nominated, I would like your assurance you are going to look into these matters in order to help us hold the VA accountable for the proper care of our veterans who deserve the best.

Mr. MISSAL. Senator, I will do so, including look at any recommendations that have been previously made on these issues and see whether or not they have been implemented.

Senator PORTMAN. Thank you, Mr. Missal.

Thank you, Mr. Chairman.

Chairman JOHNSON. And without objection, your and my records will be entered into the record.

Senator Baldwin.

OPENING STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman. I want to thank you for holding this nomination hearing today.

Welcome to the nominees. I thank you both for being here and your willingness to serve the public, and especially to serve our Na-

[1] The GAO report submitted by Senator Portman appears in the Appendix on page 346.

tion's veterans. The Special Counsel at the Office of Special Counsel and the Inspector General at the Department of Veterans Affairs both play essential roles in the oversight of our Government and the care of our veterans. As I have seen in Tomah, Wisconsin, and indeed in the rest of the Nation, effective oversight is crucial to confronting the many challenges that plague VA. Unfortunately, in the past few years, this oversight has been lacking, and troubling issues like whistleblower retaliation have persisted.

So I am glad, Mr. Chairman, that we are moving forward with these nominees today, and I hope that this hearing offers us a chance to make progress in fixing what is broken.

Mr. Missal, you are aware of some of the challenges facing the Tomah VA Medical Center in Wisconsin and the IG's early role in addressing those challenges in the form of a review that was done on inappropriate prescribing of controlled substances and abuse of authority. That review was closed—in my view, prematurely—and subsequent investigations have further exposed serious issues at the Tomah VA, issues that were allowed to go on for far too long with absolutely tragic consequences.

As we move forward, it is essential that the VA Office of Inspector General is more transparent and works more cooperatively with Congress to confront the serious problems that exist at the VA.

In order to help make the IG's office more transparent, I successfully included language in the recently passed omnibus appropriations bill to ensure that when the VA OIG completes a report, it is promptly shared with the VA Secretary, Congress, and the public. That language would help address failures of transparency and agency oversight by requiring any recommendations made by the VA OIG during investigations, audits, or other reports to be sent directly to the VA Secretary—something that was not done in the case that I described. In addition, these recommendations would be made available to the public and submitted directly to relevant congressional oversight committees.

If confirmed, will you commit to significantly improving transparency at the VA Office of Inspector General? And if so, what specific steps will you take to make sure this happens?

Mr. MISSAL. Senator, I will do so. I agree with you. I believe transparency, increased transparency, is very important. I think it is one of the things that could increase the trust and confidence that our veterans and the American public would have in not only the VA OIG but VA as well. I intend to take a number of steps, including looking at what they are doing now. If there are reports that are not being made public that should be made public, particularly on the health care side, I cannot imagine a situation—although I do need to learn more—why a health care report would not be released publicly if it is completed. So that is one of the things I am going to look at and then have further discussions with the staff about other opportunities to increase transparency.

Senator BALDWIN. Ms. Lerner, you have mentioned that 30 to 40 percent of your caseload comes from VA employees and that these employees were projected to make up approximately 37.5 percent of the whistleblower retaliation cases in the past year. As I have seen firsthand in Wisconsin with retaliation against whistleblowers at the Tomah VA and other facilities in the State, there are signifi-

cant and troubling issues with the whistleblower culture at the Department of Veterans Affairs. The Office of Special Counsel plays a key role and you are an ally in this area, both in advocating for individual whistleblowers, such as Ryan Honl, who blew the whistle on opioid overprescription at the Tomah VA, and in pressing for policy changes at the VA.

I have run out of time, but I hope you will followup on your testimony at the Appropriations Subcommittee hearing on whistleblower culture at the VA in terms of your as whether enough is being done at the VA at this point to create an environment where whistleblowers can feel safe in coming forward with information that helps improve the agency.

Chairman JOHNSON. Would you like to quickly respond?

Ms. LERNER. Sure. Just very briefly, I think that there is a really good message that is coming from the top. What I hear Secretary McDonald saying and Deputy Secretary Gibson saying, it is new from what we heard a year and a half, 2 years ago, and that sets a tone that is really important.

The problem is the VA is such a large institution. It has so many facilities. It has the regions and then the individual facilities. And that message has to trickle down throughout the country, and it may take a little bit of time, but there are things that can be done. More training: The VA is doing a lot now. They can do more. We have helped them with training. We have trained the trainers. We have trained their investigators. We have trained their regional counsel. We have made training materials available to them. They need to do more of it.

They need to hold managers accountable. One of the missing links here—we have seen a lot of progress in many ways, but the one area that still concerns me very much is discipline for managers who are found responsible. And we need to work on that. That will help change the culture.

So just in brief, I think the VA is heading in the right direction. I think a new IG is going to really help a lot, so there is reason to be optimistic, but there is still a lot of work to be done.

Chairman JOHNSON. Senator Ayotte.

OPENING STATEMENT OF SENATOR AYOTTE

Senator AYOTTE. I want to thank the Chairman, and I want to thank both of you for your service and your willingness to serve in such important positions for our country.

There has been a lot of discussion today about the Tomah VA situation, and I was very interested to hear you say, Ms. Lerner, that we need to hold managers in the VA more accountable for their actions. Yet what happened not just at Tomah but also with what happened at Phoenix is appalling because there were thousands of dollars of bonuses, actually millions overall, but thousands to individuals each at those VA facilities who were managers, who got bonuses even though they were participating in the misconduct that occurred, and this body here in HSGAC, Senator McCaskill and I introduced a bill to claw back those bonuses and to deal with this going forward. It was changed to be only prospective. Our Committee voted it out, and the VA Committee did its work and voted it out. And guess what? I tried to get it passed right before we left

at the end of the year, and people are anonymously objecting to essentially just saying if you commit misconduct—because the managers at the Tomah facility got bonuses between $1,000 to $4,000 even though they oversaw the overprescription of opiates to veterans and, of course, we know that veterans died.

So we have to be part of the solution, too, and if people are going to object to legislation like that, it is just appalling to me. So I just wanted to bring that up because, as we see more accountability, if we are going to continue giving bonuses to people who participate in misconduct, and with no mechanism in current law to actually take back those bonuses or revisit issues like that or to actually discipline managers, then we are going to continue to see this cycle going forward.

I know we did the right thing in this Committee, but I am going to continue to push this on the Senate floor because I find it appalling that anyone would object to that legislation. And so come forward, identify yourself. I look forward to having the debate on the floor with you about why you think that this is not appropriate.

I am so glad to see both of you here. Ms. Lerner, thank you for your incredible work. We are so glad to have your renomination here today. And, Mr. Missal, you are being asked to perform a very important job. On a bipartisan basis in this Committee, this position was vacant for 630 days, and all of us really pushed. This was not a partisan issue. We needed this position filled because of the many issues not just at Tomah and Phoenix, across the country we were hearing from our veterans that needed a watchdog. So I am so glad to see you here today, and you have such an important job, working with Ms. Lerner and really having accountability in the VA. Our veterans deserve that, and we need to do it, and you have such an important job.

I wanted to ask you about health care in the VA, and that is the Veterans Choice Program, which offers eligibility to veterans, the option of receiving care in their community at a private provider. This is very important in New Hampshire because we do not have a full-service veterans hospital. And, in fact, there is a provision that was passed in the VA reform law that allows our veterans in New Hampshire, almost like a pilot, allows them to go seek private care because we do not have a full-service hospital. But there have been a lot of bumps in actually getting this program right for our veterans, and the VA's Inspector General Office has issued semiannual reports. The most recent report has only a passing reference to the Choice Program.

So I would ask you, I hope that as you do your work in the Inspector General's Office, all the work that we have tried to do on the wait lists, on the issue of making sure that veterans have access to care in their community, we have to get this program right. We have to allow veterans to choose so they are not waiting and so they are not driving long distance for their care, especially in my home State of New Hampshire. But also this is an issue across the country.

So I would ask you how familiar you are with the Veterans Choice Program, what oversight you will bring to the program, and do I have your commitment to personal oversight over this program

and some review of this program to make sure we get this right for our veterans?

Mr. MISSAL. Senator, I am generally aware of the program. I know it is a relatively new program that was implemented to fill a real need out there. I do not know what oversight the OIG's office is doing right now, but you do have my commitment to look into it because I do recognize how important it is. And it is a new program. There is a possibility there could be issues, and you want to address those issues before they become larger issues.

Senator AYOTTE. Well, let me just say that I do not think there has been enough oversight at this point, and also, as a new program, this is interjecting change to the VA, and we all know that often people do not want to change when there is a new program to give veterans access to care. So I would ask you to make sure that we also deal with the issue of this type of change coming with the agency and focus on the oversight of getting it right for our veterans, because Congress, we support this program. It is important for our veterans to have the choice for their care and to have the access so that they never have to wait and they do not have to drive long distances to get the care that they have earned defending this Nation.

Mr. MISSAL. I will do so, Senator.

Senator AYOTTE. All right. Thank you both. I appreciate it.

Chairman JOHNSON. Thank you, Senator Ayotte.

Just to underscore the point, "bumps" is being kind. There is a veteran in Wisconsin who had pancreatic cancer, and they were forcing him to drive more than 100 miles to get treatment in Milwaukee, where, again, he could have gone to Marshfield.

Senator AYOTTE. Yes, it is crazy.

Chairman JOHNSON. It is.

Senator AYOTTE. It is crazy, and our veterans should not have to drive. They should be able to decide, and we owe it to them to get this right.

Chairman JOHNSON. So, again, you view that as a pilot program. There are a lot of bumps, and that is something that the Office of Inspector General really needs to look into. Senator Ernst

OPENING STATEMENT OF SENATOR ERNST

Senator ERNST. Thank you very much. It is so nice to have you both in front of us today. Thank you, Mr. Chairman, for calling for this nomination hearing.

I want to thank your families as well for joining you today. It takes a lot to put that on their shoulders as well. And for those that came from the OSC, we want to thank you for your very important work.

You can tell—this is not the Veterans' Affairs Committee, but you can tell that the members of this Committee are very, very passionate about the care that not only our veterans are provided through the VA health care system, but also those that see issues within that VA health care system and protecting those whistleblowers and making sure that they are afforded the opportunity to speak out without reprisal. So thank you again for the work that you are doing.

Mr. Missal, it is good to see you again. I appreciate you taking the time before the holidays to sit down with me and my staff and talk through a number of these issues. Again, very passionate about the care that we provide to our veterans.

It was actually last March when all of the Members of this Committee joined together in a letter to the President asking for a nominee to this position of Inspector General for the VA. So we do need to act swiftly on this. I am very excited about this opportunity, and I, like a number of our other Members—Chairman Johnson, you and Senator Baldwin have had frustrations with the VA in Wisconsin—all of us have had specific frustrations with our own VA health care centers.

Last February, I requested a review of the mental health care provided to an Iraq war veteran from the Des Moines area, a young man that committed suicide. And the VA IG's office did not report back to me for many months. And, again, this was a very serious situation. Again, a young man had taken his own life out of the frustration that he felt, and now the frustration that we all bear.

So, again, it was months before they got back to my office, and my State staff has also reported to me that the VA OIG has failed to respond to their repeated requests for an update on three cases, now three additional cases in Iowa that were opened last spring. So this is not a one-time occurrence for any of us. Repeated requests for information on cases that are going unanswered.

Can you please just repeat to me your commitment to all of us on this Committee that you will assist us in our oversight responsibilities in a timely manner and keep us effectively informed on all OIG matters?

Mr. MISSAL. Senator, I recognize the important role an IG can play in assisting the Committee and Congress in its oversight responsibility. I think you will find me highly communicative, that I would respond very quickly to requests. I may not always have the answer right away. It sometimes takes time to develop it. But I just believe it is important to keep people informed of the progress so you know exactly what is going on.

Senator ERNST. That is wonderful. I appreciate that very much because, unfortunately, as we have seen all too many times in the past that there has not been the followup necessary, and those months at delay could mean another veteran that has been left untreated or another veteran that takes their own life because of the lack of care provided by the VA. So we do have to be vigilant in this oversight, and it quite literally is a matter of life and death. So I just want to make sure that we all understand how important it is for timely response.

I was a little appalled to learn during this Committee's hearing last September that the VA OIG investigates only a fraction of the approximately 40,000 complaints—40,000—that it gets annually. And I understand that both the VA OIG and the OSC are resource constrained, but a top priority of both organizations should be ensuring that not one of these VA whistleblower complaints goes unresolved.

So I would like to hear just very briefly your general thoughts on that.

Mr. MISSAL. Sure. I understand there are 40,000 contacts to the hotline a year, give or take some. I do not know what they are doing to triage those, how they decide which ones are addressed, which ones are not. But that is, again, one thing that I find very important. If there is an issue out there that needs to be addressed, it needs to be addressed quickly and figure out a way to find resources to at least initially address them and see what can be done.

Senator ERNST. Thank you.

Ms. Lerner, just very briefly.

Ms. LERNER. Sure. Let me tell you just briefly some of the steps that OSC has taken to prioritize VA cases. We have set up a triage system that prioritizes VA health and safety cases, so any case involving health and safety, whether it is a disclosure or someone who claims retaliation for having reported a health and safety violation, those get a very quick look. We have a senior counsel who is assigned full-time to coordinate our VA cases. I have assigned one of my deputies to coordinate VA cases. They meet weekly with the VA team of employees at OSC that we created after we got this total influx of new cases. That team meets weekly.

We have worked with the VA Office of General Counsel and Office of Accountability and Review to expedite the resolution of VA retaliation cases so that we can get quicker, better results without having to do a full investigation.

So those are just some of the things that we are doing to prioritize VA cases at the OSC.

Senator ERNST. I appreciate it very much.

Thank you, Mr. Chairman.

Chairman JOHNSON. Senator Lankford.

OPENING STATEMENT OF SENATOR LANKFORD

Senator LANKFORD. Thank you both for being here and for your service to get to this point.

Ms. Lerner, let me ask you about budget items. When you first came in—well, let us go back to 2011. We have a good picture there. Your budget was $18 million. It is now $24 million. Tell us about, as you have mentioned before, how we are getting a bang for a buck in that increased spending. What has changed, both the efficiency of that kind of increase in budget, and what is the taxpayer getting better now than they were in 2011?

Ms. LERNER. Thank you for your question. I am really proud of the way we have been able to manage our budget. When I came in, we had about 108 employees. Again, we have jurisdiction for the entire Federal civilian workforce, basically more or less, a few exceptions. And we now have about 140 employees, so that increase in personnel has gone a long way towards letting us handle this influx of VA cases.

Let me give you an example of one case that I think is typical of the way we can get a return on our budget, return on the taxpayer's money.

Department of Homeland Security whistleblowers came to us reporting the abuse of overtime, widespread abuse by CBP and Border Patrol agents and other employees at the Department. We were able to do a full investigation. We did a full report, and working with this Committee, we were able to get legislation, bipartisan

legislation, through Congress that changes the overtime pay system at the Department of Homeland Security. The Congressional Budget Office (CBO) estimates that those changes are going to result in $100 million a year of savings. Our budget is, as you said, about $24 million right now.

So those types of cases are out there. We are making them. I mean, they are not all $100 million a year of savings, but that is the type of case that we think we are now capable of taking. We are working with Congress. We view ourselves as partners with this Committee and other committees to get legislation through when it is needed. So that is the kind of bang that we are getting for the buck.

Senator LANKFORD. OK. That is helpful. We will get a chance to followup in the days ahead on that as well, just to be able to see the effectiveness of that. This is a "feed the lions" type strategy to say where we are actually effective and people are efficient with dollars. That is entirely reasonable to continue to be able to help their budget because they are efficient and have to actually carry them out.

Tell me about internal controls for personally identifiable information (PII) and limiting the access of individuals to information that they really do not need to access. This has been an issue in several of the agencies where they have access to information for other people, both inside and outside the organization, and no internal controls to make sure they are not accessing it inappropriately.

Ms. LERNER. Well, that has definitely been a problem at the VA and something that we have talked to them a lot about. We think that there are technical fixes that can solve that problem fairly easily at the VA, and I look forward to talking to Mr. Missal about that.

What we have seen at the VA is, many of the folks who work there are also patients.

Senator LANKFORD. Right.

Ms. LERNER. And so what is happening is someone who might be sort of mischief-minded is going into the medical records of their coworkers or oftentimes it is people who have blown the whistle and getting access to their medical information.

Senator LANKFORD. Mr. Missal, how do we stop that?

Mr. MISSAL. I think you need to look at it very closely. If there is a technology fix to do, I think we need to——

Senator LANKFORD. Which I think there is.

Mr. MISSAL [continuing]. Use the resources to do it, and then to make a recommendation and then followup to make sure that recommendation is implemented.

Senator LANKFORD. I would highly recommend that we do look through that process to see what technology. Some agencies do a great job at that. Most agencies do not. They are not limiting the access of people that work there to getting information that they do not have any business professionally actually accessing. And VA is one of those areas of many there. Many people around this dais know—and I have talked to many others around this place. I am one of many that I look toward the horizon with VA and see the days ahead that VA will be small-scale clinics for ongoing care, but

that veterans can choose to go any place they want to go for health care in the days ahead, and that the veterans have this absolute choice to say you do not have to drive past seven good hospitals to be able to get to the VA hospital, then wait 3 months for a knee replacement that you could get 3 miles from your house, that there is the moment that we actually treat our veterans with the ability to be able to choose. And I know you have already had some conversation about the Choice Program. I think that does need a tremendous amount of oversight. My perception is from meeting with some of the individuals at VA that they seem reluctant to actually implement the congressional mandate for choice, and they are trying to find ways not to give choice, or to say, yes, we can take care of that internally. But I think that is a big issue.

I would also say to you that I would recommend that the IG looks at things like staff turnover. Every time I talk to veterans, they say, "When I return back to the VA, I am with a new doctor and I saw a different nurse than I saw last year," because the turnover rate is so high. There is a basic question there of why. Why would the turnover rate be high? Because that affects actual care for those individuals.

I would like to ask you as well just on priority of your own investigations and your own personality with this, there is a tendency with some of the IGs to look at efficiency of how the agency operates rather than the quality of care the patient receives. So as an IG, what I am interested to hear from you is when you do investigations, are you looking at how well paper is moving and how fast paper is moving through the VA or how good the care will be for the veteran when they come into the VA centers?

Mr. MISSAL. I do not think they are necessarily mutually exclusive. I think you can look at both. The quality of care to me for veterans is a critically important issue, but also the economy and efficiencies of how the Department operates, which could impact the quality of care, I think is also very important.

Senator LANKFORD. OK. So at the end of the day, veteran care will be essential. I will tell you one of the veteran families that I spoke to just last weekend, trying to gather all the records for their dad, and they cannot go any one place and get his health records. The dentist has it over here, and the general person has it here, and the surgeon has it over here, and they all have to request each other. And so there is a lot of conversation about centralized records. That is not actually occurring in the VA system. And literally the different specialists do not know what each other is doing, and when they even try to get all the files together, they literally were going section to section to be able to get it.

There is some basic operational movement of paper that does affect the quality of care for our veterans, but at the end of the day, I would encourage you to focus in on what is the care that is being received and what are the impediments to good quality care more than anything else.

Mr. MISSAL. I will, Senator.

Senator LANKFORD. Thank you.

Chairman JOHNSON. Senator Heitkamp.

OPENING STATEMENT OF SENATOR HEITKAMP

Senator HEITKAMP. Thank you, Mr. Chairman.

It is interesting, because we have been talking a lot about efficiency, a lot about quality of care, but the issues that the VA confronts are issues of life and death. That is how serious this is. That is how serious we are about making sure that we have an oversight system and that we have partnerships with both of your agencies in terms of providing oversight, because it can mean the difference between life and death. That is how critical this is.

And as we kind of look going forward, I think it is important, although you have heard a lot about choice here, that you understand this from the perspective of a rural State, where I think the Chairman talked about a 100-mile drive. I have Native American veterans who live in the northwest part of my State who literally have to drive 5 hours to get chemotherapy.

Now, as somebody who is a breast cancer survivor, the last thing I wanted to do before and after my chemotherapy was get in a car and drive 5 hours.

This is a sacred duty that we have to make sure that our veterans are treated appropriately, and this body, the U.S. Congress, signed by the President, have adopted a new policy, which is called "Choice," that there ought to be an opportunity for that veteran, that 90-year-old veteran who may be getting chemotherapy to get it at home or get it as close to home as he can or she can.

And so I would tell you, since the rollout of the Choice Program in November 2014, an overwhelming number of veterans, family members, doctors, and health care providers have contacted my office out of frustration. And you hear that frustration among all the members here. We have to have a watchdog, because this is a very big bureaucracy that thinks they are just going to wait this out, that if people's attention just deviates from the problems of the past, that we will, in fact, be pulled off target.

I am not going to be pulled off target on the Choice Program. I am not going to be pulled off target on making sure that our veterans get the benefits that they have earned by serving this country. And so, Mr. Missal—and I thank you so much for coming into my office. I know that you heard the same kind of passion there. But I want to really impress upon you how truly important it is to look at this program and look at what this means, because it can mean life and death, and to think about even if there is not outright fraud or abuse—and no one is claiming that—that the efficiency and fulfilling the promise of this program is within your mission.

Mr. MISSAL. I understand that, Senator.

Senator HEITKAMP. OK. Thank you. And I want to maybe just take a moment and talk about following up with Senator Ayotte, talk about the bonuses, because, is it appalling that these bonuses were paid and not paid back? Absolutely. And we will work through that. But what is appalling to me is that we created a system by providing bonuses that provided a huge incentive for fraud. And I know this is far-reaching, but as you look at kind of administration, how do you see being proactive on the front end of those kinds of decisions that are made to prevent fraud or prevent incentivizing fraud by staff?

Mr. MISSAL. Sure. I think there are several things. One, that could be part of the audit function when you are going to test things to identify issues before they become larger problems.

Second, the IG also can weigh in on proposed legislation to determine the efficiency, effectiveness, things like that, so the ways the IG can use his or her voice to come in on issues such as the ones you raise.

Senator HEITKAMP. So the great tragedy is that an incentive program that was built to improve the quality of care actually led, in my opinion, to fraud because all of a sudden there was a monetary reward which you could get if you lied. Right?

Mr. MISSAL. Correct.

Senator HEITKAMP. So that is the kind of thing that we need to be very proactive on, not just taking care of what are the decisions today but how decisions in administering the programs at the VA can, in fact, create even more bureaucracy for our veterans.

So I want to thank both of you for stepping up and for being part of this important life-and-death mission, which is providing those services that some of the great heroes of this country have earned. And so thank you, and if there is anything that we can do on this Committee or anything I can personally do to assist you in carrying out that mission, I hope that you pick up the phone and call me personally.

Thank you, Mr. Chairman.

Chairman JOHNSON. Thank you, Senator Heitkamp.

I think because of the strong attendance and, I think, thoughtful questions and answers, I really do not have any further questions. I know Senator Carper does. Before we give you both an opportunity to kind of make a closing comment, we will turn to Senator Carper.

Senator CARPER. Thanks so much. I was not going to ask another question, but I want to ask one lighthearted question and one serious question.

I said to the Chairman and I would say it to Senator Heitkamp—I have spoken to our staffs—I feel very fortunate. I felt fortunate walking into this hearing that one of you is already serving in an important role in our government and that the other is willing to serve. You are two very impressive people. I would just ask your wife—was it Deborah?

Mr. MISSAL. Yes.

Senator CARPER. And your husband—is it Dwight?

Ms. LERNER. Yes.

Senator CARPER. Were these two people this smart when you first met them? [Laughter.]

Have they, like, learned from you? Has it, like, rubbed off? I mean, what—I do not know.

Mr. MISSAL. I do not want her to answer that question. [Laughter.]

Ms. LERNER. My kids would tell you it is all them.

Senator CARPER. I have heard many people say of their teen-aged children that their kids think that they are just the dumbest parents in the world, and then when the kids turn 18 or 19, it all changes. How old is your son?

Mr. MISSAL. 22.

Senator CARPER. And how old are your kids?
Ms. LERNER. My daughter is 18, and my son is 21.
Senator CARPER. All right. Well, you are over the hill.
Ms. LERNER. We are still waiting for that. [Laughter.]
Senator CARPER. You are almost over the hump.

Here is my serious question: James Lankford asked really good questions, a very perceptive fellow, and talked about the idea of having a VA in the future where we have our outpatient clinics, which I think do provide great service. But for the most part, the mother ship—the hospitals and so forth—would use existing hospitals within the communities across our country, and that is an idea that has some appeal. But I also know as a veteran myself, somebody who has spent a lot of time—23 years, 5 years in a hot war in Southeast Asia, another 18 right up to the end of the cold war—as a naval flight officer. But I know that sometimes the conditions that veterans are treated for—PTSD is certainly one, Agent Orange is another, but there are others—are ones that veterans feel like they get better care and maybe better focused care in a VA facility.

Our community college back in Delaware, Delaware Technical Community College, has created a unit that is run by veterans for veterans, coming in many cases back from Afghanistan and back from Iraq. They are on the campus and are trying to acclimate to being a student, and some of the most go-to people there is a unit that is run by veterans. So that is in the back of my mind.

One of the things that he said that caused me special concern was that it sounded like he was suggesting a breakdown in communications between specialties within VA hospitals and facilities. And if that is widespread, that is a matter of huge concern to me.

It was, I do not know, maybe 15, 20 years ago that the VA began experimenting with electronic health records, and many people give the VA credit for being a pioneer, first on the beach in terms of deploying that kind of technology to provide for better health care for less money. And I would just ask of you, Mr. Missal—I will try to make you a guided missile here, as opposed to an unguided missile. But I would urge you to take a look at that. We know that there is a problem with interoperability between the electronic health records within the VA and within the Department of Defense. People come off active duty and have one kind of electronic health record. They go into the VA, and it is different, and the two do not communicate. There has been a huge effort to try to address that.

But I would ask you to monitor that interoperability between the Departments, but also Senator Lankford's comments with respect to the breakdown of communications within a hospital across specialty units.

Again, you all have done a great job. We are hopeful that we will get you reported out of here and get you confirmed by the Senate, and you can continue to do the good work you are doing, Ms. Lerner. And, Mr. Missal, you will be able to be a guided missile and go to work and do a great job there, as you have in other chapters of your life.

Again, our thanks to your families.
Mr. MISSAL. Thank you, Senator.
Chairman JOHNSON. Thank you, Senator Carper.

I will just give both of you the opportunity, if you have some closing comments, and we will let Ms. Lerner go first.

Ms. LERNER. I do not have anything prepared, but I just wanted to thank you both, Senator Johnson and Senator Carper, both for the hearing today and also for the work that you have done with my agency over the last 4½ years. I really do view us as partners in trying to make government work better, more efficiently, and keep it safe. And we can be more effective when we are working with you, and so I have really appreciated that partnership and your support over these last 4½ years. So thank you.

Chairman JOHNSON. Thank you, Ms. Lerner. Mr. Missal.

Mr. MISSAL. I would also like to thank you, Mr. Chairman, Senator Carper, and the Committee, for the courtesies extended today, the opportunity to discuss our views with you. I am committed to working tirelessly and independently on behalf of veterans and the American public. I am also committed to working cooperatively and collaboratively with this Committee as well, and I am available to answer any other questions you may have.

Thank you.

Chairman JOHNSON. OK.

Senator CARPER. Mr. Chairman.

Chairman JOHNSON. Sure.

Senator CARPER. Could I ask, Ms. Lerner, if you were just to give Mr. Missal one word of advice, just terrific advice that really helped you in the success at your agency, give him just one really great piece of advice as he prepares, once confirmed, to assume his new responsibilities, what would that be?

Ms. LERNER. Hire really great people. You are one person. I am one person. The reason that we have been able to be effective as an agency is because I have been able to recruit and retain really talented staff who do the day-to-day work of protecting whistleblowers, and I could not be prouder to serve with them, but they are the reason that we have been able to be successful. So my one piece of advice is to surround yourself with people who are smarter than you are and, who will really make a difference.

Senator CARPER. It is funny you should say that, because down in Guatemala—the Chairman and I have been down to Central America, down on the border quite a bit with Mexico. But they are going to be swearing in a new President in Guatemala on Thursday of this week, a former comedian, Jimmy Morales, who actually had his own TV show, and I met with him when I was down there a couple of months ago, and he is not that funny. [Laughter.]

Chairman JOHNSON. I am sure he is, but he is also a very serious individual.

Senator CARPER. But he has a serious side. You know what? He said, "Give me some advice." And the advice I gave him, I said, "You will have one chance to put together a world-class team around you, and the people who elected you"—two-thirds of them voted for him. "Look and see who are you going to surround yourself with, the quality of those people, the integrity of those people, their commitment to doing a good job." That is great advice, and I take that one to heart, and my guess is you already have.

Thank you.

Chairman JOHNSON. That was a good question. That is a right answer. Let us face it, for any organization, a bunch of people. And so good answer.

I want to thank again the nominees. I want to thank their families. Families, look very carefully at these two individuals because you will see them probably less. I think Ms. Lerner's family already realizes that. Mr. Missal's family will soon find that out, because this is an enormous task.

I appreciate a lot of the answers to our questions talking about working with this Committee, cooperating, being a partner. When you need legislation out of this Committee, let us know. You are the ones that understand that. And I hope if you walk away from this hearing with basically one thought or one piece of understanding, that it is how even in divided government, even when, a lot of times things are pretty partisan, I hope that you understand as well as the American people watching this understand, this is one area of completely unanimous agreement that we must honor the promises to the finest among us to provide them with quality care. You are the tip of the spear to provide the transparency and the accountability to actually accomplish that shared goal, that shared purpose.

So, again, I just want to thank you, your families, all my colleagues for understanding how important these positions are and your willingness to serve.

With that, for the record, I just want to state that both nominees have filed responses to biographical and financial questionnaires, answered prehearing questions submitted by the Committee, and had their financial statements reviewed by the Office of Government Ethics. Without objection, this information will be made part of the hearing record,[1] with the exception of the financial data, which is on file and available for public inspection in the Committee offices.

The hearing record will remain open until noon tomorrow, January 13, 2016, for the submission of statements and questions for the record. And I will give you my commitment we will move very expeditiously on these two nominations so you can continue your important work or start your important work.

With that, this hearing is adjourned.

[Whereupon, at 11:33 a.m., the Committee was adjourned.]

[1] The information of Mr. Missal appears in the Appendix on page 37 and the information for Ms. Lerner appears in the Appendix on page 84.

APPENDIX

Opening Statement of Chairman Ron Johnson:
"Nomination Hearing To Consider Michael J. Missal To Be Inspector General, Department Of Veterans Affairs And Carolyn N. Lerner To Be Special Counsel, U.S. Office Of Special Counsel"

Tuesday, January 12, 2016

As submitted for the record:

Good morning and welcome.

We have convened this hearing to consider the nomination of Michael J. Missal to be Inspector General of the Department of Veterans Affairs (VA) and the renomination of Carolyn N. Lerner to serve a second five-year term as United States Special Counsel.

The nominees before the committee this morning have the important tasks of rooting out waste, fraud and abuse within the federal government, and of fostering an environment where whistleblowers can come forward and expose wrongdoing.

I am particularly pleased that we are considering a permanent nominee for the VA Office of Inspector General. The VA Office of Inspector General has been without a permanent leader for more than two years. For more than a year, I have called on President Obama to appoint a permanent Inspector General to serve as an independent and transparent watchdog at the Department of Veterans Affairs.

I strongly believe that the lack of permanent leadership at the VA Office of Inspector General has led to a lack of accountability that has compromised veteran care and significantly decreased the public's trust and confidence in the VA's chief watchdog. One of those scandals touched close to home for me. As this committee has been investigating, the VA Office of Inspector General conducted an incomplete and nonpublic review of opioid prescribing practices at the Tomah VA facility in my home state of Wisconsin. After the office finished and administratively closed its investigation, a 35-year-old veteran, Jason Simcakoski, died of mixed drug toxicity. In the aftermath, and facing criticism for its actions, the VA Office of Inspector General resorted to despicable attacks against VA whistleblowers in the form of a "white paper" this past summer.

In addition, the VA OIG still has not fully complied with this committee's subpoena for documents relating to its Tomah review. Moving forward, it is vital that this committee receive the full cooperation of the VA OIG so we can fully understand the failures that led to the tragedies in Tomah and to enact the necessary reforms to enhance whistleblower protections and prevent future tragedies.

Today the committee will also consider the renomination of Carolyn Lerner to serve as United States Special Counsel. Along with its other duties, the Office of Special Counsel (OSC) is the neutral investigator of whistleblower claims brought by federal employees. It serves an

important role in rooting out waste, fraud and abuse in the federal government and serves as an outlet for federal whistleblowers to expose wrongdoing.

It is fitting that Ms. Lerner's nomination is before us at the same time as Mr. Missal's. As Ms. Lerner testified before this committee a few months ago, cases of whistleblower retaliation against VA employees make up 35 percent of the caseload of the Office of Special Counsel. Her office received more retaliation complaints from VA employees in 2014 than from Department of Defense (DoD) employees, even though the DoD has twice as many civilian employees as the VA. Under Ms. Lerner's leadership, the OSC has procured favorable outcomes for hundreds of federal whistleblowers.

I am grateful to both of the nominees today for their willingness to serve in these important roles, and I hope to have a frank discussion about their vision to enhance the independence and transparency of the VA OIG and to protect federal whistleblowers. I look forward to your testimony.

Statement Of Ranking Member Tom Carper:
"Nomination Of Michael J. Missal To Be Inspector General, U.S. Department Of Veterans Affairs, And The Honorable Carolyn N. Lerner To Be Special Counsel, Office Of Special Counsel"

Tuesday, January 12, 2016

As prepared for delivery:

I want to thank both of our nominees and their families for being here today. My thanks as well to Senator Johnson for holding this hearing and moving forward quickly to consider these nominees.

Let me begin by welcoming back Carolyn Lerner, who is no stranger to this committee nor to the position to which she is nominated. The Office of Special Counsel, or OSC, has a number of very important functions. Around here, it is probably best known as the primary office for enforcing whistleblower protections.

Whistleblowers play an important role in rooting out waste, fraud, and abuse in government. They're often the first to raise concerns and highlight instances where we can better serve the American people. The Special Counsel's Office plays an important role in ensuring that whistleblowers are heard and that they are protected after they speak up.

I have seen firsthand the good work of this office when they investigated allegations several years ago at the Port Mortuary in Dover. The work of the Office of Special Counsel led to disciplinary action against several people in leadership positions at the Base and to the reinstatement of the whistleblowers who had been retaliated against after revealing serious problems at the mortuary.

It is my understanding that, under your leadership, Ms. Lerner, these positive outcomes have become more frequent, and that your agency has markedly improved as a resource for whistleblowers. I look forward to hearing from you about what you and your team have accomplished, as well as to learn of your plans for continued improvement going forward.

Let me also welcome this morning Michael Missal and thank him for his willingness to be considered for the very important position of Inspector General at the VA.

As we all know, Inspectors General play an extremely important role in our government. Their work helps us save money, reveal and prosecute wrongdoing, promote the integrity and efficiency of government, and, hopefully, increase the confidence and faith that the American people have in our government.

Unfortunately, we have seen far too many IG positions, including the one Mr. Missal has been nominated to fill, sit vacant for far too long. In fact, the VA has been without a permanent Senate-confirmed Inspector General for more than two years.

In the past several years, the members of this Committee have joined together in sending a letters to the President urging him to nominate people to fill all IG vacancies, including one that specifically pointed out the importance of filling the VA IG vacancy. I want to thank the President for responding by sending the Senate a number of well-qualified nominees, including Mr. Missal, for consideration and I hope we will all continue to work together to reduce the number of these vacant positions.

Permanent leadership of the Department of Veterans Affairs Office of Inspector General is long overdue and will go a long way toward providing stable leadership and oversight of the agency. I am pleased that we are moving quickly to consider Mr. Missal's nomination and I hope that the Senate will soon confirm him to this position that has been vacant for far too long so he can go to work on behalf of our veterans and the American people.

Again, thank you both for being here and for your willingness to serve. I look forward to hearing from you today.

Testimony of Michael J. Missal
Nominee to be the Inspector General
U.S. Department of Veterans Affairs
Before the Senate Committee on Homeland Security and Governmental Affairs
January 12, 2016

Chairman Johnson, Ranking Member Carper, distinguished Members of the Committee on Homeland Security and Governmental Affairs and veterans who have served our great nation. It is an honor and privilege to testify before you today as the nominee to be the Inspector General of the Department of Veterans Affairs.

I would like to recognize my wife Deborah and our son Jordan, who is a senior at Washington and Lee University. I would also like to thank the friends and colleagues who are attending today.

This would have been an incredibly proud day for my parents, Harold and Rose Missal, but unfortunately both passed away a number of years ago. Aside from family, the most important things in my father's life were his military service and his public service. My father was a World War II veteran who fought in Europe with the Army's 286th Engineer Combat Battalion. He was a proud veteran and truly one of the "Greatest Generation."

My father was also a state judge in Connecticut for more than 30 years. He instilled in me the importance of public service and the concept of "giving back." He believed that there was no higher calling than being in public service and working hard to make a difference in people's lives. I started my legal career in public service and have always desired to return to it. I cannot imagine a more meaningful or important role than the Inspector General of the Department of Veterans Affairs.

The Mission Statement of the Department of Veterans Affairs is to fulfill President Lincoln's promise: "To care for him who shall have borne the battle and for his widow, and his orphan" by serving and honoring the men and women who are America's veterans. VA provides essential services and benefits to our Veterans, but it has more work to do to live up fully to President Lincoln's promise.

This is a particularly critical time for VA as it attempts to rebuild the trust and confidence it has lost from our Veterans, Congress, Veterans Service Organizations and the American public. The VA Inspector General plays a crucial and independent role in assisting VA meet its mission and identifying the instances where it falls short. The need to eliminate waste, fraud and abuse and to promote efficiency and integrity at VA may never have been greater. Recent public reports from the Office of Inspector General and elsewhere underscore the need for significant and prompt improvements in the way VA is servicing our Veterans. If confirmed, I look forward to playing a role in strengthening the programs, policies and culture of VA.

I have had the opportunity recently to meet with many of you and to hear your thoughts and views about VA and the workings of the Office of Inspector General. The discussions have been extremely

constructive and valuable. I recognize your bipartisan approach to these issues and the great frustration in VA not fully meeting its mission.

Many of you discussed the important role that whistleblowers play in identifying potential issues. I also believe that whistleblowers are immensely important to the work of the VA Office of Inspector General. If confirmed, one of my goals will be to promote an improved environment in which whistleblowers have confidence that their concerns will be fairly and effectively considered by the Office of Inspector General and that their identities will be protected from disclosure. I will also take the necessary steps to ensure that whistleblowers are fully aware of their right to be free from reprisal for making protected disclosures and how to seek redress from appropriate authorities if reprisal occurs.

I believe that I have the experience, skills, judgment and temperament to be a highly effective Inspector General. My professional career has provided me with valuable and extensive experience in investigations, audits and inspections, three of the primary functions of an Inspector General. I have successfully conducted a number of complex and high-profile investigations, including serving as the Lead Counsel to the Examiner in the WorldCom bankruptcy proceeding, Lead Counsel to the Independent Review Panel investigating the *60 Minutes Wednesday* segment on President George W. Bush's Texas Air National Guard Service, assisting the Senate Select Committee on Ethics in its investigation of Senator John Ensign and being appointed by the Department of Justice to be the Examiner in the bankruptcy proceeding of New Century Financial, one of the largest originators of subprime mortgages. With respect to audits, I have routinely dealt with accounting principles and auditing standards and have chaired the Washington and Lee University Audit Committee. Finally, I have been involved in the inspections of various entities. This work included making recommendations on how to improve the efficiencies and effectiveness of the programs and policies of those entities.

My service on the Management Committee of K&L Gates and my role as the co-Practice Area Leader of the Policy and Regulatory practices have provided me with significant management experience. One of the practices under my jurisdiction is the firm's national healthcare practice. As a co-Practice Area Leader, I am responsible for the performance of more than 200 policy and regulatory lawyers and professionals. Among other duties, I am involved in recruiting, professional development, evaluations, compensation determinations, risk management and strategic positioning of the practices. The Management Committee is also responsible for the overall business and operations of the firm, including developing a budget for a firm with over $1 billion in revenues.

If confirmed, I pledge to work tirelessly and independently on behalf of our Veterans and the American public. I also pledge to work collaboratively with this Committee and other members of Congress and their staff. Thank you for the opportunity to testify before you today and I look forward to your questions.

REDACTED

HSGAC BIOGRAPHICAL QUESTIONS FOR EXECUTIVE NOMINEES

1. Basic Biographical Information

Please provide the following information.

Position to Which You Have Been Nominated	
Name of Position	Date of Nomination
Inspector General, Department of Veterans Affairs	October 5, 2015

Current Legal Name			
First Name	Middle Name	Last Name	Suffix
Michael	Joseph	Missal	

Addresses					
Residential Address (do not include street address)			Office Address (include street address)		
[redacted]			Street: 1601 K Street, NW		
City: Chevy Chase	State: MD	Zip: 20815	City: Washington	State: DC	Zip: 20006

Other Names Used						
First Name	Middle Name	Last Name	Suffix	Check if Maiden Name	Name Used From (Month/Year) (Check box if estimate)	Name Used To (Month/Year) (Check box if estimate)
					Est ☐	Est ☐
					Est ☐	Est ☐

Birth Year and Place	
Year of Birth **(Do not include month and day.)**	**Place of Birth**
1956	Bristol, CT

Marital Status					
Check All That Describe Your Current Situation:					
Never Married	**Married**	**Separated**	**Annulled**	**Divorced**	**Widowed**
☐	**XX**	☐	☐	☐	☐

Spouse's Name *(current spouse only)*			
Spouse's First Name	**Spouse's Middle Name**	**Spouse's Last Name**	**Spouse's Suffix**
Deborah	Stashower	Missal	

Spouse's Other Names Used *(current spouse only)*						
First Name	**Middle Name**	**Last Name**	**Suffix**	**Check if Married Name**	**Name Used From** (Month/Year) (Check box if estimate)	**Name Used To** (Month/Year) (Check box if estimate)
Deborah	Lee	Stashower			02/55 Est ☐	08/89 Est ☐
					Est ☐	Est ☐

Children's Names (if over 18)			
First Name	Middle Name	Last Name	Suffix
Jordan	Bernard	Missal	

2. Education

List all post-secondary schools attended.

Name of School	Type of School (vocational/technical/trade school, college/university/military college, correspondence/distance/extension/online school)	Date Began School (month/year) (check box if estimate)	Date Ended School (month/year) (check box if estimate) (check "present" box if still in school)	Degree	Date Awarded
Washington and Lee University	College/University	08/74	06/78	BS	06/78
The Catholic University of America	College/University	08/79	05/82	JD	05/82
		Est ☐	Est ☐ Present ☐		
		Est ☐	Est ☐ Present ☐		

3. Employment

(A) List all of your employment activities, including unemployment and self-employment. If the employment activity was military duty, list separate employment activity periods to show each change of military duty station. Do not list employment before your 18th birthday unless to provide a minimum of two years of employment history.

Type of Employment (Active Military Duty Station, National Guard/Reserve, USPHS Commissioned Corps, Other Federal employment, State Government (Non-Federal Employment), Self-employment, Unemployment, Federal Contractor, Non-Government Employment (excluding self-employment), Other	Name of Your Employer/ Assigned Duty Station	Most Recent Position Title/Rank	Location (City and State only)	Date Employment Began (month/year) (check box if estimate)	Date Employment Ended (month/year) (check box if estimate) (check "present" box if still employed)
Congressional Employment	Senator Abraham Ribicoff	Intern	Washing ton, DC	04/77	08/77
Federal Employment	The White House	Staff Assistant	Washing ton, DC	07/78	01/81 (full and part-time)
Non-Government Employment	Akin, Gump, Hauer and Strauss	Summer Associate	Washing ton, DC	05/79	08/79
State Government Employment	Chief Judge H. Carol Moultrie I	Law Clerk	Washing ton, DC	08/82	08/83
Federal Employment	U.S. Securities and Exchange Commission	Senior Counsel	Washing ton, DC	09/83	06/87
Non-Government Employment	K&L Gates LLP	Partner	Washing ton, DC	06/87	Present
Unemployment	Full-time student			08/74 - 06/78 08/79 - 05/82	

(B) List any advisory, consultative, honorary or other part-time service or positions with federal, state, or local governments, not listed elsewhere. None.

Name of Government Entity	Name of Position	Date Service Began (month/year) (check box if estimate)	Date Service Ended (month/year) (check box if estimate) (check "present" box if still serving)
		Est ☐	Est ☐ Present ☐

		Est -	Est Present □ □
		Est □	Est Present □ □

4. Potential Conflict of Interest

(A) Describe any business relationship, dealing or financial transaction which you have had during the last 10 years, whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated. None.

(B) Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any legislation or affecting the administration or execution of law or public policy, other than while in a federal government capacity. None.

5. Honors and Awards

List all scholarships, fellowships, honorary degrees, civilian service citations, military medals, academic or professional honors, honorary society memberships and any other special recognition for outstanding service or achievement.

Martindale-Hubbell AV Preeminent Rated

Chambers USA Ranked Lawyer

U.S. News and World Report Best Lawyers

Best Lawyers in America

Washington DC Super Lawyers

6. Memberships

List all memberships that you have held in professional, social, business, fraternal, scholarly, civic, or charitable organizations in the last 10 years.

Unless relevant to your nomination, you do NOT need to include memberships in charitable organizations available to the public as a result of a tax deductible donation of $1,000 or less, Parent-Teacher Associations or other organizations connected to schools attended by your children, athletic clubs or teams, automobile support organizations (such

as AAA), discounts clubs (such as Groupon or Sam's Club), or affinity memberships/consumer clubs (such as frequent flyer memberships).

Name of Organization	Dates of Your Membership (You may approximate.)	Position(s) Held
Washington and Lee University	May 2011 to the present	Board of Trustees
Kenwood Golf and Country Club	January 1997 to the present	Member

7. Political Activity

(A) Have you ever been a candidate for or been elected or appointed to a political office?

No.

Name of Office	Elected/Appointed/ Candidate Only	Year(s) Election Held or Appointment Made	Term of Service (if applicable)

(B) **List any offices held in or services rendered to a political party or election committee during the last ten years that you have not listed elsewhere.**

None.

Name of Party/Election Committee	Office/Services Rendered	Responsibilities	Dates of Service

(C) Itemize all individual political contributions of $200 or more that you have made in the past five years to any individual, campaign organization, political party, political action committee, or similar entity. Please list each individual contribution and not the total amount contributed to the person or entity during the year.

Name of Recipient	Amount	Year of Contribution
K&L Gates Political Action Committee	$5,000	2011, 2012, 2013, 2014 and 2015
Heather Mizeur for Governor of Maryland	$1,000	2014

8. Publications and Speeches

(A) List the titles, publishers and dates of books, articles, reports or other published materials that you have written, including articles published on the Internet. Please provide the Committee with copies of all listed publications. In lieu of hard copies, electronic copies can be provided via e-mail or other digital format.

Title	Publisher	Date(s) of Publication
Conducting Internal Investigations (co-author)	Securities Industry and Financial Markets Association ("SIFMA")	April 2015

D.C. Circuit Broadly Applies Attorney-Client Privilege to Internal Investigations (co-author)	K&L Gates LLP	July 2014
The Consumer Financial Protection Bureau: A FirstYear Retrospective (co-author)	K&L Gates LLP	July 2012
Global Foreclosure Settlement: The Success of Herding Cats (co-author)	K&L Gates LLP	March 2012
Dodd-Frank's Whistleblower Bounties: An Effective Hotline May Keep You Out of Hot Water (co-author)	K&L Gates LLP	September 2010
More Enforcers at Your Door: Preparing for and Responding to Increased Government Investigations and Actions (co-author)	K&L Gates LLP	November 2009
A Congressional Investigation of Wall Street Looms (co-author)	K&L Gates LLP	April 2009
How to Prepare for an SEC Examination m(co-author)	K&L Gates LLP	November 2008
The Foreign Corrupt Practices Act: US Legislation with Global Implications (co-author)	Practical Law Company	November 2008
The Credit Crisis and the Audit Committee (co-author)	Metropolitan Corporate Counsel	November 2008
Investigating the Insider (co-author)	Security Management	October 2008
New Century Financial: Lessons Learned (co-author)	K&L Gates LLP	October 2008
Conducting Corporate Internal Investigations (co-author)	International Journal of Disclosure and Governance	July 2007
The SEC's New Executive Compensation Disclosure Rules: Liability Concerns for Officers and Directors (co-author)	Andrews Litigation Reporter	September 2006

(B) List any formal speeches you have delivered during the last five years and provide the Committee with copies of those speeches relevant to the position for which you have been nominated. Include any testimony to Congress or any other legislative or administrative body. These items can be provided electronically via e-mail or other digital format. None.

Title/Topic	Place/Audience	Date(s) of Speech

(C) List all speeches and testimony you have delivered in the past ten years, except for those the text of which you are providing to the Committee. None.

Title	Place/Audience	Date(s) of Speech

9. Criminal History

Since (and including) your 18th birthday, has any of the following happened?

- Have you been issued a summons, citation, or ticket to appear in court in a criminal proceeding against you? (Exclude citations involving traffic infractions where the fine was less than $300 and did not include alcohol or drugs.) - No.
- Have you been arrested by any police officer, sheriff, marshal or any other type of law enforcement official? - No.
- Have you been charged, convicted, or sentenced of a crime in any court? - No.
- Have you been or are you currently on probation or parole? - No.
- Are you currently on trial or awaiting a trial on criminal charges? - No.

- To your knowledge, have you ever been the subject or target of a federal, state or local criminal investigation? - **No.**

If the answer to any of the questions above is yes, please answer the questions below for each criminal event (citation, arrest, investigation, etc.). If the event was an investigation, where the question below asks for information about the offense, please offer information about the offense under investigation (if known).

A) Date of offense:

   a. Is this an estimate (Yes/No):

B) Description of the specific nature of the offense:

C) Did the offense involve any of the following?
   1) Domestic violence or a crime of violence (such as battery or assault) against your child, dependent, cohabitant, spouse, former spouse, or someone with whom you share a child in common: **Yes / No**
   2) Firearms or explosives: **Yes / No**
   3) Alcohol or drugs: **Yes / No**

D) Location where the offense occurred (city, county, state, zip code, country):

E) Were you arrested, summoned, cited or did you receive a ticket to appear as a result of this offense by any police officer, sheriff, marshal or any other type of law enforcement official: **Yes / No**

   1) Name of the law enforcement agency that arrested/cited/summoned you:

   2) Location of the law enforcement agency (city, county, state, zip code, country):

F) As a result of this offense were you charged, convicted, currently awaiting trial, and/or ordered to appear in court in a criminal proceeding against you: **Yes / No**

   1) If yes, provide the name of the court and the location of the court (city, county, state, zip code, country):

   2) If yes, provide all the charges brought against you for this offense, and the outcome of each charged offense (such as found guilty, found not-guilty, charge dropped or "nolle pros," etc). If you were found guilty of or pleaded guilty to a lesser offense, list separately both the original charge and the lesser offense:

   3) If no, provide explanation:

G) Were you sentenced as a result of this offense: **Yes / No**

H) Provide a description of the sentence:

I) Were you sentenced to imprisonment for a term exceeding one year: **Yes / No**

J) Were you incarcerated as a result of that sentence for not less than one year: **Yes / No**

K) If the conviction resulted in imprisonment, provide the dates that you actually were incarcerated:

L) If conviction resulted in probation or parole, provide the dates of probation or parole:

M) Are you currently on trial, awaiting a trial, or awaiting sentencing on criminal charges for this offense: **Yes / No**

N) Provide explanation:

10. Civil Litigation and Administrative or Legislative Proceedings

(A) Since (and including) your 18th birthday, have you been a party to any public record civil court action or administrative or legislative proceeding of any kind that resulted in (1) a finding of wrongdoing against you, or (2) a settlement agreement for you, or some other person or entity, to make a payment to settle allegations against you, or for you to take, or refrain from taking, some action. Do NOT include small claims proceedings. - No.

Date Claim/Suit Was Filed or Legislative Proceedings Began	Court Name	Name(s) of Principal Parties Involved in Action/Proceeding	Nature of Action/Proceeding	Results of Action/Proceeding

(B) In addition to those listed above, have you or any business of which you were an officer, director or owner ever been involved as a party of interest in any administrative agency proceeding or civil litigation? Please identify and provide details for any proceedings or civil litigation that involve actions taken or omitted by you, or alleged to have been taken or omitted by you, while serving in your official capacity. - No.

Date Claim/Suit Was Filed	Court Name	Name(s) of Principal Parties Involved in Action/Proceeding	Nature of Action/Proceeding	Results of Action/Proceeding

(C) For responses to the previous question, please identify and provide details for any proceedings or civil litigation that involve actions taken or omitted by you, or alleged to have been taken or omitted by you, while serving in your official capacity. - None.

11. Breach of Professional Ethics

(A) Have you ever been disciplined or cited for a breach of ethics or unprofessional conduct by, or been the subject of a complaint to, any court, administrative agency, professional association, disciplinary committee, or other professional group? Exclude cases and proceedings already listed. - No.

Name of Agency/Association/ Committee/Group	Date Citation/Disciplinary Action/Complaint Issued/Initiated	Describe Citation/Disciplinary Action/Complaint	Results of Disciplinary Action/Complaint

(B) Have you ever been fired from a job, quit a job after being told you would be fired, left a job by mutual agreement following charges or allegations of misconduct, left a job by mutual agreement following notice of unsatisfactory performance, or received a written warning, been officially reprimanded, suspended, or disciplined for misconduct in the workplace, such as violation of a security policy? - No.

12. Tax Compliance

(This information will not be published in the record of the hearing on your nomination, but it will be retained in the Committee's files and will be available for public inspection.)

REDACTED

REDACTED

13. Lobbying

In the past ten years, have you registered as a lobbyist? If so, please indicate the state, federal, or local bodies with which you have registered (e.g., House, Senate, California Secretary of State). - No.

14. Outside Positions

XX See OGE Form 278. (If, for your nomination, you have completed an OGE Form 278 Executive Branch Personnel Public Financial Disclosure Report, you may check the box here to complete this section and then proceed to the next section.)

For the preceding ten calendar years and the current calendar year, report any positions held, whether compensated or not. Positions include but are not limited to those of an officer, director, trustee, general partner, proprietor, representative, employee, or consultant of any corporation, firm, partnership, or other business enterprise or any non-profit organization or educational institution. Exclude positions with religious, social, fraternal, or political entities and those solely of an honorary nature.

Name of Organization	Address of Organization	Type of Organization (corporation, firm, partnership, other business enterprise, other non-profit organization, educational institution)	Position Held	Position Held From (month/year)	Position Held To (month/year)

15. Agreements or Arrangements

XX See OGE Form 278. (If, for your nomination, you have completed an OGE Form 278 Executive Branch Personnel Public Financial Disclosure Report, you may check the box here to complete this section and then proceed to the next section.)

As of the date of filing your OGE Form 278, report your agreements or arrangements for: (1) continuing participation in an employee benefit plan (e.g. pension, 401k, deferred compensation); (2) continuation of payment by a former employer (including severance payments); (3) leaves of absence; and (4) future employment.

Provide information regarding any agreements or arrangements you have concerning (1) future employment; (2) a leave of absence during your period of Government service; (3) continuation of payments by a former employer other than the United States Government; and (4) continuing participation in an employee welfare or benefit plan maintained by a former employer other than United States Government retirement benefits.

Status and Terms of Any Agreement or Arrangement	Parties	Date (month/year)

16. Additional Financial Data

All information requested under this heading must be provided for yourself, your spouse, and your dependents. (This information will not be published in the record of the hearing

on your nomination, but it will be retained in the Committee's files and will be available for public inspection.)

REDACTED

REDACTED

SIGNATURE AND DATE

I hereby state that I have read the foregoing Statement on Biographical and Financial Information and that the information provided therein is, to the best of my knowledge, current, accurate, and complete.

District of Columbia, SS

Subscribed and sworn to before me, in my presence,

this 15th day of October, 2015

by

Notary Public

My Commission Expires 9/14/2020

CAROL MICHAELSEN NOTARY PUBLIC EXPIRES SEPT. 14, 2020 DISTRICT OF COLUMBIA

This 15th day of October 2015

UNITED STATES OFFICE OF
GOVERNMENT ETHICS

OCT 15 2015

The Honorable Johnny Isakson
Chairman
Committee on Veterans' Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Michael J. Missal, who has been nominated by President Obama for the position of Inspector General, Department of Veterans Affairs.

We have reviewed the report and have obtained advice from the agency concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is an ethics agreement outlining the actions that the nominee will undertake to avoid conflicts of interest. Unless a date for compliance is indicated in the ethics agreement, the nominee must fully comply within three months of confirmation with any action specified in the ethics agreement.

Based thereon, we believe that this nominee is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

David J. Apol
General Counsel

Enclosures **REDACTED**

October 2, 2015

Mark T. Jaynes
Alternate Designated Agency Ethics Official
810 Vermont Avenue NW
Washington, D.C. 20420

Dear Mr. Jaynes:

The purpose of this letter is to describe the steps that I will take to avoid any actual or apparent conflict of interest in the event that I am confirmed for the position of Inspector General of the Department of Veterans Affairs.

As required by 18 U.S.C. § 208(a), I will not participate personally and substantially in any particular matter in which I know that I have a financial interest directly and predictably affected by the matter, or in which I know that a person whose interests are imputed to me has a financial interest directly and predictably affected by the matter, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2). I understand that the interests of the following persons are imputed to me: any spouse or minor child of mine; any general partner of a partnership in which I am a limited or general partner; any organization in which I serve as officer, director, trustee, general partner or employee; and any person or organization with which I am negotiating or have an arrangement concerning prospective employment.

I will divest my interests in the entities listed on Attachment A within 90 days of my confirmation. With regard to each of these entities, I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the entity until I have divested it, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2).

I understand that I may be eligible to request a Certificate of Divestiture for qualifying assets and that a Certificate of Divestiture is effective only if obtained prior to divestiture. Regardless of whether I receive a Certificate of Divestiture, I will ensure that all divestitures discussed in this agreement occur within the agreed upon timeframes and that all proceeds are invested in non-conflicting assets.

If I rely on a *de minimis* exemption under 5 C.F.R. § 2640.201(b) with regard to any of my financial interests in sector mutual funds, I will monitor the value of those interests. If the aggregate value of my interests in sector mutual funds that concentrate in any one sector exceeds $50,000, I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of any holdings of the funds that are in the specific sector in which the funds concentrate, unless I first obtain a written waiver pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2).

Upon confirmation, I will withdraw from the partnership of K&L Gates, LLP. Before I assume the duties of the position of Inspector General, I will receive a refund of my capital account, the balance of my draw account, and a partner equity distribution, which includes my allocated share of the partnership's income based on the firm's operations through the date of my withdrawal. For a period of one year after my resignation, I will not participate personally and substantially in any particular matter involving specific parties in which I know that K&L Gates, LLP is a party or represents a party, unless I am first authorized to participate, pursuant to 5 C.F.R. § 2635.502(d). In addition, I will not participate personally and substantially in any particular matter involving specific parties in which I know a former client of mine is a party or represents a party for a period of one year after I last provided service to that client, unless I am first authorized to participate, pursuant to 5 C.F.R. § 2635.502(d).

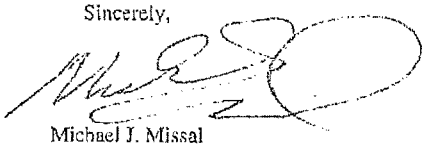
Upon confirmation, I will resign from my position as the Chair of the Independent Review Committee with Vanguard Investments Canada, Inc. For a period of one year after my resignation, I will not participate personally and substantially in any particular matter involving specific parties in which I know Vanguard Investments Canada, Inc., is a party or represents a party, unless I am first authorized to participate, pursuant to 5 C.F.R. § 2635.502(d).

Prior to appointment as Inspector General of the Department of Veterans Affairs, I will resign from my position as a trustee of Washington & Lee University. For a period of one year after my resignation, I will not participate personally and substantially in any particular matter involving specific parties in which I know Washington & Lee University is a party, or represents a party, unless I am first authorized to participate, pursuant to 5 C.F.R. § 2635.502(d).

I understand that as an appointee I am required to sign the Ethics Pledge (Exec. Order No. 13490) and that I will be bound by the requirements and restrictions therein in addition to the commitments I have made in this ethics agreement.

Finally, I have been advised that this ethics agreement will be posted publicly, consistent with 5 U.S.C. § 552, on the website of the U.S. Office of Government Ethics with ethics agreements of other Presidential nominees who file public financial disclosure reports.

Sincerely,



Michael J. Missal

Attachment A

Vanguard Health Care Fund Admiral Shares
American Airlines Group
Apple
AT & T
Bank Of America
Berkshire Hathaway
BP (ADR, Nasdaq)
Carlyle Group LP
Caterpillar
Chubb Corp.
Cisco Systems
Citigroup
Community Bankers Trust
Crossroads Systems
Discover Financial Services
Discovery Holdings Corp. (Trades As Discovery Minerals Ltd)
EBay
Express Scripts
Facebook
Goldman Sachs
Google A
Google C
Hilltop Holdings Inc.
IBM
IShares Nasdaq Biotechnology Index ETF
Johnson & Johnson
Kennedy-Wilson Holdings Inc.
Kingsway Financial Services Inc.
KKR & Co, LP
Metlife Inc.
Morgan Stanley
Mueller Water Products, Inc.
Novartis Ag ADR (NYSE)
Pico Holdings
PayPal Holdings
Procter & Gamble
SPDR S&P Biotech ETF
Stryker Corp.
Tetra Tech Inc.
Timken Co.
Toyota Motor Corp.
Verizon Communications
Accuray Inc.
Ally Financial Inc.

Bank Of New York Mellon Corp.
Baxalta Inc. (BXLT)
1347 Property Insurance Holdings Inc.
Baxter International Inc.
Bluestem Group (OTC Mkts: BGRP)
Bristol-Myers Squibb
Comcast Corp.
Micron Technology, Inc.
Microsoft Corp.
Qualcomm, Inc.
Southwest Airlines Co.
Starwood Hotels & Resorts
United Rentals Inc.
Ventas Inc.
Leucadia National Corp.
Dow Chemical Co.
New Residential Investment Corp
Two Harbors Investment Corp.
Unilever PLC (ADR) (NYSE)
PennantPark
Saratoga Investment Corp

U.S. Senate Committee on Homeland Security and Governmental Affairs
Pre-hearing Questionnaire
For the Nomination of Michael J. Missal to be
Inspector General, Department of Veterans Affairs

I. Nomination Process and Conflicts of Interest

1. Why do you believe the President nominated you to serve as the Inspector General (IG) of the Department of Veterans Affairs ("VA")?

   I believe I was nominated because I have the skillset, experience, judgment and temperament to be a highly effective Inspector General. I wanted to return to public service and am committed to serving our Veterans and the American public.

2. Were any conditions, expressed or implied, attached to your nomination? If so, please explain.

   No.

3. If confirmed, are there any issues from which you may have to recuse or disqualify yourself because of a conflict of interest or the appearance of a conflict of interest? If so, please explain the procedures and/or criteria that you will use to carry out such a recusal or disqualification.

   I agreed not to participate personally and substantially in any matter involving any former law client of mine for one year and not to participate in any matter in which K&L Gates is a party for one year, unless I am authorized to participate. There will be a process in place to identify any such matters.

4. What specific background and experience affirmatively qualify you to be an IG?

   My professional career has provided me with valuable and extensive experience in investigations, audits and inspections, three of the primary functions of an Inspector General. I have successfully conducted a number of complex and high-profile investigations, including serving as the Lead Counsel to the Examiner in the WorldCom bankruptcy proceeding, Lead Counsel to the Independent Review Panel investigating the 60 Minutes Wednesday segment on President George W. Bush's Texas Air National Guard Service, assisting the Senate Select Committee on Ethics in its investigation of Senator John Ensign and being appointed by the Department of Justice to be the Examiner in the bankruptcy proceeding of New Century Financial, one of the largest originators of subprime mortgages. With respect to audits, I have routinely dealt with accounting principles and auditing standards and have chaired the Washington and Lee University Audit Committee. Finally, I have been involved in the inspections of various entities. This work included making recommendations on how to improve the efficiencies and effectiveness of the programs and policies of those entities.

My service on the Management Committee of K&L Gates and my role as the co-Practice Area Leader of the Policy and Regulatory practices have provided me with significant management experience. One of the practices under my jurisdiction is the firm's national healthcare practice. As a co-Practice Area Leader, I am responsible for the performance of more than 200 policy and regulatory lawyers and professionals. Among other duties, I am involved in recruiting, professional development, evaluations, compensation determinations, risk management and strategic positioning of the practices. The Management Committee is also responsible for the overall business and operations of the firm, including developing a budget for a firm with over $1 billion in revenues.

5. Have you made any commitments with respect to the policies and principles you will attempt to implement as IG? If so, what are they, and to whom were the commitments made?

No.

II. Background of the Nominee

6. Please briefly describe the type of work you did at the United States Securities and Exchange Commission (SEC), including the different positions you held and the responsibilities of each.

I began my career in the Division of Enforcement at the Securities and Exchange Commission as a Staff Attorney and was promoted to Senior Counsel. My primary responsibility was to investigate possible violations of the federal securities laws and to make recommendations to the Commission for an action if I believed that an entity or person violated the federal securities laws.

7. How has your work at the SEC prepared you for work at the VA Office of Inspector General (OIG)?

My work at the Division of Enforcement of the SEC provided me with valuable experience in conducting investigations and dealing with accounting principles. I conducted a number of investigations in which I reviewed documents and interviewed witnesses. Some of these investigations involved accounting issues. I also prepared memorandum for the Commission analyzing the facts with relevant law and making recommendations for potential actions against companies and individuals.

8. Please briefly describe the type of work you have done at K&L Gates LLP, including the different positions you have held and the responsibilities of each.

My work at K&L Gates, first as an associate and then as a partner, has primarily been to represent clients in regulatory matters and to conduct internal investigations. Some of the investigations have been large and complex. I have also served in various management functions at K&L Gates, including as a member of the firm's Management Committee

and as a co-Practice Area Leader of the firm's Policy and Regulatory practices. The Policy and Regulatory practices include some relevant to the work of the VA OIG, including healthcare, FDA and internal investigations.

9. What lessons, if any, did you learn working at K&L Gates LLP that prepared you for work at the VA OIG?

My work at K&L Gates provided me with extensive experience in conducting investigations and inspections. These investigations and inspections have covered a number of issues, including but not limited to, health care and financial services. Both of these are significant services provided by the VA. I also had experience dealing with accounting principles, which will assist me in leading the VA OIG audit function. In addition, my approximately 17 year service on the K&L Gates Management Committee, as well as being a co-Practice Area Leader of the Policy and Regulatory practices, have provided me with significant management experience.

10. During your time at K&L Gates LLP, have you had any significant interaction with employees of the VA?

No.

11. What experience, if any, do you have in either directly managing or overseeing the core management functions of an organization (human capital, acquisitions, information technology, and financial management)?

I have served on the K&L Gates Management Committee for approximately 17 years. The Management Committee is responsible for the business of the firm, which is now approximately 2,000 lawyers and 1,500 administrative personnel in 47 cities around the globe. The firm has revenues of over $1 billion. I am also the co-Practice Area Leader for the Policy and Regulatory practices. These practices have over 200 lawyers and other professionals around the world. In these roles, I have had significant experience in many issues, including evaluations, personnel decisions, compensation, information technology, setting budgets, mergers of law firms, marketing and professional development.

III. Role and Responsibilities of the VA IG

Management of the Workforce

12. How do you view the role of the VA OIG?

In general, the role of the VA OIG is to act independently and to identify instances of waste, fraud and abuse, as well as ways the VA can operate more effectively and efficiently. The VA OIG does this primarily through audits, inspections and investigations. The VA OIG prepares numerous public reports and keeps the Secretary

and Congress fully and timely informed of significant issues. The VA OIG also recommends ways that the VA can improve its operations and processes.

13. What do you anticipate being the greatest challenges you would face as an IG coming from private law practice, and how would you seek to prepare for those challenges?

The biggest challenge in transitioning from private practice may be learning the various processes and procedures that are unique to the OIG and the VA. If confirmed, I intend to immerse myself as quickly as possible to better understand the policies, practices and culture of the OIG and the VA. I will also implement any improvements at the OIG that I believe will strengthen the office and make it more effective.

14. What do you believe are the qualities of an effective manager?

Some of the more significant qualities of an effective manager are to be an excellent leader, a strong and clear communicator, a good listener, an effective multi-tasker, have unquestioned integrity and the ability to instill confidence.

a. How would you describe your management style?

My management style is based on the overriding principle that I treat others as I would like to be treated. I lead by example and emphasize integrity and respect for others. I have a great deal of personal interaction with my team and communicate regularly with them about my ideas, expectations and goals. I promote strong teamwork and provide opportunities for professional growth and advancement. I am a good listener and am always open to ideas on how to improve the quality of our work and our processes.

b. What are the most important lessons you have learned about management in previous management positions you have held?

One of the most important lessons is that the tone at the top sets the culture of an organization. A strong and consistent message should filter down to subordinates. It is also important for management to treat others respectfully and with dignity. It is further critical to communicate management's goals and expectations clearly and effectively.

c. What qualities do you look for in assembling a management team?

I look for a number of different qualities. Among the more significant are integrity, effectiveness, teamwork, hard work, communication skills and commitment.

d. What is your approach to delegating work and responsibilities to others?

I think it is important to delegate responsibility. This not only makes the team more effective, but it also enhances professional development. If someone has shown that he or she can accept more responsibility, then I will give them more responsibility.

15. In your current position at K&L Gates LLP, do you play any role in the disciplinary process of other attorneys? If so, please explain.

The Management Committee of K&L Gates is responsible for the more significant disciplinary actions. As a member of the Management Committee, I will be involved in disciplinary matters that are considered by the Management Committee. This includes reviewing the relevant facts and circumstances and to vote on any proposed disciplinary action. If the matter is less significant and involves lawyers in the firm's Policy and Regulatory practices, I would review the facts and circumstances and make any disciplinary decision.

a. How do you respond to underperforming individuals within your law firm?

With respect to underperforming individuals, I first mentor them to improve their performance and inform them of the specific issues that need improvement. I give underperforming individuals the opportunity to correct their performances. If this is not successful, then additional steps will be taken as necessary and appropriate for the circumstances. This could include termination if the individual is not performing to the standards expected and communicated.

b. Please explain your views on putting an employee on paid administrative leave pending an investigation or disciplinary action.

This situation has come up more frequently for me in connection with my advice to clients in regulatory matters. My view is that it may be appropriate in some situations to put an employee on paid administrative leave pending an investigation or disciplinary action. A number of factors should be considered, including the strength and seriousness of the allegations, the prior disciplinary history of the employee, and any legal authority and appropriate precedent. My advice is based on a consideration of all of these factors and any others that are relevant.

c. How, if at all, would your handling of disciplinary issues change if you are confirmed as IG?

I recognize that it would be my responsibility to make these decisions. Aside from the factors listed above, I would also take into consideration any relevant policies and practices at the VA and the OIG. I would also consult with my counsel and any other appropriate person within the OIG so that I had the necessary information before making a decision.

16. Do you believe there is any tension between the need to issue high quality OIG reports and the need to issue those reports in a timely manner so as to ensure findings and recommendations remain relevant? If so, how would you seek to balance those potentially conflicting requirements?

I believe that both requirements are important and will seek to achieve both in each matter. I would expect that each OIG report would be of high quality. For the more extensive or complex issues, it may be necessary to devote additional resources to issue them in a timely manner.

17. As the VA IG, what measures would you use to determine whether your office is successful? How do you measure success in your current position?

There are a variety of measures of success, but perhaps the most important is for our Veterans, Congress and the American public to have confidence and trust in the work of the OIG. I would also measure success if whistleblowers were more comfortable in making their concerns known to the OIG and that they felt that their concerns were fairly and objectively reviewed by the OIG. In my current position, some of the ways I measure success are by the level of satisfaction from clients and the overall success of the law firm.

18. IGs are charged with achieving a balance among conflicting demands on resources, including fulfilling statutory and other obligations, responding to direct requests from Congress, and furthering their own priorities. How would you strive to achieve the appropriate balance among these competing demands?

In my current position, I successfully balance a number of competing demands. I would use these skills and experience to balance all of these demands in an appropriate manner. For example, I frequently balance legal representations of multiple matters with my management responsibilities. I use my judgment to determine the proper balance. If after assessing the resources of the OIG I believed that additional resources were needed for the OIG to perform effectively its responsbilities, I would notify Congress.

19. The Government Accountability Office (GAO) also does extensive auditing and evaluation work of agencies. What policy or operational mechanisms do you believe should be adopted to coordinate OIG and GAO work, prevent work duplication and overlap where possible, and avoid gaps in coverage of important mission area programs?

I would seek to be aware of the work of the GAO and to communicate with them as appropriate to avoid duplication and overlap. I would assess the mechanisms to coordinate currently in place and determine whether they need to be enhanced. I would expect to have regular communications with the GAO.

Communications with VA and Congress

20. How do you foresee keeping the Secretary informed about issues identified by your office?

I expect to have a strong but independent working relationship with the Secretary. I would seek to have regular meetings with the Secretary so that he could be fully and timely informed of appropriate issues identified by the OIG. In addition, I would also

promptly inform the Secretary outside of our regular meetings of any significant issues that require more immediate attention. Aside from meetings with the Secretary, I would also seek to keep him informed of other issues through e-mails, memorandum and other written communications.

21. In addition to uncovering waste, fraud, and abuse within the executive branch, IGs can play an important role in helping agencies proactively avoid problems rather than just auditing for mistakes after the fact.

    a. Do you believe an IG should take this more proactive role, which necessarily requires a more collaborative relationship with agency managers, while also serving as the independent watchdogs who expose agency mismanagement?

       I believe that an IG should also take this more proactive approach. An important goal for an IG is to try to anticipate problems before they occur. One of the ways this can be accomplished is by testing and analyzing new programs and practices either before they are implemented or just after they are implemented. This needs to be done while maintaining the necessary independence of the OIG from senior management at the VA.

    b. How would you balance the two approaches?

       If confirmed, I will immerse myself into the priorities of the OIG to better understand how these two approaches are currently balanced. I believe that taking a more proactive approach is important to identifying issues before they become wide scale problems. I will examine the funding and resources of the OIG and ensure that the proactive approach is a meaningful part of the work of the OIG.

    c. What role should the IG play in identifying effective programs or best practices within VA that, if replicated, could promote increased efficiencies or improved mission performance?

       The IG should play a role in identifying programs or best practices to promote increased efficiencies and improved mission performance. This is one of the stated responsibilities for an IG in the Inspector General Act of 1978, as amended. The IG can identify effective programs and best practices through its audit and inspection functions. However, the responsibilities for implementing programs lie with the Department and it is important for the OIG to maintain its independence.

22. IGs are required by law to report their findings to Congress, as well as to executive branch officials. IGs also routinely provide testimony at hearings on key issues of concern.

    a. What additional methods, if any, would you take to keep Congress timely and effectively informed about all OIG matters?

I recognize the importance of keeping Congress timely and effectively informed to assist Congress in its oversight responsibilities. My goal is to have a highly transparent OIG. In addition to public reports and testimony, I would also provide information to Congress and their staff through other methods including meetings, telephone calls and e-mails.

b. More generally, what role should Congress play in setting priorities for the OIG?

It is important for the OIG to have a strong working relationship with Congress. If confirmed, I will confer with Congress and their staff to obtain their views on the priorities of the OIG. I will consider those views in setting the priorities for the OIG.

23. IGs are required by Section 5 of the Inspector General Act of 1978 to report "serious or flagrant problems, abuses, or deficiencies relating to the administration of programs and operations of [VA]" to Congress through "seven-day letters."

a. Do you view this as an important tool at the IG's disposal? Why or why not?

I consider this an important tool. This procedure requires the Secretary and Congress to be informed promptly of significant issues. This should allow the Secretary to take any remedial steps as quickly as possible. It also provides prompt information necessary for Congress in its oversight role.

b. How do you envision using seven-day letters in practice?

The issue that requires a seven-day letter is obviously critical and one that needs prompt attention. I would make sure that the Secretary fully understands the issue requiring a seven-day letter. I would accomplish this through a meeting or conversation after the seven-day letter is delivered as appropriate.

c. How would you define "serious or flagrant problems, abuses, or deficiencies relating to the administration of programs and operations"?

The definition would include certain criminal matters, those that have a broad and extensive impact on the quality of healthcare or the delivery of benefits, and those with a significant monetary impact. I would also keep current about how other Inspectors General define "serious or flagrant problems, abuses or deficiencies" and modify the interpretation as appropriate.

d. Do you believe that, upon notifying the VA of a serious problem that requires the agency's urgent attention, you have a concurrent obligation to notify Congress, including this Committee, of that problem?

I do not believe that Section 5 of the Inspector General Act of 1978 as amended requires it. However, given the importance of seven-day letters, I would make sure that Congress was notified promptly of the issue.

e. If confirmed, do you agree without reservation to report any "serious or flagrant problems, abuses, or deficiencies relating to the administration of programs and operations of [VA]" to Congress, recommend corrective actions, and report on the agency's progress in implementing corrective actions?

I agree without reservation to file seven-day letters as appropriate and make sure that Congress receives prompt notification of the issue. To the extent corrective actions are appropriate, I also agree without reservation to recommend corrective actions and report to Congress on the progress in implementing any recommendation.

24. IGs from time to time make recommendations to the agency as a part of their report, audit, or investigation. How would you ensure all such recommendations are provided directly to the Secretary?

I recognize the importance of recommendations by the OIG and the need to have them receive the proper attention and action by the VA. I expect to have regular interactions with the Secretary and will make sure he is aware of the more significant recommendations.

25. Do you intend to alert Congress to problems at the VA that are caused by, or partly caused by, a lack of resources or a lack of statutory authority?

I will alert Congress to problems that are caused by, or partly caused by, a lack of resources or a lack of statutory authority as appropriate. I expect that the problems that would result in a notification to Congress would be the more significant ones.

26. Congress made clear in Section 6(a)(1) of the Inspector General Act of 1978, as amended, that IGs are to have full access to agency records, reports, papers, etc. If confirmed as IG, what recourse would you take in the event that the OIG experienced problems with access to information from VA? Would you notify Congress about problems with access to information from VA?

I believe that it is critically important for the OIG to have full access to VA records in order to meet fully its obligations and responsibilities. If the OIG experienced problems with getting access to information from the VA, I would first determine why the VA was not providing the requested information. If I continued to believe that the OIG needed the requested information, I would then escalate the issue all the way to the Secretary if necessary. If the OIG still did not get access to necessary information, I would notify Congress.

IG Transparency, Accountability, and Independence

27. Section 8M(b) of the Inspector General Act of 1978 requires IGs to publish their reports and audits on their websites "not later than 3 days after any report or audit . . . is made publicly available." The VA OIG has been criticized for failing to make closed reports

public. If confirmed, what would your policy be for making reports public and posting a closed report or audit on your website? Please explain.

One of my goals is to increase transparency of the work of the VA OIG. I will review the practice of not making public closed reports of audits or inspections. I will assess the reasons for not making closed reports publicly available and examine the practices of other Inspectors General. I recognize that there may be benefits to making public certain closed reports of audits and inspections.

28. It is critically important that OIGs are sufficiently independent from the agency which they work within to ensure OIGs can fulfill their role in combatting waste, fraud, and abuse.

a. Is any appearance of improper agency influence over an OIG concerning to you?

Yes. Even the appearance of improper agency influence is unacceptable. Any such appearance could impair the credibility of the OIG.

b. Do you believe it is appropriate to ever consider changes to a report based on comments from the agency that is the subject of the report? If so, under what circumstances?

It may be appropriate in certain situations. For example, it may be appropriate if it assists in promoting the accuracy and fairness of the report. However, the findings included in the report should be those of only the OIG.

c. If confirmed, what steps would you take if VA officials attempted to inappropriately influence an ongoing OIG investigation, audit, inspection, or evaluation? Would you commit to notifying Congress?

I would immediately review the facts and circumstances surrounding the VA official who attempted to influence inappropriately an ongoing OIG investigation, audit or inspection. Based on what I learned, it might be appropriate to notify more senior VA officials about the matter. I would notify Congress if I believed that there was a deliberate and significant effort to improperly influence an ongoing OIG investigation, audit or inspection, particularly if it involved a senior official.

d. If confirmed, what safeguards will you implement to ensure the independence of the OIG's office?

I will make sure that there are constant reminders within the office concerning the importance of the independence of the OIG. I will also assess and enhance as appropriate any training of the OIG staff. I will further take steps to ensure that I am notified if there is even an appearance of a lack of independence.

IV. Policy Questions

29. What do you believe are the highest priority issues facing VA OIG?

The highest priority issue may be to restore the trust and confidence that our Veterans, Congress, VSOs and the American public have in the VA OIG. A further priority issue is to try to anticipate issues before they become large problems. Another priority issue is to create an environment where whistleblowers feel comfortable that there concerns are being effectively addressed.

a. What steps will you take to remediate those issues?

There are a number of steps that I would take. Among the most significant would be to review the policies, practices and priorities at the OIG and make whatever improvements are necessary. I would also try to anticipate issues better through the audit and inspection functions and meetings with senior management. With respect to whistleblowers, I would try to enhance communications with them so that they will understand better how their concerns are being objectively reviewed.

b. What longer-term goals would you like to achieve in your tenure as VA IG?

Important longer term goals are for the VA OIG to be universally viewed as an effective, fair and aggressive watchdog; to assist the VA in making its programs more effective and efficient, and to have Congress believe that the OIG has been of great assistance in its oversight responsibilities.

30. What do you believe are the highest priority issues facing the VA? How, if at all, would you task the VA IG to investigate or otherwise shed light on those issues?

Based on published reports, among the highest priority issues are accessibility to high quality healthcare, limiting the disability backlog, delivery of mental health services and prescription drugs. I would review the work done by the OIG in these areas, determine what additional investigations, audits or inspections need to be conducted, review the recommendations that have previously been made, analyze the implementation of those recommendations and follow up with senior management as appropriate with respect to these recommendations.

31. Are you aware of the VA IG healthcare inspection concerning the VA Medical Center in Tomah, Wisconsin, entitled *Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority*, and closed administratively in March 2014 (MCI# 2011-04212-HI-0267)?

I am aware of that inspection.

a. Do you agree with the VA OIG's decision to administratively close the inspection in 2014 without making it available to Congress or the public?

I do not have enough information to know whether I agree with that decision. If confirmed, I will review the facts and circumstances surrounding that decision.

b. Will you commit to improve transparency around administratively closed reports issued by the VA OIG?

One of my goals is to improve the transparency of the work of the OIG. I commit to reviewing the practice of not making public closed reports of audits or inspections. Among other things, I will assess the reasons for not making closed reports publicly available and examine the practices of other Inspectors General. I recognize that it may be beneficial to make public certain closed reports of audits and inspections.

32. According to the Office of Special Counsel, the number of whistleblower retaliation claims coming to them from the VA has increased significantly in the past few years.

a. Do you believe there is a problem with whistleblower retaliation within the VA system?

I do not have enough information to know the extent of whistleblower retaliation within the VA system. However, the mere fact that the number of whistleblower retaliation claims has increased significantly for the OSC is troubling. Addressing this issue would be one of my priorities.

b. If confirmed, how would you rectify this problem?

I would take a number of steps to address this issue. I would meet with the Office of Special Counsel to better understand the retaliation claims that they have received. I would also examine the retaliation matters being handled by the OIG. I would then develop an action plan, which would include getting input from senior management at the VA. There should be no tolerance for whistleblower retaliation.

c. What do you believe your role is as an IG with respect to whistleblowers within the VA system?

I believe that whistleblowers are important to the work of the IG. If confirmed, one of my goals would be to promote an improved environment in which whistleblowers have confidence that their concerns will be fairly and effectively considered by the IG.

d. If confirmed, will you investigate allegations of retaliation against whistleblowers within the VA system?

Yes. The OIG would investigate aggressively allegations of retaliation against whistleblowers.

33. The Office of Special Counsel has stated that a substantial majority of its whistleblower retaliation caseload involves VA employees. Are you familiar with the relationship between the VA OIG and the Office of Special Counsel?

I am familiar with the relationship.

a. If confirmed, what actions will you take to improve the VA OIG's relationship with the Office of Special Counsel?

I will review the status of the relationship and take the necessary and appropriate actions to have a strong and collaborative relationship with the Office of Special Counsel. One of my first priorities would be to meet with the Office of Special Counsel.

34. On April 29, 2015, the Committee subpoenaed Richard Griffin, then-VA Deputy Inspector General, for material relating to the VA OIG's health care inspection of the Tomah VAMC. Although numerous documents have been provided in response to the subpoena, to date, the VA OIG has not fulfilled all of the requirements of the subpoena, withholding material on the basis of promises of confidentiality, deliberative process concerns, and attorney-client privilege concerns. The VA OIG, however, has not claimed privilege on any of the subpoenaed material. If confirmed, will you commit to review the subpoena issued on April 29, 2015 and respond to it?

Yes.

35. If confirmed, what changes to the VA OIG organization or staffing, if any, do you anticipate on making?

I do not have sufficient information at this time about the OIG organization or staffing. If confirmed, one of my first priorities would be to review the structure and staffing of the OIG. To maximize its performance, the OIG needs to have the right organizational structure and staffing. I will make any improvements as appropriate.

V. Assistance

36. Are these answers your own? Have you consulted with VA OIG or any other interested parties? If so, please indicate which entities.

These answers are my own and I have not consulted with any other interested party.

Chairman Ron Johnson
Supplemental Pre-hearing Questionnaire
For the Nomination of Michael J. Missal to be
Inspector General, Department of Veterans Affairs

37. S. 579, the Inspector General Empowerment Act of 2015, would ensure that IGs cannot misinterpret Section 8M(b) by making clear that all reports and audits must be posted on an IG website within three days of it being submitted in final form to the head of the agency, rather than being made "public". There is an exception for publicly disclosing information that is prohibited from disclosure from some other provision of law. If confirmed, do you commit to publishing all reports and audits on your website within three days of it being submitted in final form to the agency? Please explain.

If confirmed, I will review the process for publishing reports and audits on the IG website. My desire is to have final reports and audits published as soon as possible and I will comply with applicable laws and regulations.

38. On June 4, 2015 the VA IG issued a "white paper" concerning its health care inspection of the Tomah VAMC. Are you familiar with this "white paper"?

I am familiar with the "white paper."

a. If confirmed, will you assist the Committee in learning the process by which the VA OIG issued the "white paper," including the identities of the VA OIG employees involving in drafting and issuing the "white paper"? Please explain.

If confirmed, I will work with the Committee to get the information it seeks about the process for issuing the "white paper."

b. If confirmed, will you produce all documents the Committee requires to fully understand the process by which the VA OIG issued the "white paper"?

If confirmed, I will produce the appropriate documents necessary for a full understanding of the process for issuing the "white paper."

c. The Office of Special Counsel has stated that this "white paper" could amount to whistleblower retaliation. Do you agree?

I do not have enough information to know whether the "white paper" could amount to whistleblower retaliation.

d. What do you believe your role is as an IG with respect to whistleblowers within the VA system?

I believe that whistleblowers are important to the work of the IG. If confirmed, one of my goals would be to promote an improved environment in which whistleblowers have

confidence that their concerns will be fairly and effectively considered by the IG. I will also protect the identities of whistleblowers as appropriate and take the necessary steps to ensure that whistleblowers are fully aware of their right to be free from retaliation for making protected disclosures.

e. If confirmed, will you investigate allegations of retaliation against whistleblowers within the VA system?

Yes.

f. If confirmed, will you retract this "white paper?"

I do not have information about the facts and circumstances surrounding the publishing of the "white paper." If confirmed, I will review whether it is appropriate to retract it.

39. There have been public reports over the past few years alleging an improper and excessively close relationship between the VA OIG and the VA, including allegations that this close relationship influenced aspects of an ongoing VA OIG investigation. Are you aware of reports to this effect?

I am generally aware of those reports.

a. What, if any, measures would you take to address any perceptions that the VA OIG is not independent?

I will work to prevent even a perception that the VA OIG is not independent. I will make sure that there are constant reminders within the OIG concerning the importance of the independence of the OIG. I will also assess and enhance as appropriate any training of the OIG staff. I will further take steps to ensure that I am notified if there is even an appearance of a lack of independence.

40. According to a June 2014 letter from Acting Inspector General Richard Griffin, the VA OIG issued 1,200 administrative subpoenas between January 2011 and June 2014, including a subpoena to the Project on Government Oversight (POGO) for information about VA whistleblowers who contacted POGO with concerns. Do you believe the subpoena issued to POGO on May 30, 2014 was a proper use of the OIG's authorities under the IG Act? Please explain.

I do not know all of the facts and circumstances surrounding the issuance of the subpoena to POGO, so I do not know whether it was a proper use of the OIG's authority.

41. Inspectors General have the authority to issue administrative subpoenas to compel information, if needed. If confirmed, how do you intend to use the compulsory process to obtain documents for OIG actions?

Section 6(a) (4) of the Inspector General Act of 1978, as amended, allows an IG to subpoena all information necessary in the performance of the IG's duties and responsibilities. I consider this authority important as it should allow the OIG to get information as thoroughly and promptly as possible. I would expect to make full use of administrative subpoenas to obtain necessary information.

42. Do you agree without reservation to comply with any request or summons to appear and testify before any duly constituted committee of Congress if you are confirmed?

Yes.

43. Do you agree without reservation to make any subordinate official or employee available to appear and testify before, or provide information to, any duly constituted committee of Congress if you are confirmed?

I agree to make the appropriate person available to appear and testify before any duly constituted committee of Congress. I also agree to have the necessary and appropriate information provided.

44. Do you agree without reservation to comply fully, completely, and promptly to any request for documents, communications, or any other agency material or information from any duly constituted committee of the Congress if you are confirmed?

I agree to comply fully, completely and promptly to requests for documents, communications or any other agency material or information from any duly constituted committee of the Congress, subject to applicable laws, rules and regulations. My goal is to provide promptly to Congress all of the information necessary for their oversight responsibilities.

a. If confirmed, do you agree without reservation to produce to Congress all documents, communications, and other material requested by a chairman of a committee of competent jurisdiction, including deliberative material?

I agree to produce to Congress all documents, communications and other materials requested by a chairman of a committee of competent jurisdiction, subject to applicable laws, rules and regulations. My goal is to provide promptly to Congress all of the information necessary for their oversight responsibilities.

Ranking Member Tom Carper
Supplemental Pre-hearing Questionnaire
For the Nomination of Michael J. Missal to be
Inspector General, Department of Veterans Affairs

1. Do you agree without reservation to respond to any reasonable request or summons to appear and testify before any duly constituted committee of Congress if you are confirmed?

Yes.

2. Do you agree without reservation to reply to any reasonable request for information from any duly constituted committee of the Congress if you are confirmed?

Yes.

I, Michael J. Missal, hereby state that I have read the foregoing Pre-Hearing Questionnaire and that the information provided therein is, to the best of my knowledge, current, accurate, and complete.

(Signature)

This 30th day of November, 2015

Post-Hearing Questions for the Record
Submitted to Michael J. Missal
From Senator Ron Johnson

Nomination Hearing to Consider
Michael J. Missal to be Inspector General, Department of Veterans Affairs
and
Carolyn N. Lerner to be Special Counsel, U.S. Office of Special Counsel
January 12, 2015

1. The Committee's April 29, 2015 subpoena of the Department of Veterans Affairs Office of Inspector General (VA OIG) for all documents referring or relating to its investigation of Department of Veterans Affairs Medical Center in Tomah, Wisconsin (Tomah VAMC) has not fully been complied with. The VA OIG documents that are being withheld are critically important to fully understanding the OIG's investigation and its rationale for refusing to initially publish the results of its Tomah inspection. In the hearing, you testified that you had not read the subpoena and did not fully commit to fully complying with the subpoena. My staff provided you a copy of the subpoena and corresponding schedule after the hearing for your review. After reviewing the subpoena, if confirmed, will you unequivocally commit to complying in full with the Committee's subpoena for documents?

   I commit to complying in full with the Committee's April 29, 2015 subpoena for documents.

2. On June 4, 2015, the VA OIG issued a white paper attacking the whistleblowers of the Tomah VAMC. During a hearing on September 22, 2015, I asked Linda Halliday, the Acting Inspector General, for the identity of the VA OIG employees who prepared the white paper. Ms. Halliday declined to provide that information. On September 29, 2015, I requested from Ms. Halliday certain material about drafting of the white paper. On October 6, 2015, Ms. Halliday responded without providing any material; instead, she asked that I "withdraw" my requests. Will you unequivocally commit to complying in full with my request to Ms. Halliday dated September 29, 2015, for material about the drafting of the VA OIG white paper?

   I commit to complying in full with the September 29, 2015 request for material about the drafting of the VA OIG white paper.

3. In your pre-hearing questionnaire and during your testimony, you noted that one of your goals is to improve transparency of the work of the VA OIG. What particular steps do you plan to take to accomplish that goal?

   There are a number of steps I would take to improve transparency of the work of the VA OIG. Among other steps, I would review all reports that are not currently being released publicly. Unless there is a legal or other similar reason not to release the report, such as

if release could negatively impact a prosecution, I would publicly release the report. I would also review the policies and procedures for releasing reports and enhance those policies and procedures to promote greater transparency, as noted above. I would further meet with individuals and groups interested in the VA OIG, including Veterans Service Organizations, to discuss the work of the VA OIG. In addition, I would increase the frequency and quality of communications with Congress and its staff. If confirmed, and once I have had the opportunity to immerse myself in the VA OIG, I am confident that I will identify other steps that I will take to improve transparency.

4. Will you commit to releasing all VA OIG reports, including reports about misconduct of high-ranking VA OIG officials?

   I do not know the nature or details of all reports prepared by the VA OIG. Some may need to remain non-public due to prosecutorial or other compelling reasons. There also may be material in reports that should be protected by privacy or other regulations. Subject to these caveats, I commit to release all VA OIG reports. My goal is to increase transparency at the VA OIG.

Testimony of Special Counsel Carolyn N. Lerner
U.S. Office of Special Counsel

U.S. Senate
Committee on Homeland Security and Governmental Affairs

Nomination of Michael J. Missal to be Inspector General, U.S. Department of Veterans Affairs, and the Honorable Carolyn N. Lerner to be Special Counsel, Office of Special Counsel

January 12, 2016, 10:00 A.M.

Chairman Johnson, Ranking Member Carper, and Members of the Committee:

Thank you for inviting me to testify today. I am honored that the President nominated me to serve a second term as head of the Office of Special Counsel (OSC). I would like to thank my family for their support and encouragement over the past 4 ½ years as I took on the new challenge of heading OSC.

I want to acknowledge the OSC leaders who are here with me today. I am very proud to serve with these exemplary public servants. I can say, without hesitation, that OSC is engaged in the most productive period in its history. This productivity is due to the hard work of the individuals in the room today and all of OSC's employees throughout the country, in D.C., Dallas, Detroit, and Oakland.

Our strong results in whistleblower retaliation, whistleblower disclosure, Hatch Act, and Uniformed Services Employment and Reemployment Rights Act (USERRA) cases demonstrate this office's ability to promote better and more efficient government. For example, our work with whistleblowers has prompted improvements in the quality of care provided to veterans at Department of Veterans Affairs (VA) medical centers across the country. And, by protecting and promoting the disclosures of over a dozen Customs and Border Protection whistleblowers, and working with this Committee, we curbed hundreds of millions of dollars of waste and improper overtime payments.

We helped the Air Force better fulfill its sacred mission on behalf of fallen service members and their families and protected the employees who blew the whistle on gross abuses at the Port Mortuary, Dover Air Base. We vigorously enforced the Hatch Act and worked with then-Chairman Akaka and Senator Mike Lee to modernize the Act by limiting the federal government's unnecessary interference with state and local elections. This has allowed OSC to better allocate our resources toward more effective enforcement of this important law. Finally, we have vigorously protected the employment rights of returning service members and helped them to restore successful post-deployment civilian careers in the government.

When I was first nominated as Special Counsel in 2011, I often remarked that OSC was the best kept secret in the federal government. I wanted this to change, so that more employees and taxpayers could benefit from the work of this small but effective agency.

Our commitment to protecting whistleblowers and other employees, and our efforts to reach out to the federal community, are moving us in the right direction. In 2015, for the first time in the agency's history, we received and resolved over 6,000 cases, a 50 percent increase from 2011, when I took office.

This dramatic increase in filings indicates that whistleblowers believe they can make a difference by bringing a claim to OSC. Studies have shown that the number one reason employees do not report waste, fraud, or abuse is not because they fear retaliation. It is because they do not believe any good will come from their risk. If the number of whistleblower cases is any indication of employees' willingness to raise concerns—and I think it is—then we are certainly moving in the right direction.

Over the past four years, demand for OSC's services has far exceeded our small agency's resources. Given our small size, we have needed to find new and more efficient ways to approach resource management and increasing caseloads. And we have.

OSC's cost to resolve a case is down by 45 percent, leading to record levels of productivity. My efforts to promote greater efficiencies have been large and small. I have focused on being a careful steward of taxpayer dollars by cutting unnecessary expenditures and found better ways to manage our cases.

I have implemented several policy initiatives to better manage our caseload. For example, I reinvigorated our alternative dispute resolution program. Mediation saves OSC, the employee, and the agency time and resources, while often resulting in better solutions for complainants and agencies alike. Advocates for whistleblowers and agency counsel have praised OSC's mediation program and its ability to bring about effective results. And, we are currently experimenting with a new and innovative approach to managing whistleblower cases. The new approach consolidates four OSC positions: intake examiner, disclosure attorney, investigative attorney, and mediator. We are receiving positive feedback from employees and agencies, because they no longer have to communicate with multiple OSC staff when seeking resolution on the same case.

By taking these smart approaches to our growing caseload, and focusing on positive outcomes for whistleblowers and employees, we have managed to generate efficiencies without compromising the quality of OSC's work. Indeed, when evaluating what is arguably the most important statistic for OSC—the number of favorable actions on behalf of whistleblowers and the merit system—we are consistently setting records. In fact, each year since my term began, OSC has reached new milestones.

In 2015, we secured 278 favorable actions for whistleblowers and other employees, up from 201 favorable actions in 2014. Prior to my tenure, the number of favorable actions had dropped to 29, and was consistently below 100 per year throughout the agency's 35-year history. These "victories" for whistleblowers include reinstatement, back pay, and other remedies, such as stays of improper removals or reassignments, and disciplinary actions against those who retaliate. These actions are a key measure of OSC's success.

While I am proud of these accomplishments, our numbers do not tell the whole story. Statistics cannot capture the true impact and value of OSC's work. Our efforts to support whistleblowers often save lives and spark reforms that prevent wasteful, inefficient, or unsafe practices.

For example, early in my tenure, whistleblowers at the Air Force's Port Mortuary in Dover, Delaware, disclosed misconduct regarding the improper handling of human remains of fallen service members. After OSC reviewed the allegations and made recommendations to congressional oversight committees, the Air Force took important corrective action. OSC's work helped to ensure that problems were identified and corrected, and the Air Force is now better able to uphold its sacred mission on behalf of fallen service members and their families.

In addition, OSC's work with whistleblowers at the Department of Homeland Security (DHS) exposed the Department's longstanding failure to manage hundreds of millions of dollars in annual overtime payments. The lack of adequate safeguards in these overtime payments resulted in a significant waste of taxpayer dollars over many years. Investigations in response to OSC referrals confirmed that overtime payments were routinely provided to individuals who were not eligible to receive them. This work resulted in a series of reforms within DHS, multiple congressional hearings, including by this Committee, and bipartisan support for legislation to revise the pay system for Border Patrol agents that will result in $100 million in annual cost savings at DHS—an amount roughly four times the size of OSC's annual appropriation.

OSC's work with VA whistleblowers has improved the quality of care for veterans throughout the country and promoted accountability. In numerous reports to the President and Congress, I documented severe shortcomings in VA internal investigations of threats to patient care at VA hospitals throughout the country. This led to an overhaul of the VA's internal medical oversight office, as well as other systemic changes at the VA.

In summary, I am grateful for the opportunity to have served as Special Counsel. But there is still much to be accomplished. If confirmed for a second term, I will look to expand the important work of this office by building on our current successes, continuing to protect VA and all other employees from retaliation, and finding additional ways to utilize our limited resources to build better and more accountable government. I will further increase our efforts to educate federal managers and employees, because the best way to safeguard the merit system and cut waste, fraud, and abuse is by preventing problems from occurring in the first place. By highlighting the important work of whistleblowers and this office, I hope to promote a culture in the government that encourages disclosures of waste and acts quickly to correct identified wrongs.

Mr. Chairman and Ranking Member Carper, thank you for the opportunity to testify today, and for 4 ½ years of a productive relationship that has made our government more accountable, efficient, and safer. I look forward to answering your questions.

* * * * *

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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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

Ms. Lerner earned her undergraduate degree from the Honors College at 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.

REDACTED

HSGAC BIOGRAPHICAL QUESTIONS FOR
EXECUTIVE NOMINEES

1. Basic Biographical Information

Please provide the following information.

Position to Which You Have Been Nominated	
Name of Position	**Date of Nomination**
Special Counsel, U.S. Office of Special Counsel	10/2/15

Current Legal Name			
First Name	**Middle Name**	**Last Name**	**Suffix**
Carolyn	Nancy	Lerner	

Addresses					
Residential Address (do not include street address)			**Office Address** (include street address)		
[redacted]			Street: 1730 M Street, 3rd Floor		
City: Chevy Chase	State: MD	Zip: 20815	City: Washington	State: D.C.	Zip: 20036

Other Names Used						
First Name	**Middle Name**	**Last Name**	**Suffix**	**Check if Maiden Name**	**Name Used From** (Month/Year) (Check box if estimate)	**Name Used To** (Month/Year) (Check box if estimate)
					Est ☐	Est ☐

Birth Year and Place

Year of Birth (Do not include month and day.)	Place of Birth
1965	Detroit, Michigan

Marital Status

Check All That Describe Your Current Situation:

Never Married	Married	Separated	Annulled	Divorced	Widowed
☐	☒	☐	☐	☐	☐

Spouse's Name (current spouse only)

Spouse's First Name	Spouse's Middle Name	Spouse's Last Name	Spouse's Suffix
Dwight	Phillip	Bostwick	

Spouse's Other Names Used (current spouse only)

First Name	Middle Name	Last Name	Suffix	Check if Maiden	Name Used From (Month/Year) (Check box if estimate)	Name Used To (Month/Year) (Check box if estimate)
					Est ☐	Est ☐
					Est ☐	Est ☐

Children's Names (if over 18)			
First Name	**Middle Name**	**Last Name**	**Suffix**
Ben	**Lerner**	**Bostwick**	
Anna	**Lerner**	**Bostwick**	

2. Education

List all post-secondary schools attended.

Name of School	**Type of School** (vocational/technical/trade school, college/university/military college, correspondence/distance/extension/online school)	**Date Began School** (month/year) (check box if estimate)	**Date Ended School** (month/year) (check box if estimate) (check "present" box if still in school)	**Degree**	**Date Awarded**
University of Michigan	University	**Est** 1/83 ☐	**Est Present** 5/86 ☐ ☐	BGS	5/86
London School of Economics	University	**Est** 9/84 ☐	**Est Present** 6/85 ☐ ☐	Non-degree Program	
New York University School of Law	Law School	9/86	**Est Present** 5/89 ☐ ☐	J.D.	5/89

3. Employment

(A) List all of your employment activities, including unemployment and self-employment. If the employment activity was military duty, list separate employment activity periods to show each change of military duty station. Do not list employment before your 18th birthday unless to provide a minimum of two years of employment history.

Type of Employment (Active Military Duty Station, National Guard/Reserve, USPHS Commissioned Corps, Other Federal employment, State Government (Non-Federal Employment), Self-employment, Unemployment, Federal Contractor, Non-Government Employment (excluding self-employment), Other	**Name of Your Employer/ Assigned Duty Station**	**Most Recent Position Title/Rank**	**Location** (City and State only)	**Date Employment Began** (month/year) (check box if estimate)	**Date EmploymentEnded** (month/year) (check box if estimate) (check "present" box if still employed)
Federal Government	U.S. Office of Special Counsel	Special Counsel	Wash., D.C.	**Est 6/11** □	**Est Present** □
Self-Employment	Heller, Huron, Chertkof, Lerner, Simon & Salzman	Partner	Wash., D.C.	**Est 3/97** □	Est 5/11 □
Non-Government Employment	Kator, Scott, Heller & Huron	Associate Attorney	Wash., D.C.	**Est 11/91** □	Est 2/97 □
Non-Government Employment	George Washington University School of Law	Adjunct Law Professor	Wash., D.C.	**Est 1/07** □	**Est 4/11** □
Federal Government	Chief United States District Court Judge Julian A. Cook., Jr	Law Clerk	Detroit, MI	**Est 9/89** □	**Est 8/91** □

(B) List any advisory, consultative, honorary or other part-time service or positions with federal, state, or local governments, not listed elsewhere.

Name of Government Entity	**Name of Position**	**Date Service Began** (month/year) (check box if estimate)	**Date Service Ended** (month/year) (check box if estimate) (check "present" box if still serving)
District of Columbia Department of Corrections	Court appointed Special Inspector	2003	2005
City of Oakland, CA	Consultant	2007	2007
District of Columbia Department of Parks and Recreation	Consultant	2005	2005

4. Potential Conflict of Interest

(A) Describe any business relationship, dealing or financial transaction which you have had during the last 10 years, whether for yourself, on behalf of a client, or acting as an agent, that could in any way constitute or result in a possible conflict of interest in the position to which you have been nominated.

None.

(B) Describe any activity during the past 10 years in which you have engaged for the purpose of directly or indirectly influencing the passage, defeat or modification of any legislation or affecting the administration or execution of law or public policy, other than while in a federal government capacity.

None.

5. Honors and Awards

List all scholarships, fellowships, honorary degrees, civilian service citations, military medals, academic or professional honors, honorary society memberships and any other special recognition for outstanding service or achievement.

Pillar Award for Person of Conscience in Government Reform, 2014; Harry S. Truman Scholar (national merit-based scholarship for outstanding academic achievement and commitment to public service); James B. Angel Scholar (award for academic achievement at the University of Michigan); Root-Tilden-Snow public interest scholarship (merit-based tuition scholarship for public interest commitment and academic achievement at New York University School of Law); American Jurisprudence Award in Labor Law; Best Lawyers in America for Civil Rights Law; *Washingtonian Magazine's* Top Employment Lawyer; Invited to become Fellow of the American Bar Association Foundation. My former law firm, Heller, Huron, Chertkof, Lerner, Simon & Salzman, received several awards including recognition from the Washington Lawyers' Committee for Civil Rights Under Law for outstanding achievement in 2002 and 2006; and the Washington Counsel of Lawyers award for exceptional public interest service in 2002.

6. Memberships

List all memberships that you have held in professional, social, business, fraternal, scholarly, civic, or charitable organizations in the last 10 years.

Unless relevant to your nomination, you do NOT need to include memberships in charitable organizations available to the public as a result of a tax deductible donation of $1,000 or less, Parent-Teacher Associations or other organizations connected to schools attended by your children, athletic clubs or teams, automobile support organizations (such as AAA), discounts clubs (such as Groupon or Sam's Club), or affinity memberships/consumer clubs (such as frequent flyer memberships).

Name of Organization	Dates of Your Membership (You may approximate.)	Position(s) Held
Washington Council of Lawyers	1994-2010	President, Vice President and Board Member
Council for Court Excellence	2005-2010	Board member
WAGE Project	2007-2010	Advisory Board member
Center for WorkLife Law	2006-2010	Board Chair
Metropolitan Washington Employment Lawyers Association	1997-2010	Member
National Employment Lawyers Association (NELA)	2006-2010	Member

District of Columbia Women's Bar Association	2006-2010	Member
American Bar Association	2000-present	Member
AFL-CIO Lawyers Coordinating Committee	2008	Member

7. Political Activity

(A) Have you ever been a candidate for or been elected or appointed to a political office?

No.

Name of Office	Elected/Appointed/ Candidate Only	Year(s) Election Held or Appointment Made	Term of Service (if applicable)

(B) List any offices held in or services rendered to a political party or election committee during the last ten years that you have not listed elsewhere.

None.

Name of Party/Election Committee	Office/Services Rendered	Responsibilities	Dates of Service

(C) Itemize all individual political contributions of $200 or more that you have made in the past five years to any individual, campaign organization, political party, political action committee, or similar entity. Please list each individual contribution and not the total amount contributed to the person or entity during the year.

None.

Name of Recipient	Amount	Year of Contribution

8. Publications and Speeches

(A) List the titles, publishers and dates of books, articles, reports or other published materials that you have written, including articles published on the Internet. Please provide the Committee with copies of all listed publications. In lieu of hard copies, electronic copies can be provided via e-mail or other digital format.

Title	Publisher	Date(s) of Publication
The Hatch Act: A Law Misused	New York Times	10/30/2011

(B) **List any formal speeches you have delivered during the last five years and provide the Committee with copies of those speeches relevant to the position for which you have been nominated. Include any testimony to Congress or any other legislative or administrative body. These items can be provided electronically via e-mail or other digital format.**

Title/Topic	Place/Audience	Date(s) of Speech
Copies of all speeches and testimony are provided		

(C) List all speeches and testimony you have delivered in the past ten years, except for those the text of which you are providing to the Committee.

Title	Place/Audience	Date(s) of Speech
Copies of all speeches and testimony are provided		

9. Criminal History

Since (and including) your 18th birthday, has any of the following happened? No.

- Have you been issued a summons, citation, or ticket to appear in court in a criminal proceeding against you? (Exclude citations involving traffic infractions where the fine was less than $300 and did not include alcohol or drugs.)
- Have you been arrested by any police officer, sheriff, marshal or any other type of law enforcement official?
- Have you been charged, convicted, or sentenced of a crime in any court?
- Have you been or are you currently on probation or parole?
- Are you currently on trial or awaiting a trial on criminal charges?
- To your knowledge, have you ever been the subject or target of a federal, state or local criminal investigation?

If the answer to any of the questions above is yes, please answer the questions below for each criminal event (citation, arrest, investigation, etc.). If the event was an investigation, where the question below asks for information about the offense, please offer information about the offense under investigation (if known).

A) Date of offense:

   a. Is this an estimate (Yes/No):

B) Description of the specific nature of the offense:

C) Did the offense involve any of the following?
   1) Domestic violence or a crime of violence (such as battery or assault) against your child, dependent, cohabitant, spouse, former spouse, or someone with whom you share a child in common: **Yes / No**
   2) Firearms or explosives: **Yes / No**
   3) Alcohol or drugs: **Yes / No**

D) Location where the offense occurred (city, county, state, zip code, country):

E) Were you arrested, summoned, cited or did you receive a ticket to appear as a result of this offense by any police officer, sheriff, marshal or any other type of law enforcement official: **Yes / No**

   1) Name of the law enforcement agency that arrested/cited/summoned you:

   2) Location of the law enforcement agency (city, county, state, zip code, country):

F) As a result of this offense were you charged, convicted, currently awaiting trial, and/or ordered to appear in court in a criminal proceeding against you: **Yes / No**

   1) If yes, provide the name of the court and the location of the court (city, county, state, zip code, country):

   2) If yes, provide all the charges brought against you for this offense, and the outcome of each charged offense (such as found guilty, found not-guilty, charge dropped or "nolle pros," etc). If you were found guilty of or pleaded guilty to a lesser offense, list separately both the original charge and the lesser offense:

   3) If no, provide explanation:

G) Were you sentenced as a result of this offense: **Yes / No**

H) Provide a description of the sentence:

I) Were you sentenced to imprisonment for a term exceeding one year: **Yes / No**

J) Were you incarcerated as a result of that sentence for not less than one year: **Yes / No**

K) If the conviction resulted in imprisonment, provide the dates that you actually were incarcerated:

L) If conviction resulted in probation or parole, provide the dates of probation or parole:

M) Are you currently on trial, awaiting a trial, or awaiting sentencing on criminal charges for this offense: **Yes / No**

N) Provide explanation:

Civil Litigation and Administrative or Legislative Proceedings

(A) Since (and including) your 18th birthday, have you been a party to any public record civil court action or administrative or legislative proceeding of any kind that resulted in (1) a finding of wrongdoing against you, or (2) a settlement agreement for you, or some other person or entity, to make a payment to settle allegations against you, or for you to take, or refrain from taking, some action. Do NOT include small claims proceedings.

Date Claim/Suit Was Filed or Legislative Proceedings Began	Court Name	Name(s) of Principal Parties Involved in Action/Proceeding	Nature of Action/Proceeding	Results of Action/Proceeding
1989	Montgomery County Circuit Court	Plaintiff name unavailable. I was the defendant. Case #41466	Civil action for damages stemming from car accident where amount of damages were in contention.	Jury verdict for plaintiff under $2000.

(B) In addition to those listed above, have you or any business of which you were an officer, director or owner ever been involved as a party of interest in any administrative agency proceeding or civil litigation? Please identify and provide details for any proceedings or civil litigation that involve actions taken or omitted by you, or alleged to have been taken or omitted by you, while serving in your official capacity. No.

Date Claim/Suit Was Filed	Court Name	Name(s) of Principal Parties Involved in Action/Proceeding	Nature of Action/Proceeding	Results of Action/Proceeding

(C) For responses to the previous question, please identify and provide details for any proceedings or civil litigation that involve actions taken or omitted by you, or alleged to have been taken or omitted by you, while serving in your official capacity.

10. Breach of Professional Ethics

(A) Have you ever been disciplined or cited for a breach of ethics or unprofessional conduct by, or been the subject of a complaint to, any court, administrative agency, professional association, disciplinary committee, or other professional group? Exclude cases and proceedings already listed.

Name of Agency/Association/ Committee/Group	Date Citation/Disciplinary Action/Complaint Issued/Initiated	Describe Citation/Disciplinary Action/Complaint	Results of Disciplinary Action/Complaint
Council of Inspectors General Integrity Committee	5/12/15 email	I referred an email from an OSC employee with false allegations of wrongdoing against my Principal Deputy and me to the Integrity Committee for disposition	Dismissed

(B) Have you ever been fired from a job, quit a job after being told you would be fired, left a job by mutual agreement following charges or allegations of misconduct, left a job by mutual agreement following notice of unsatisfactory performance, or received a written warning, been officially reprimanded, suspended, or disciplined for misconduct in the workplace, such as violation of a security policy?

No

11. Tax Compliance

(This information will not be published in the record of the hearing on your nomination, but it will be retained in the Committee's files and will be available for public inspection.)

REDACTED

REDACTED

13. Lobbying

In the past ten years, have you registered as a lobbyist? If so, please indicate the state, federal, or local bodies with which you have registered (e.g., House, Senate, California Secretary of State). No.

14. Outside Positions

[X] See OGE Form 278. (If, for your nomination, you have completed an OGE Form 278 Executive Branch Personnel Public Financial Disclosure Report, you may check the box here to complete this section and then proceed to the next section.)

For the preceding ten calendar years and the current calendar year, report any positions held, whether compensated or not. Positions include but are not limited to those of an officer, director, trustee, general partner, proprietor, representative, employee, or consultant of any corporation, firm, partnership, or other business enterprise or any non-profit organization or educational institution. Exclude positions with religious, social, fraternal, or political entities and those solely of an honorary nature.

Name of Organization	Address of Organization	Type of Organization (corporation, firm, partnership, other business enterprise, other non-profit organization, educational institution)	Position Held	Position Held From (month/year)	Position Held To (month/year)

15. Agreements or Arrangements

[X] See OGE Form 278. (If, for your nomination, you have completed an OGE Form 278 Executive Branch Personnel Public Financial Disclosure Report, you may check the box here to complete this section and then proceed to the next section.)

As of the date of filing your OGE Form 278, report your agreements or arrangements for: (1) continuing participation in an employee benefit plan (e.g. pension, 401k, deferred compensation); (2) continuation of payment by a former employer (including severance payments); (3) leaves of absence; and (4) future employment.

Provide information regarding any agreements or arrangements you have concerning (1) future employment; (2) a leave of absence during your period of Government service; (3) continuation of payments by a former employer other than the United States Government; and (4) continuing participation in an employee welfare or benefit plan maintained by a former employer other than United States Government retirement benefits.

Status and Terms of Any Agreement or Arrangement	Parties	Date (month/year)

16. Additional Financial Data

All information requested under this heading must be provided for yourself, your spouse, and your dependents. (This information will not be published in the record of the hearing on your nomination, but it will be retained in the Committee's files and will be available for public inspection.)

REDACTED

REDACTED

SIGNATURE AND DATE

I hereby state that I have read the foregoing Statement on Biographical and Financial Information and that the information provided therein is, to the best of my knowledge, current, accurate, and complete.

Carolyn Kresmer

This 14th day of October, 2015

Carolyn N. Lerner
U.S. Senate Committee on Homeland Security & Governmental Reform
Question 8 – Publications and Speeches

I. Testimony

Statement of the U.S. Special Counsel

as prepared for delivery on November 17, 2011

Chairman Wilson, Chairman Whitman, Ranking Member Davis, Ranking Member Cooper, and other members of the Committee: Thank you for inviting me today. I appreciate the opportunity to discuss the important issues brought to light by the three Port Mortuary whistleblowers. I'd like to introduce Jennifer Pennington, an attorney in our Disclosure Unit, who had primary responsibility for this matter.

To begin, I want to acknowledge the Air Force for the time it has committed to investigating these serious allegations, and for the substantial corrective action it has taken thus far. For example, the Air Force has enhanced training and implemented policies and procedures to improve the accountability of remains at the Port Mortuary. I also want to emphasize that the Office of Special Counsel (OSC) and the Air Force have a shared goal in this matter: both agencies want to ensure that the issues are adequately addressed so that our fallen service members are provided the highest level of reverence, care and dignity.

In recent days, I have spoken with General Schwartz and Secretary Donley, and I am encouraged by our positive, productive conversations. I sincerely look forward to working with the Air Force as we move forward.

My statement today will focus on six areas: 1) OSC's Role and General Procedures; 2) the specific procedures followed in this matter; 3) OSC's areas of concern with the Air Force's findings; 4) notification of families; 5) disciplinary action against wrongdoers; and 6) reprisal against the whistleblowers.

I. OSC's Role and Process

Congress has tasked OSC with providing an important oversight role in reviewing government investigations of potential misconduct raised by whistleblowers. Our agency is intended to provide a safe channel for federal employees to disclose allegations of waste, fraud, and abuse, or a danger to public health and safety. As an independent agency within the Executive Branch, OSC performs an important accountability and quality control function.

Our process is dictated by statute. When a disclosure is received from a whistleblower, OSC evaluates it to determine if there is a substantial likelihood that wrongdoing has been disclosed. We do not have authority to investigate these complaints. If we find a substantial likelihood of wrongdoing, we inform the head of the appropriate agency, who is required by statute to conduct an investigation and submit a report of their findings to OSC.

After receiving the agency's report, OSC determines 1) whether the report contains the required information, and 2) whether the findings of the agency appear reasonable. The whistleblower also has an opportunity to review and comment on the agency report. OSC then transmits the agency's report, our review and recommendations and the whistleblower's comments to the President and the relevant Congressional oversight committees. OSC is also required to place this material in a public file.

It was within this statutory framework that OSC received disclosures from three whistleblowers at the Port Mortuary at Dover Air Force Base.

II. Procedural Case Chronology

In April 2010, OSC received a disclosure from James Parsons, an Embalming/Autopsy Technician. Mr. Parsons alleged that then-Port Mortuary Director Quinton Keel had instructed both him and an Embalmer to cut off the arm bone of a deceased Marine in order to fit the Marine into his uniform. Mr. Parsons refused to cut off the bone. The Embalmer, however, complied with Mr. Keel's instruction. Permission from the Marine's family to remove the bone was neither sought nor obtained. Nor were they notified at the time.

In May 2010, OSC received additional disclosures from two more whistleblowers from the Port Mortuary. Mary Ellen Spera, a Mortuary Specialist, alleged that management failed to take adequate precautions or provide sufficient notice to employees regarding remains that were possibly infected with contagious tuberculosis. She also alleged that management failed to address instances in which fetal remains of military dependents were transported to the Port Mortuary in an improper and disrespectful manner, and that these remains were cremated without required authorization.

Ms. Spera and William Zwicharowski, a Senior Mortuary Specialist, also alleged that in two instances, portions of services members' remains were lost, and Port Mortuary leadership had failed to properly resolve those cases or notify the families of the service members.

In July 2010, after OSC determined that there was a substantial likelihood of a violation of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public health, we sent these allegations to the Secretary of Defense.

On May 11, 2011, OSC received the Air Force's report. Our review led us to raise a number of concerns with the Air Force. At the same time, we requested copies of the reports of investigation prepared by the Air Force and Army OIG's and Air Force OSI. The Air Force responded with a supplemental report on August 30, 2011, but they did not provide the OIG and AFOSI reports.

OSC then reviewed and analyzed the reports' findings and conclusions, as required by law. And on November 8, 2011 this review and analysis was sent to the Congress and President.

III. OSC Comments and Areas of Concern Regarding Air Force Findings

The Air Force investigation confirmed most of the whistleblower's factual allegations, and while the Air Force should be credited for its investigation, OSC has several concerns about its conclusions. I will summarize them, and defer to Jennifer Pennington for additional details in response to questions.

First, the Air Force concluded that Port Mortuary personnel did not engage in any wrongdoing by cutting off the arm bone of a deceased Marine without first obtaining permission from his family. To the contrary, our review of the evidence suggests that this decision did not uphold Port Mortuary's responsibility to maintain the "highest standards of the funeral service profession."

Second, while the Air Force conceded transporting fetal remains in used cardboard boxes was "substandard" and "not the best option," it still determined the remains were treated with reverence, care, and dignity.

Third, there is conflicting testimony and conclusions in the report on the handling of possibly contagious remains, and whether the efforts taken by management protected the health and safety of mortuary personnel.

Fourth, and finally, the Air Force substantiated the allegations concerning two incidents in which the Port Mortuary lost portions of deceased service members' remains. It found that Port Mortuary leadership engaged in gross mismanagement, and that the loss of these portions was "a negligent failure" to meet the requisite standard of care for handling remains – and resulted in many violations of agency rules and regulations. However, the Air Force concluded that the failure to notify families was not wrong because there is no specific law, rule, or regulation requiring notification of the family when a portion is lost

IV. Notification of Families

Turning now to this issue of notification to families: The Air Force has stated that it does not believe that the family of the deceased Marine needed to be informed prior to removing his arm bone. It also concluded there was no obligation to tell the families of the service members about the lost portions of remains, or the shipping of fetal remains in used cardboard boxes. And, after the allegations were referred by OSC and the Air Force's investigation was completed, the Air Force still did not notify the families.

Because of some reports to the contrary, I want to emphasize that OSC did not at any time, in any way, constrain the Air Force from communicating with these families. OSC staff, in conversations with the Air Force Office of General Counsel dating back to March 2011, repeatedly asked why the families had not yet been notified and encouraged the Air Force to notify them immediately.

On October 24, the Air Force OGC indicated they would notify the families only after OSC provided them with 48 hours' notice before transmitting our report to the President and Congress. My staff was clear in expressing disagreement with the Air Force's decision. We hope that further thought is given to the issue of communicating with families of the fallen.

V. Disciplinary Action against wrongdoers and Reprisal against whistleblowers

Finally, I want to address the issues of disciplinary action and reprisal.

On the issue of **disciplinary action**, despite the substantial evidence of gross mismanagement, violations of rules and regulations, and a disturbing pattern of dishonesty and misconduct, each of the three culpable individuals remains employed by the Air Force. OSC believes that simply demoting them is insufficient, particularly when the mortuary director was given a manager level position created specifically for him and another was given a job of his preference. The retention of these individuals sends an inappropriate message to the workforce.

This is in sharp contrast to the treatment of the whistleblowers.

During the Air Force investigation, one of the whistleblowers – Mr. Parsons - was abruptly fired, along with David Vance, another employee who participated in the OIG investigation. OSC promptly contacted the Air Force, as it seemed clear that these terminations were retaliatory. Mr. Parsons and Mr. Vance were subsequently returned to work and their terminations were rescinded after an internal review.

Ms. Spera and Mr. Zwicharowski also allege that they were victims of multiple adverse personnel actions in reprisal for their disclosures. Because all four still have retaliation complaints pending with OSC, I am limited in the details I can provide. However, we are moving towards a conclusion of these investigations.

VI. Conclusion

To conclude, the Air Force has taken significant corrective action to address the issues exposed through the whistleblowers' disclosures. And, by all accounts, the new commander has made great strides in restoring the Port Mortuary's exceptional reputation.

I am also heartened by my recent communications with Secretary Donley, who acknowledged the important role played by the whistleblowers. OSC looks forward to working together with the Air Force to ensure that the remaining issues and concerns are fully addressed.

I greatly appreciate the committee's time and interest in this important matter and would be pleased to take any questions you may have.

Testimony of Special Counsel Carolyn Lerner
United States Office of Special Counsel
before the
Senate Subcommittee on Oversight of
Government Management, the Federal
Workforce, and the District of Columbia

Tuesday, March 20, 2012

Chairman Akaka, Ranking Member Johnson, and Members of the Subcommittee:

I am delighted to be here today to testify about the U.S. Office of Special Counsel, the OSC. It is an honor to be on this panel with MSPB Chair Grundmann. It was just a little over a year ago that I was here for my nomination hearing. Since then, much has changed at the Office of Special Counsel and much also remains to be done. I look forward to sharing these updates and goals with you.

OSC protects the merit system for over 2.1 million civilian employees in the federal government. Congress has tasked OSC with four distinct mission areas: First, we protect federal employees from prohibited personnel practices, especially retaliation for whistleblowing. Second, we provide a safe and secure channel for employees to disclose waste, fraud and abuse, and threats to public health, safety or security. Third, we enforce the Hatch Act, which keeps the federal workplace free from political coercion and improper partisan politics. Finally, we protect the employment rights of Veterans and members of the reserves and the National Guard.

We fulfill these important roles with a dedicated career staff of approximately 110 employees – and the smallest budget of any federal watchdog agency.

In the past, I have talked about OSC being the best kept secret in government. I am pleased to report that federal employees are starting to take notice of our agency.

OSC's caseload is increasing across all of our program areas. Filings are up 30% over the last three years. Our FY2012 caseload is currently 10% above the FY2011 numbers. And, in just one important area – whistleblower disclosures of waste, fraud and abuse – our numbers are up 32% over last year's level. I refer you to the graphics at the end of my testimony for additional detail on OSC's caseload.

While our workload increases at record rates, OSC's budget remains relatively flat, and may actually see a decrease in FY2013. Nevertheless, we are finding innovative ways to do more with less.

For example, for the first time, we have recruited several Presidential Management Fellows for rotations at our agency. We are increasing our use of alternative dispute resolution which helps avoid costly and time intensive litigation while providing better outcomes for employees and agencies alike. And, to avoid increased rent payments,

we have converted our library, which was largely underutilized, into work spaces. Small savings add up too – just switching computerized legal research providers saved nearly $50,000 annually. In an agency of this size, these modest changes make a difference, and allow us to put every available tax dollar toward fulfilling OSC's good government mission.

Even with our modest budget, the OSC gets a lot of bang for the buck. We know that whistleblower disclosures to OSC save tax dollars and make the government more efficient.

For example, a U.S. Army whistleblower disclosed that the Army failed to properly review and approve an $8 million staffing contract with a private company, resulting in a substantial overpayment to the contractor. While this case remains open, we know that OSC's efforts will result in a significant recovery of tax dollars and reforms that will help prevent wasteful practices in the future. The Army division responsible for the contract already implemented new quality control safeguards and will increase scrutiny of all contracts over $100,000.

In another case, a Department of Homeland Security (DHS) whistleblower told OSC that more than 145 uniformed Border Patrol officers were regularly and improperly paid overtime at a cost of about $50 per day. By stopping these payments, the government saved approximately $2 million annually – at just one DHS facility. In addition, because of OSC's intervention, the Border Patrol initiated an agency-wide policy to improve control over the use of overtime authority.

In a third recent case, a Defense Contracts Audit Agency (DCAA) employee disclosed audit practices that prioritized speed over accuracy and potentially cost the government millions of dollars. Her supervisors retaliated against her. OSC intervened and got the employee significant relief. The employee's disclosures led to hearings before this Committee and reforms at DCAA with significant potential cost-savings.

These types of results are not unique. OSC's efforts to support whistleblowers often stop the immediate problem and spark reforms that prevent wasteful, inefficient, or unsafe practices.

Indeed, this was the result when whistleblowers at the U.S. military's mortuary in Dover disclosed misconduct regarding the improper handling of human remains. After OSC reviewed the allegations and made recommendations, the Air Force took important, wide-scale corrective action. We also know that our report prompted other whistleblowers to come forward regarding the dumping of remains in a landfill.

OSC's work helped to ensure that problems were identified and corrected, and the Air Force is now better able to uphold its sacred mission on behalf of fallen service members and their families.

OSC Initiatives

Since I took office in June 2011, OSC has also launched several important new initiatives.

Hatch Act Reform

I will start with one that I know is on your list as well: Hatch Act reform. When I first arrived at OSC, I discovered the overreach of this otherwise important federal law. At its best, the Hatch Act keeps partisan politics out of the workplace and prevents those in political power from abusing their authority toward political ends. But at its worst, the law prevents state and local candidates from running for partisan office if their job has even a trivial connection to federal funding. This provision disqualifies otherwise well-qualified candidates from running for office. And, this law is increasingly being used as a political weapon that keeps qualified candidates from serving their local communities.

I applaud your recent introduction of the Hatch Act Modernization Act of 2012. This bipartisan, good government legislation will prevent unnecessary federal interference with state and local contests. It will also modify the overly-restrictive penalty structure for federal employees.

Retaliation Pilot Project

Second, after taking office last summer, I launched a program that we refer to as the Retaliation Pilot Project. This project reallocated agency resources for the investigation and prosecution of whistleblower retaliation cases. Taking this step is beginning to reduce the backlog in OSC's investigation unit. Additionally, the project is a professional development tool to train attorneys from other OSC units in whistleblower law.

Strengthened Mediation Program

Third, I have strengthened OSC's Alternative Dispute Resolution program. We hired an expert mediator to head up our efforts and entered into an inter-agency agreement with the Federal Mediation and Conciliation Service. This partnership allows us to mediate cases nationwide and at a lower cost. With significantly increasing caseloads in all program areas, a strong ADR program will allow us to resolve many cases without resource-intensive investigations and litigation. It also provides quicker and better results for both employees and agencies. The program has been operating for just a few months and already we're seeing excellent results.

USERRA Demonstration Project

Fourth, shortly after my arrival at OSC we initiated a Demonstration Project in our unit that enforces the Uniformed Services Employment and Reemployment Rights Act, or USERRA. This Demonstration Project significantly increases OSC's responsibilities to

protect the employment rights of veterans, reservists, and members of the Guard. We have already received approximately 90 claims of employment discrimination against veterans. OSC is playing a central role in ensuring that the federal government upholds its responsibility to be a "model employer" under USERRA.

Improved Communication

Finally, another top priority for OSC is to enhance our communication with complainants and their counsel. Complainants must have a fair opportunity to be heard. So, we are building into the early portion of the screening process a mechanism to ensure that our examiners fully understand the nature of the allegations. And we are requiring investigators and attorneys in our Investigation and Prosecution Division to provide periodic updates to complainants during the course of an investigation to inform them of the status of their case and to offer them an opportunity to respond to the agency's position. To improve customer service, we are working to make our complaint filing process more user friendly and enabling whistleblowers to file both a disclosure and a retaliation complaint at the same time.

Support for Stronger Whistleblower Protections

As you know, in addition to the Hatch Act and USERRA, OSC enforces the Whistleblower Protection Act, a law that is also in need of an upgrade. Senator Akaka's legislation, the Whistleblower Protection Enhancement Act of 2011 (WPEA), would strengthen whistleblower law, restore congressional intent in this important area, and help OSC better perform its mission.

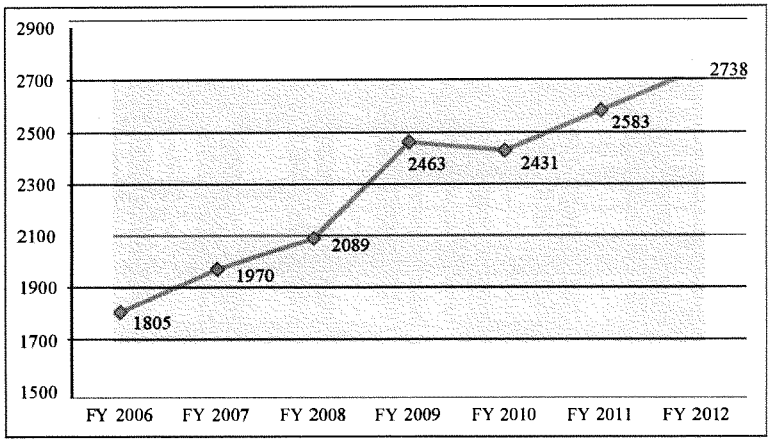
Right now, we are handcuffed by court decisions that too narrowly define who is protected for whistleblowing. The WPEA would broaden that definition by ensuring that employees are protected for any lawful disclosure, including those made in the course of their job duties. This is a key reform that will allow employees in critical positions, such as auditors and safety inspectors, to receive full protection under the law, as Congress always intended.

In addition, OSC cannot effectively deter retaliation by seeking disciplinary action against the retaliators before the MSPB because the current legal burden is extremely high. In addition, if OSC is not successful, even if our decision to pursue disciplinary action is reasonable and supported by the evidence, the agency may be required to pay attorneys' fees. Both of these obstacles would disappear if this legislation passed.

Conclusion

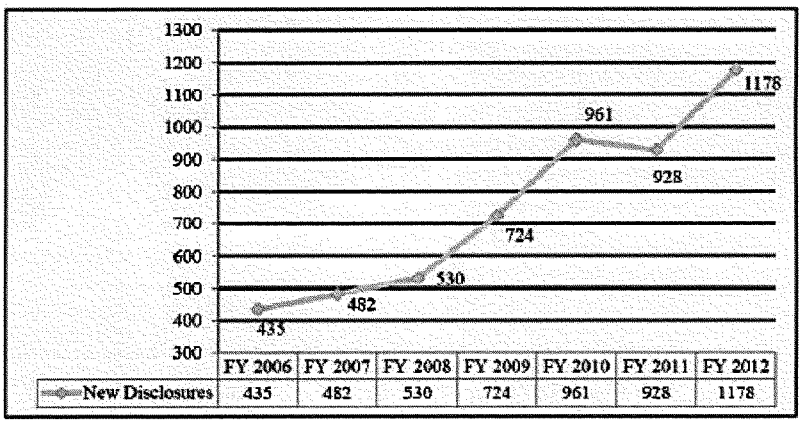
In conclusion, I appreciate and applaud this Subcommittee's efforts to reform the Hatch Act and the WPA. I also thank you for your support for our important work. I look forward to answering your questions.

OSC New Prohibited Personnel Practices Cases



- For FY2012, a 6% increase in Prohibited Personnel Practice (PPP) cases is expected over the record level of PPP cases received in FY 2011

OSC New Whistleblower Disclosures



- For FY2012, new whistleblower disclosures are up 32% over FY 2011

Special Counsel Carolyn N. Lerner

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

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights. Ms. Lerner is in *Best Lawyers in America* with a specialty of civil rights law and is one of *Washingtonian* magazine's top employment lawyers.

Ms. Lerner earned her undergraduate degree from the University of Michigan with highest honors, 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.

Testimony of Special Counsel Carolyn N. Lerner
United States Office of Special Counsel

House Committee on Oversight and Government Reform
Subcommittee on the Federal Workforce,
U.S. Postal Service and Labor Policy

May 16, 2012

Chairman Ross, Ranking Member Lynch, and Members of the Subcommittee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel's (OSC) administration of the Hatch Act. With me today is Ana Galindo-Marrone, the Chief of OSC's Hatch Act Unit.

It has been nearly 20 years since the last major revision of the Hatch Act, and reform is again needed. I appreciate the Subcommittee's consideration of this important issue and your willingness to consider our views as you work toward legislative reform.

OSC's primary mission is to protect the merit system and provide a safe and secure channel for government whistleblowers who report waste, fraud, abuse, and threats to public health and safety. The agency also protects veterans and service members from discrimination under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Finally, OSC enforces the Hatch Act, which was enacted in 1939 to restrict partisan political activity of federal employees and certain employees of state and local governments.

On June 14, 2011, I was sworn in as Special Counsel. During my initial months in office, I carefully reviewed OSC's Hatch Act program. I quickly discovered the overreach of this otherwise important federal law.

At its best, the Hatch Act keeps partisan politics out of the public workplace and prevents those in political power from abusing their authority to advance partisan political causes. At its worst, however, the Hatch Act causes the federal government to unnecessarily interfere with the rights of well-qualified candidates to run for local office.

This concern, along with several others about the current state of the law, prompted me to send Congress a legislative proposal for amending the Hatch Act in October of last year. I applaud the bipartisan group of lawmakers that introduced legislation in March to make these proposed reforms a reality.

The Hatch Act Modernization Act of 2012, H.R. 4152, was introduced on March 7, 2012. Companion legislation, S. 2170, was introduced on the same day in the Senate. And, similar legislation, H.R. 4186, was also introduced in the House on March 8, 2012.

Allowing State and Local Public Servants to Run for Partisan Elective Office

The primary reform in each of these good government bills is removing the Hatch Act's current prohibition on state and local employees running for partisan elective office. Removing this restriction will promote good government, demonstrate respect for the independence of states and localities, and allow OSC to better allocate its scarce resources toward more effective enforcement of the Hatch Act.

The Hatch Act's Broad Application Leads to Bad Outcomes for Affected State and Local Employees and their Communities

Under 5 U.S.C. § 1502, state and local public employees covered by the Hatch Act are ineligible to run for partisan elective office. A state or local employee is "covered" for purposes of the Hatch Act if the employee works "in connection" with an activity financed in whole or in part by federal loans or grants. In plain language, this means that state and local government employees cannot actively participate in their community's democratic electoral process if they are in some way tied to a source of federal funds in their professional lives.

In practice, the substantial increase in federal grant programs since 1940 and the case law interpreting the Hatch Act have extended the law's coverage well beyond Congress' initial intent to cover a small number of state and local public workers. Hundreds of thousands of public servants, in essentially every locality in the country, are now covered by this prohibition. OSC routinely finds first responders, healthcare workers, police officers, and many other positions across state and local government covered by the Hatch Act.

This expansive application of the law leads to absurd results and does nothing to advance the law's purpose or the public interest. For example, in 2011, OSC told Matthew Arlen, a police officer in a Philadelphia-area canine unit, that he could not run for the local school board because his partner, a black Labrador, is funded in part through Department of Homeland Security grants.

Mr. Arlen expressed his frustration in a recent Associated Press article on the Hatch Act. He rightly questioned, "How much influence can my dog have over what I could do on the school board?" Nevertheless, the Hatch Act prohibited Mr. Arlen from serving his community.

Unfortunately, Mr. Arlen's case is not unique. OSC similarly advised a paramedic in South Carolina that he could not run for county coroner because some of the patients he transports are Medicaid recipients. In another matter, OSC told a deputy controller that she could not run for county tax collector because some of her duties included auditing a federally funded program.[1]

[1] These cases, in which there is only a minor connection to federal funds, help illustrate some of the absurd results caused by enforcement of the candidacy prohibition. However, cases in which employees are significantly or fully funded by federal dollars often lead to equally unfair results. For example, OSC recently told a reemployment specialist for a State Department of Labor that he could not run for local office because his position is fully funded by a federal grant. Similarly, OSC recently told a maintenance worker for the New York State Canal Corporation that his candidacy was in violation of the Hatch Act because the agency received a federal grant that financed the personnel costs and supplies for various positions including maintenance workers. Despite being fully or significantly funded by federal dollars, these employees were not engaged in coercive conduct or the misuse of federal funds, and OSC sees no federal interest in preventing their candidacies.

In addition, OSC routinely advises deputy sheriffs that they are ineligible to run for sheriff. The number of local law enforcement Hatch Act cases has increased with the influx of federal grant dollars to local police departments after September 11, 2001. This is a disservice to local communities because the most qualified candidates for law enforcement and other positions are commonly disqualified from participating in a local election. The concern is especially acute in rural areas where the pool of potential candidates for elective office is limited by the area's population.

The Existing Prohibition on State and Local Workers Leads to Inconsistent and Unfair Results

While the reach of the Hatch Act is, on the one hand, too broad, OSC can only investigate those cases in which it receives a complaint. An allegation that an individual has violated federal law, even in the absence of wrongdoing or specific evidence, can cast a cloud over a candidacy. This fact has led opponents to discover the political utility of filing complaints with our office. In this way, the Hatch Act is increasingly being used as a political weapon. In these cases, our enforcement efforts actually increase the level of partisanship in politically-charged contests. Communities are again disserved by enforcement of this law, because Hatch Act complaints frequently create a campaign issue that distracts voters from the merits or policies of individual candidates.

In addition, OSC has no jurisdiction in states and localities that designate electoral contests as non-partisan. As this Committee discussed at its June 2011 hearing on the Hatch Act, this exemption for non-partisan elections creates confusing and inconsistent results between neighboring counties and cities. It is also unclear how the public interest is being served by the exception. For example, the Mayor of Chicago is elected on a non-partisan basis, which means that any employee in any position can run for that office without violating the Hatch Act. Yet, as discussed, elections for lower offices throughout the country are often partisan contests, and employees are routinely prohibited from stepping forward to serve.

These inconsistencies reinforce the need to allow states and localities to decide the appropriate level of restrictions in the political activity of their employees. Indeed, all 50 states already regulate the political activity of their public employees in some way. Michigan, for example, has chosen to restrict the electoral activity of its workers in a more tailored manner. Rather than a blanket candidacy restriction, employees are required under some circumstances to take a leave of absence in order to pursue their candidacy. The decision on the appropriate level of restrictions for public employees is best left to the judgment of a state or locality, and should not be decided by an unrelated connection to federal funds or the agenda of a political opponent.

Investigating State and Local Campaign Cases is a Poor Use of Tax Dollars

Despite my deep concerns about the impact of the Hatch Act on local communities and the rights of candidates, OSC is required by law to intervene in state and local contests hundreds of times a year through formal investigations. OSC also issues thousands of advisory opinions annually to potential state and local candidates.

Over 45% of OSC's overall Hatch Act caseload, including more than 500 investigations over the last two years and the vast majority of our advisory opinions, involved state and local campaign cases. These cases do not involve any allegation of coercive or abusive political conduct.

Rather, OSC must conduct a detailed and thorough inquiry into the financial and administrative structure of state and local agencies throughout the country. A determination on coverage is fact-specific, and depends on the specific functions of an individual employee and the structure of the state or local entity. State and local agencies must spend time and resources responding to document and interview requests.

Investigating hundreds of state and local campaign cases annually is a poor use of OSC's limited budget and creates a burden on state and localities who must respond to these investigations. It is also an improper function for the federal government.

Removing the Candidacy Prohibition Would Not Allow Employees to Misuse Federal Funds or Engage in Coercive Conduct to Support Their Own Candidacy

As demonstrated in the examples above, individual state and local employees have not engaged in any political misconduct or wrongdoing. Instead, they have chosen to step forward to participate in the democratic process in their communities. If the candidacy prohibition were removed, a covered state or local employee who runs for partisan political office would remain subject to the Act's prohibitions on misuse of official authority and coercive conduct. For example, a covered employee who runs for office would still be in violation of the Hatch Act if the employee:

- used federal (or any other public) funds to support his own candidacy;
- used his state or local office to support his candidacy, including by using official email, stationary, office supplies, or other equipment or resources; or
- compelled subordinates to volunteer for his campaign or contribute to the campaign.

By removing the candidacy provision, Congress would allow OSC to target its resources on conducting better and timelier investigations in cases involving actual misconduct, the objective initially sought by Congress.

I strongly encourage the Committee to Act quickly on legislation to remove this prohibition on state and local public servants.

Modifying Overly-Restrictive Penalty Structure

The Hatch Act Modernization Act of 2012 would also modify the Hatch Act's penalty structure for federal employees. OSC supports this reform because it will result in more flexibility and fairness in OSC's enforcement efforts. Current law requires that employees be removed from office for violating the Hatch Act -- unless the Merit Systems Protection Board (MSPB) unanimously finds that the violation does not warrant removal. Even in these cases, the MSPB may not impose a penalty of less than 30 days' suspension without pay. This structure is overly restrictive, can lead to unjust results, and may even deter agencies from referring potential violations to OSC.

The pending legislation would amend the penalty provisions of the Hatch Act to mirror the range of penalties provided in 5 U.S.C. § 1215, which apply to other disciplinary actions under OSC's jurisdiction. Under section 1215, depending on the severity of the action and other mitigating factors, the Board may impose a range of disciplinary actions consisting of removal, reduction in

grade, debarment from federal employment for a period not to exceed 5 years, suspension, reprimand, or an assessment of a civil penalty not to exceed $1,000. OSC supports this reform, and believes it will aid our enforcement efforts in federal sector cases.

Other Issues for Congress to Consider

In prior communications with Congress, OSC has noted several other potential areas for legislative reform of the Hatch Act to ensure that OSC's advisory and enforcement efforts are consistent with both congressional intent and the realities of the 21st century federal workplace. It is also important to clarify ambiguities in the law so that employees have full and fair notice of their obligations under the Hatch Act.

Codify a Definition of "Political Activity" and Clarify the Definition of "Federal Workplace"

The Hatch Act prohibits most federal employees from engaging in political activity while on duty, in uniform, in the federal workplace, or while using a federal vehicle. The statute, however, does not define "political activity." The Hatch Act's attendant regulations define the term as activity directed at the success or failure of a candidate for partisan political office, political party, or partisan political group. 5 C.F.R. § 734.101. Congress should consider defining "political activity" in the statute to make clear its intent regarding this prohibition and to provide clearer notice to federal workers on the law's prohibitions. OSC believes that the current definition in the regulations is appropriate.

In addition, the restriction on political activity can be confusing given technology-driven workplace developments not anticipated in 1993, when Congress last reformed the Hatch Act. For example, there is confusion about the application of the "on-duty" political activity prohibition to the telework model. Current telework policies have led to a large number of employees working from home several days a week and using government issued equipment to perform their duties where they reside. In general, the regulations define federal workplace as federally owned or leased space. Employees' homes do not meet the definition of federal workplace. While extending the definition of the federal workplace to an employee's home would be inappropriate, Congress may want to consider clarifying that the "on-duty" political activity prohibition applies to an employee while teleworking.

Additionally, although the statute currently restricts the use of government vehicles to engage in political activity it is silent as to government laptops, Blackberries, and iPhones. Agencies should be encouraged to develop clear computer-usage and government equipment policies. And, Congress may want to consider whether the use of ".gov" email addresses to engage in political activity, even while off duty, is consistent with the goals of the Hatch Act.

Similarly, the internet and social media have dramatically changed the way we gather and share information, communicate our views, or engage in the political process. These changes were not contemplated when the Hatch Act was last amended to restrict political activity on duty or in the federal workplace. OSC has issued detailed advisory opinions on the use of social media and the Hatch Act. Congress may want to consider OSC's guidance in this area in any effort to reform the Hatch Act.

Clarify the Scope of the Exemption for High Level and White House Employees

The Hatch Act, under 5 U.S.C. § 7324(b), exempts certain employees from the prohibition against engaging in political activity while on duty or in the federal workplace, as discussed above. This exemption includes an employee paid from an appropriation for the Executive Office of the President (EOP), the duties of whose position continue outside normal duty hours and while away from the normal duty post. The Committee's June 2011 Hatch Act hearing highlighted differing views on the proper scope of this exemption. Clarifying the scope of the §7324(b) exemption would benefit OSC's advisory efforts and all impacted employees.

In addition, section 7324(b) applies only to a Presidentially-appointed, Senate-confirmed (PAS) employee who "determines policies to be pursued by the United States in relations with foreign powers or in the nationwide administration of Federal laws." Clarifying the scope of this limitation would similarly benefit OSC's advisory efforts and impacted employees.

District of Columbia Employees

The Hatch Act, under 5 U.S.C. § 7322, includes in the definition of employee an individual employed or holding office in the government of the District of Columbia, other than the Mayor, a member of the City Council, or the Recorder of Deeds. According to this definition, the Hatch Act currently applies to all District of Columbia employees, including those in the judicial and legislative branches of government. In contrast, the Hatch Act's application to federal, state and local employees is limited to executive branch employees. Any Hatch Act reform should consider this discrepancy. Pending legislation in the House and Senate would move District of Columbia employees from the provisions of the federal Hatch Act to those that cover state and local employees under chapter 15 of title 5. The change would address the discrepancy cited above.

Statute of Limitations

Under 5 U.S.C. § 1216(a)(2), OSC is required to investigate Hatch Act allegations after receiving a complaint, regardless of when the underlying conduct occurred. Congress has not provided a statute of limitations for Hatch Act allegations, and may want to consider this issue as it pursues other reforms to the Hatch Act.

Political Activity of State and Local Elected Officials

Pending legislation in the House and Senate would allow sheriffs to participate in designated political activities in their official capacity without violating the Hatch Act's prohibition on the use of official authority for political purposes. These proposed legislative changes are consistent with OSC's current understanding of the law in this area. In fact, OSC recently issued an advisory opinion that clarifies the scope of permissible political activity for all state and local elected officials. For example, in recognition of the fact that these individuals already hold a partisan political office, OSC concluded that state and local elected officials would not violate the Hatch Act by wearing their uniforms or using their titles while campaigning or supporting

another candidate for office. Congress may want to consider codifying these rules, which would provide greater clarity to affected state and local elected officials.

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Special Counsel Carolyn N. Lerner

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

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights. Ms. Lerner is in *Best Lawyers in America* with a specialty of civil rights law and is one of *Washingtonian* magazine's top employment lawyers.

Ms. Lerner earned her undergraduate degree from the University of Michigan with highest honors, 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.

Testimony of the Honorable Carolyn N. Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on the Efficiency and Effectiveness
of Federal Programs and the Federal Workforce

"Strengthening Government Oversight: Examining the Roles and Effectiveness of Oversight Positions within the Federal Workforce"

November 19, 2013, 2:30 P.M.

Chairman Tester, Ranking Member Portman, and Members of the Subcommittee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC). OSC is an independent investigative and prosecutorial federal agency. We protect the merit system for over 2.1 million civilian federal employees in four distinct mission areas. OSC protects federal workers from "prohibited personnel practices," especially retaliation for whistleblowing. We provide a safe and secure channel for whistleblowers to report waste, fraud, abuse, and health and safety issues. We enforce the Hatch Act, keeping the federal workplace free from improper partisan politics. Finally, OSC enforces the Uniformed Services Employment and Reemployment Rights Act (USERRA).

We fulfill these important roles with a staff of approximately 110 employees – and the smallest budget of any federal law enforcement agency. I am pleased to report that our dedicated staff is performing more efficiently and effectively than at any point in OSC's 35-year history.

However, our capacity for improving government is limited by extreme resource challenges. In the past two years, OSC's caseloads skyrocketed to historic levels. In addition, Congress imposed important new mandates on OSC with passage of the "Whistleblower Protection Enhancement Act of 2012." Despite these increases in our workload, OSC's already flat budget took a dramatic hit with sequestration, causing workforce reductions.

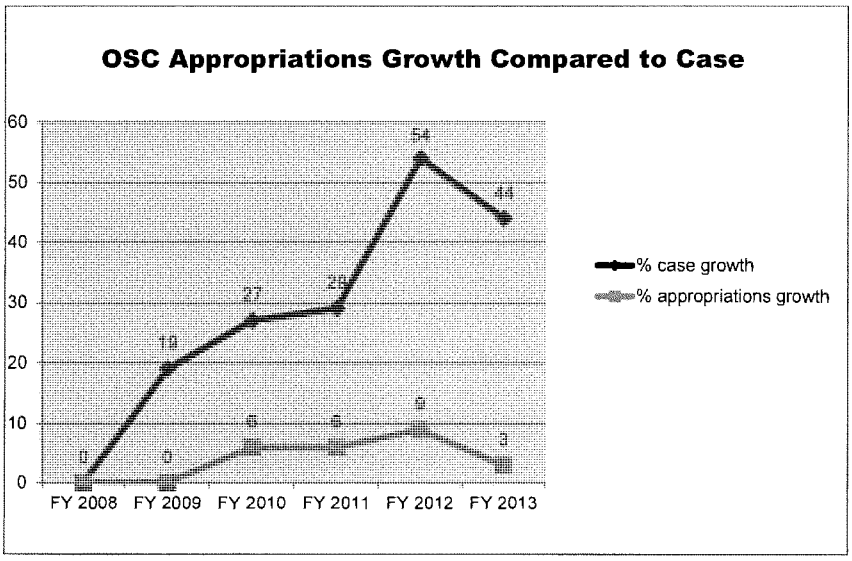
The simple mathematics of historically-high case levels and a shrinking budget poses the biggest challenge to OSC in realizing our oversight potential. The good news is that Congress and the administration recognize that the status quo is not sustainable. The President's Fiscal Year 2014 budget request for OSC provides a necessary increase of approximately $1.7 million, which both the House and Senate Appropriations Committees approved. While we are currently operating, like most agencies, under a continuing resolution, I am hopeful that final spending bills for 2014 will include this modest increase.

With that overview, I want to provide more detail on OSC's track record over the last two years and conclude by briefly noting issues beyond resource challenges that may pose obstacles to OSC.

OSC Accomplishments with Limited Resources and Staff

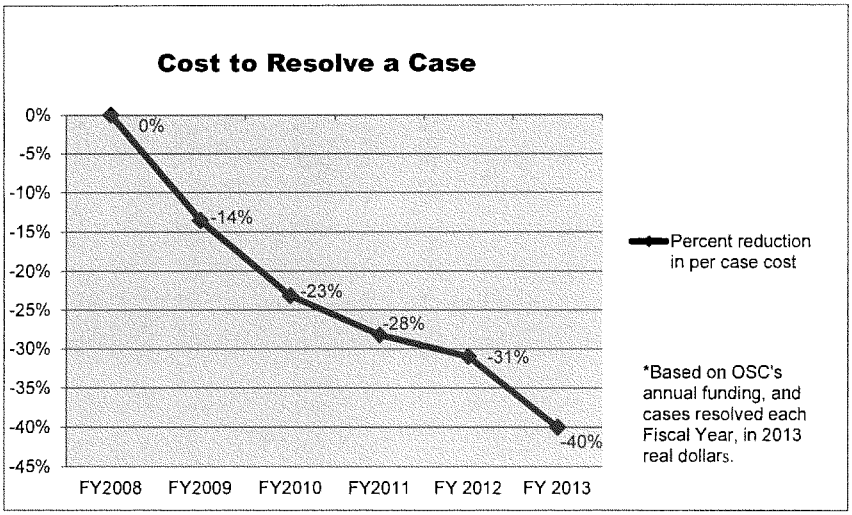
The last two fiscal years (FY2012 and FY2013) have been a record-setting period for OSC. By nearly every statistical measure, OSC achieved the most positive results in its history. These successes result in greater confidence in OSC's ability to perform its good government mission. However, such confidence can be a double-edged sword, as it directly correlates to our increased caseload.

To illustrate, cases increased by 50% in five years, with the sharpest increase over the last two. During this period, funding levels actually decreased in real terms, considering inflation, automatic pay adjustments, and other mandatory expenses.



In addition to receiving more cases, OSC is processing them more efficiently and effectively. For example, in FY2008, OSC completed a total of 2,875 cases. In FY2013, just five years later, OSC resolved 4,808 cases, nearly doubling our productivity. Completing cases quickly benefits employees and enables agencies to manage their workforce with less disruption and uncertainty.

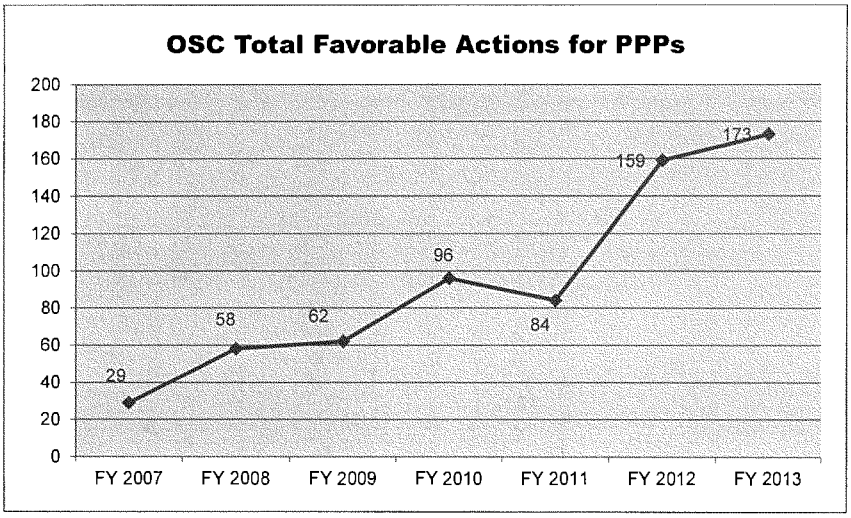
OSC's increased efficiency helps us manage the growing caseload, and translates into real savings. OSC's cost to resolve a case dropped by 40% in the last 5 years, a decrease of over $2,640 per case. Stated simply, we're making every dollar count.



Our increased efficiency has not compromised OSC's effectiveness. In fact, when evaluating the most important statistic for OSC – the number of favorable actions on behalf of whistleblowers and the merit system – we are again setting records. We're not just closing cases, we're getting more relief than ever before for whistleblowers. Favorable actions include the relief that OSC secures for employees who are the victims of retaliation, such as back pay, reinstatement, or reassignment to a non-retaliatory environment. They include disciplinary actions taken against employees who engage in retaliation or other prohibited conduct. And favorable actions also include cases where we work with agencies to implement systemic reforms to prevent problems from recurring.

In FY2012, the first full year of my tenure, our staff achieved an 89% increase in favorable actions from the prior fiscal year. This was a 175% increase from five years ago. FY2012's total of 159 favorable actions, or "victories" for whistleblowers and the merit system, exceeded any previous year in the agency's history. We set an extremely high bar in FY2012, and then surpassed it in FY2013. The total number of favorable actions rose again in FY2013 – to 173. This is an astonishing total, considering only 29 favorable actions were achieved in 2007.

It is a testament to the hard work of our dedicated career staff, who have endured furloughs and increased caseloads while managing to improve productivity and outcomes in all measures.



These numbers don't tell the whole story. Statistics cannot capture the true impact and value of OSC's work. Our efforts to support whistleblowers often stop the immediate problem and spark reforms that prevent wasteful, inefficient, or unsafe practices.

For example, OSC recently issued a report detailing serious overtime abuse by Department of Homeland Security employees. Improper claims of Administratively Uncontrollable Overtime, or AUO, cost the government up to $9 million annually at six DHS offices identified by whistleblowers in OSC cases. The annual cost of AUO abuse nationwide is likely to reach tens of millions of dollars, according to the whistleblowers. And this estimate excludes overtime claims by agents in the field – those whose need for AUO would seem to be most justified. It is my sincere hope that OSC's role in highlighting this gross waste of scarce government funds will assist the Subcommittee in its efforts to reform the DHS overtime system, and I applaud you for your efforts in this area.

In the past year, OSC also worked with whistleblowers at the VA Medical Center in Jackson, Mississippi. Physicians and other employees raised concerns about unlawful prescriptions of narcotics, chronic understaffing of the Primary Care Unit, unsterile medical equipment, and other threats to Veterans at the facility. OSC's efforts resulted in greater oversight of the Jackson VAMC by the administration and Congress, and we are continuing to work with whistleblowers to identify and address similar problems throughout the VA system.

In the last two years, OSC also successfully carried out its expanded role to protect the rights of returning service members under USERRA. Under a three-year pilot program mandated by Congress, OSC is investigating half of all federal sector USERRA claims, while the Department

of Labor continues to investigate the other half. OSC is using an effective and low-cost approach to resolving USERRA cases through Alternative Dispute Resolution. OSC achieved a 100% success rate in resolving USERRA claims referred to mediation.

In one recent USERRA case, a member of the Air Force Reserves worked with the Department of Energy in New Mexico. Upon her return from active duty, the Department refused to promote her, after initially promising that it would. Management officials cited her absence for military service as the reason. OSC investigated and informed the agency of its obligations under USERRA. The Department of Energy then gave the reservist a retroactive promotion with corresponding back pay and reassigned her within the agency, enabling her to get the experience and training necessary for further promotion.

Among the favorable actions OSC received for whistleblowers was a case originating in Syracuse, NY. Two whistleblowers at the Transportation Security Administration blew the whistle on misuse of a government vehicle, misuse of financial rewards, and a hostile work environment at the Syracuse Hancock International Airport. The whistleblowers were retaliated against after making these disclosures, and both received full corrective action after OSC's investigation. One of the whistleblowers told a Syracuse newspaper, "We were a little frustrated, like no one's going to help us . . . And (OSC) hung in there and did good things for us." The whistleblower specifically noted the work of OSC Attorney Clarissa Pinherio, who worked on the case for three years and ultimately was able to negotiate relief for the employees.

Finally, during 2012, OSC successfully enforced the Hatch Act during a difficult presidential election year, including finding a sitting cabinet secretary in violation of the Hatch Act for the first time in the Act's history.

Whistleblower Protection Enhancement Act (P.L. 112-199) Will Further Increase OSC's Caseloads

OSC is also in the process of implementing the first major reform to the federal whistleblower law in 20 years. The Whistleblower Protection Enhancement Act (WPEA) was signed into law on November 28, 2012. The landmark reform was supported by a broad, bipartisan coalition in Congress, with strong support from good government and taxpayer protection organizations. OSC is the primary agency responsible for implementing this good government reform and already has seen a significant increase in claims. During the first quarter of FY2013, OSC experienced the highest number of quarterly filings in the agency's 35-year history.

The Congressional Budget Office conservatively estimated that OSC would need an additional $1 million annually to successfully implement the WPEA. However, under sequestration, OSC's resources have been reduced by $1 million since enactment of the WPEA, significantly impeding OSC's ability to carry out the law's good government mandates. While we shifted additional staff to our Investigation and Prosecution Division to help manage the workload, our budget to pay for basic investigative expenses – such as transcription services – is inadequate. Similarly, we cannot afford to conduct on site investigations in whistleblower reprisal cases and other matters, except for the most extraordinary circumstances.

The WPEA's mandates include: a significant expansion of OSC's jurisdiction; a requirement to conduct investigations in hundreds of whistleblower cases that previously would have been dismissed; a direction from Congress to initiate more formal litigation and disciplinary actions against agency managers; and training requirements for all other government agencies. The WPEA also provides OSC with the authority to file amicus briefs in federal court cases that involve whistleblower protection issues. OSC exercised this new authority for the first time in the case of *Kaplan v. Conyers*, arguing that the Federal Circuit Court of Appeals' decision threatened to undermine the enhanced whistleblower protections passed by Congress.

Other Challenges

In conclusion, I would like to flag two additional areas that the Subcommittee may want to consider as it examines possible efforts to strengthen oversight positions in the government.

First, the Federal Circuit's decision in *Kaplan v. Conyers* poses a significant threat to whistleblower protections for hundreds of thousands of federal employees in sensitive positions and may chill civil servants from blowing the whistle. I understand that the Subcommittee will hold a hearing to examine the impact of *Conyers*, and I applaud your efforts to better understand this important issue.

While the *Conyers* Court did not specifically address the applicability of the decision to whistleblower and other prohibited personnel practice cases, it may be helpful for Congress to clarify that OSC and the MSPB maintain jurisdiction over employee claims of retaliation and other prohibited conduct, even where an adverse employment action is based on the employee's eligibility to hold a sensitive position. It may also be helpful for Congress to track the number of adverse actions taken because an employee is deemed ineligible to hold a sensitive position, rather than the traditional bases for punishment – employee conduct or performance. If the number of actions based on eligibility begins to trend upward, it would indicate that agencies are more actively utilizing the authority provided by *Conyers*, and my concerns about the impact on the merit system and due process rights for federal workers would increase.

Second, OSC has not been formally reauthorized since 2007. While this does not prevent OSC from receiving appropriations, reauthorization provides Congress with an opportunity to evaluate OSC's authorities and responsibilities and make any necessary adjustments. In light of our steadily increasing workload, Congress may want to consider the onerous procedural requirements imposed on OSC in all prohibited personnel practice cases as a possible area for revision. Additionally, there is no statute of limitations for filing a prohibited personnel practice complaint with OSC. Congress may want to consider whether a reasonable time limit for filing a complaint with OSC is appropriate. Finally, OSC's authority to compel the production of documents in whistleblower disclosure cases could be clarified, and the mechanism for enforcing OSC subpoenas against federal entities should be updated and streamlined.

Investing in OSC is one of the most cost-effective methods of promoting good government and preventing violations of merit system laws. I thank you for the opportunity to testify today, and I look forward to your questions.

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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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights. When she was in private practice, Ms. Lerner was in *Best Lawyers in America*, with a specialty of civil rights law, and was one of *Washingtonian* magazine's top employment lawyers.

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.

Testimony of the Honorable Carolyn N. Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. House of Representatives Committee on Oversight and Government Reform
Subcommittee on National Security

"Abuse of Overtime at DHS: Padding Paychecks and Pensions at Taxpayer Expense"

November 20, 2013, 10:00 A.M.

Chairman Chaffetz, Ranking Member Tierney, and members of the Subcommittee:

Thank you for inviting me to testify today on behalf of the U.S. Office of Special Counsel (OSC). I am pleased to have the opportunity to discuss the long-standing abuse of overtime payments brought to light by whistleblowers at the Department of Homeland Security (DHS). I appreciate the Committee's interest in taking a closer look at this problem. I'd like to introduce Lynn Alexander and Johanna Oliver, attorneys in our Disclosure Unit, who had primary responsibility for these matters.

My statement today will focus on three areas: 1) the role of the Office of Special Counsel in whistleblower disclosures, 2) the specific procedures followed in this matter, and 3) our findings and areas of concern.

OSC's Role and Process

As an independent agency within the Executive Branch, the Office of Special Counsel provides a safe channel for federal employees to disclose allegations of waste, fraud, abuse; violations of law, rule, or regulation; and health or safety concerns. We evaluate disclosures to determine if there is a "substantial likelihood" that wrongdoing has been disclosed. If this substantial likelihood standard is met, I am required to send the information to the head of the appropriate agency. After a referral, the agency is required to conduct an investigation and to submit a written report to my office. OSC received approximately 1,150 disclosures from federal employees in Fiscal Year 2012, and just over three percent of the disclosures were referred for investigation.

After reviewing the agency's report of investigation, I make two determinations. First, I determine whether the report contains the information required by the statute, and second, whether the findings of the agency appear reasonable. In addition, the whistleblower is given an opportunity to comment on the agency report. My office then transmits the report along with findings and recommendations to the President and congressional committees with oversight responsibility for the agency involved.

It was within this statutory framework that we received disclosures from seven whistleblowers at six separate offices at the Department of Homeland Security over the past two years.

Now I'll turn to the procedures that were followed in those cases.

Procedural Case Chronology

In September 2012, the Office of Special Counsel received a disclosure from Jose Ducos-Bello. Mr. Ducos-Bello alleged that DHS employees working in the U.S. Customs and Border Protection (CBP) Commissioner's Situation Room, in Washington, D.C., regularly abuse Administratively Uncontrollable Overtime (AUO), and that the Director and Assistant Director authorize and abet this improper use. These routine overtime payments to Situation Room employees functionally extend their daily shift by two hours every day, increasing pay by 25%. This practice is a violation of the regulations governing AUO.

According to regulations, this type of overtime may only be used when an employee's hours cannot be scheduled in advance due to a substantial amount of irregular work. For example, AUO is appropriate when an employee's work requires responding to the behavior of suspected criminals and it would "constitute negligence" for the employee to leave the job unfinished. AUO should only be used for irregular and unpredictable work beyond an employee's normal shift. 5 C.F.R. Sec. 150.151-154.

The Situation Room employees in Mr. Ducos-Bello's disclosure were not using AUO as the result of any unpredictable or compelling law enforcement need. Rather, most claimed the overtime for administrative tasks that do not qualify. And, according to Mr. Ducos-Bello, many of these employees spent the extra two hours per day not working at all; they were relaxing, surfing the internet, watching sports and entertainment channels, or taking care of personal matters.

The abuse of this type of overtime at the Commissioner's Situation Room was not an isolated occurrence. Over the past year, we received disclosures from six more whistleblowers at five other offices throughout DHS. These allegations are outlined in my October 31, 2013, letter to the President, which is attached to this testimony. Much of the AUO at these locations involved desk jobs or training assignments, where compelling law enforcement reasons for staying on duty are highly unlikely to arise. You will hear more from John Florence about his specific concerns at the DHS training office in Glynco, GA.

At these six facilities alone, a conservative estimate of the overtime abuse is nearly $9 million each year. The whistleblowers estimate that the cost nationwide is likely to reach tens of millions of dollars annually. This estimate excludes any overtime claims by agents in the field – those whose need for AUO would seem to be most justified.

In the Situation Room case, after we determined that there was a substantial likelihood of a violation of law, rule, or regulation and gross waste of government funds, we referred these allegations to then DHS Secretary Janet Napolitano for investigation. In April 2013, we received the agency's report, which substantiated the allegations. The report concluded that there was no way to verify whether employees in the Commissioner's Situation Room were entitled to the AUO they were receiving; previous warnings regarding proper use of AUO were disregarded; and it was "evident that the regular and consistent addition of two hours of AUO to the regularly scheduled eight-hour day implies hours of duty are controllable by management."

As to the other five investigations of overtime abuse, DHS's reports to my agency are expected back within the next several weeks and months, and we will keep the Subcommittee informed of further developments.

OSC Comments and Areas of Concern Regarding Custom and Border Protection's Findings

I credit the Customs and Border Protection (CBP) Office of Internal Affairs for conducting a thorough investigation into the whistleblower's allegations. And, as noted, the CBP investigation confirmed most of the whistleblower's factual allegations. However, while the agency has pledged to take corrective action, I remain concerned about whether the agency is ultimately willing or able to do so.

As I noted in my communication to Congress and the President, in 2007 the identical concerns about overtime abuse were raised and the agency made similar promises about correcting them. Specifically, at that time, our agency received a disclosure that Customs and Border Protection employees in Blaine, Washington were improperly using AUO. In response, the agency confirmed the allegations, finding that employees were given blanket authorization to work overtime and managers improperly provided excess overtime. Much of that overtime was controllable, and therefore it should not have been classified as AUO. The report also found that employees were paid when they were not actually working.

At that time, CBP outlined a corrective plan, requiring training in AUO and annual certification. Much of the agency's response to the 2007 complaint mirrored its response to the current round of allegations.

In its current report, CBP cites a number of obstacles that will make it difficult to implement a directive to correct this problem, including collective bargaining obligations and the need for updated regulations from the Office of Personnel Management.

While I am hopeful that the Department will overcome these obstacles and take definitive action to correct this overtime abuse, I am also realistic. Based both on the magnitude of the problem and the history of ineffective solutions, it will require a serious commitment to make necessary changes. I am pleased that Congress and this Committee have shown an interest in helping the Department find ways to solve this problem, including through legislative reform.

In conclusion, I want to applaud Mr. Florence, Mr. Ducos-Bello, and the other courageous DHS whistleblowers who spoke out about this important issue, often against their own financial self-interest. Had they not stepped forward, these problems would not have come to light, and the taxpayers would continue to foot the bill for these improper payments.

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

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

The Special Counsel

October 31, 2013

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

Re: OSC File No. DI-13-0002

Dear Mr. President:

I write to express deep concerns about long-standing abuse of overtime payments by the Department of Homeland Security (DHS). The enclosed report details one of six whistleblower cases currently before the Office of Special Counsel (OSC). Each of the six cases discloses misuse of a specific pay authority known as Administratively Uncontrollable Overtime (AUO). According to information provided by the whistleblowers, abuse of AUO at these six DHS offices alone costs the taxpayers approximately $8.7 million annually, a gross waste of government funds.

The enclosed report substantiates disclosures made by DHS employee Jose R. Ducos-Bello. The report confirms that employees in the Commissioner's Situation Room (Situation Room), an office within Customs and Border Protection (CBP) in Washington, D.C., violate the federal AUO regulation by claiming two hours of AUO pay nearly every day. The report also confirms that the Situation Room Director and Assistant Director "authorize and abet" the improper use of AUO. OSC recently referred to the Secretary of Homeland Security five additional AUO cases – a strong indication that DHS has a profound and entrenched problem.

AUO is intended to be used only when an employee's hours cannot be scheduled in advance due to a substantial amount of irregular work. For example, under the governing regulation, AUO is appropriate if an employee's work hours depend on responding to the behavior of suspected criminals and it would "constitute negligence" for the employee to leave the job unfinished. CBP and other DHS components have the authority to use AUO to effectively secure the borders, which may require irregular and unpredictable work beyond an employee's normal shift. See 5 C.F.R. § 150.151--154. Despite this definition, thousands of DHS employees routinely file for AUO, claiming up to two hours a day, nearly every day, even in headquarters and training assignments where no qualifying circumstances are likely to exist.

The attached report confirms that Situation Room employees in Washington, D.C., claim to have worked two hours of AUO following their assigned shift 89 percent of the time. These routine AUO payments to Situation Room employees "functionally [extend] their daily shift by two hours each day," but are not the result of any unpredictable or compelling law enforcement need. Most of the claimed overtime work is "administrative in nature, often consisting of Headquarters or local taskings" that do not qualify for AUO. Mr. Ducos-Bello alleged that the

employees who "work" overtime frequently watch sports and entertainment channels during their claimed AUO periods, or spend the two additional hours at their duty station relaxing, joking, surfing the internet, and taking care of personal matters.

This case is not an isolated occurrence. Rather, it is part of a persistent pattern of AUO allegations raised by DHS employees. Some of these whistleblowers are authorized to receive AUO. They are disclosing information against their own financial self-interest due to concerns about the ethics of the practice and the resulting impact on the federal budget. While DHS officials have acknowledged AUO abuse when confronted with specific allegations, they have taken insufficient steps to correct the problem.

For example, on February 20, 2008, OSC referred a whistleblower's allegations of AUO abuse at the Office of Border Patrol in Lynden, WA (OSC File No. DI-08-0663). The DHS report in response to those disclosures confirmed that employees in Lynden routinely abused AUO and that senior managers also benefited from improperly approved AUO. At the time, CBP promised to implement "an Agency-wide AUO policy directive [to] bring conformity to the policies and practices" – a step that would cease the practices in Lynden and prevent misuse throughout the agency.[1]

That commitment was made more than five years ago. In the current report on AUO abuse in the Situation Room, CBP repeats its desire "to work towards a unified and simplified agency-wide directive on AUO." The report adds an additional, minor commitment by CBP to show a video to all employees to reinforce rules on proper AUO use and administration.

Much of the language regarding the Situation Room AUO abuse and proposals for corrective action is taken directly from the 2008 Lynden report. Roughly one-quarter of the 2013 report is identical to the concerns cited in the 2008 report. The lack of progress in implementing plans first outlined five years ago raises questions about the agency's willingness or ability to confront this important problem.

CBP cites an array of obstacles to full implementation of an agency-wide AUO directive, including collective bargaining obligations and the need for updated regulations from the Office of Personnel Management. DHS and CBP must overcome these challenges and move quickly to reform AUO practices. OSC is currently processing five additional AUO cases, each of which met the high "substantial likelihood" standard for investigative referral by OSC to DHS. These cases include:

- A whistleblower at the CBP Office of Training and Development in Glynco, GA, alleged that agents routinely abuse AUO by claiming two hours of AUO daily while failing to perform any qualifying duties. The fact that AUO is claimed at a training facility – where compelling law enforcement reasons for staying on duty are unlikely to arise – raises concerns about the propriety of its use by these employees. According to the

[1] In 2012, OSC resolved a whistleblower case brought by another employee in Washington, who alleged retaliation for disclosing evidence of AUO abuse to his superiors.

whistleblower, CBP pays out nearly $5 million annually to employees in the Office of Training and Development, including to 50 managers at Headquarters. DHS is required to submit a report to OSC in response to these allegations by January 2, 2014.

- A whistleblower at the U.S. Citizenship and Immigration Services headquarters facility in Washington, D.C., alleged abuses of AUO in 2010 while the whistleblower worked in the Office of Security and Integrity (OSI). The whistleblower alleged that everyone in OSI claimed 10 hours of AUO every week, even though no employee performed work that qualified. This whistleblower requested that her position be made ineligible for AUO and also advised supervisors that AUO was being routinely misused. The whistleblower was initially told she could not be decertified from AUO because it would draw unwanted attention to the office. While the whistleblower was eventually decertified, the AUO abuse by others has not stopped. DHS is required to submit a report in response to these allegations by November 13, 2013.

- A whistleblower at the Immigration and Customs Enforcement (ICE) facility in Houston, TX, alleged that ICE supervisors authorize and abet the improper use of AUO. The whistleblower disclosed that employees are directed to stay beyond their normal duty hours to complete routine administrative tasks that are not time-sensitive or investigative in nature. These employees are instructed to certify the time as AUO. OSC received an inadequate report from ICE on September 11, 2013, and will seek a supplemental report.

- Two whistleblowers at the CBP facility in San Ysidro, CA, allege that Border Patrol Agents at the Asset Forfeiture Office routinely claim two hours of AUO each day, but fail to perform duties that qualify for AUO payments. The whistleblowers further alleged that employees work on routine administrative matters during the claimed AUO periods or are not even present for the AUO time they claim. DHS is required to submit a report to OSC in response to these allegations by November 6, 2013.

- Finally, a report issued by CBP in response to a whistleblower's disclosures at the CPB facility in Laredo, TX, confirms that AUO is being used for routine shift change activities in violation of rules and regulations. OSC requested additional information from CBP on the Laredo activities.

These additional cases indicate that AUO problems are ongoing and pervasive throughout DHS. Indeed, according to CBP's own data, during one three-month period in 2013 agents at Border Patrol Headquarters in Washington, D.C., averaged 1.99 AUO hours per day, or 20 hours per pay period. This is one of the highest AUO rates of any CBP duty station, including many duty stations in border areas. One whistleblower noted to OSC that if all AUO claims by agents in the field were excluded, and only AUO claims by agents in office jobs were examined, "the dollar amount of AUO abuse would be in the tens of millions per year."

Such abuse of overtime pay is a violation of the public trust and a gross waste of scarce government funds. It is incumbent upon DHS to take effective steps to curb the abuse. It is up to the administration and Congress to develop a revised pay system, if warranted, that ensures fair compensation for employees who are legitimately working overtime.

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The allegations regarding AUO abuse at the CSR were referred to former DHS Secretary Janet Napolitano on January 2, 2013, for an investigation and report.[2] On April 17, 2013, James F. Tomshek, Assistant Commissioner, Office of Internal Affairs (IA), submitted a report based on the results of an investigation conducted by CBP's IA. On May 3, 2013, a copy of the report was forwarded to Mr. Ducos-Bello, who provided comments in response to the report on May 5, 2013.

The report contains all of the information required by statute. However, there remain serious questions about the agency's ability or willingness to adequately address the AUO abuse issue. Therefore, I find the report unreasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency report and Mr. Ducos-Bello's comments to the Chairman and Ranking Member of the Senate Committee on Homeland Security and Governmental Affairs and the Chairman and Ranking Member of the House Committee on Homeland Security. I have also filed a copy of the report and the whistleblower's comments in our public file, which is now available online at www.osc.gov, and closed the matter.

Respectfully,

Carolyn Lerner

Carolyn N. Lerner

Enclosures

[2] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). If the Special Counsel determines that there is a substantial likelihood that the disclosures are accurate, she is required to advise the appropriate agency head and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel solicits comments from the whistleblower and reviews the agency's report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2).

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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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

Prior to becoming Special Counsel, Ms. Lerner taught mediation as an adjunct professor at George Washington University School of Law, and was mediator for the United States District Court for the District of Columbia and the D.C. Office of Human Rights. When she was in private practice, Ms. Lerner was in *Best Lawyers in America*, with a specialty of civil rights law, and was one of *Washingtonian* magazine's top employment lawyers.

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.

Testimony of the Honorable Carolyn N. Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on the Efficiency and Effectiveness
of Federal Programs and the Federal Workforce

"Examining the Use and Abuse of Administratively Uncontrollable Overtime at the Department of Homeland Security"

January 28, 2014, 2:30 P.M.

Chairman Tester, Ranking Member Portman, and members of the Subcommittee:

Thank you for inviting me to testify today on behalf of the U.S. Office of Special Counsel (OSC). I am pleased to have the opportunity to discuss the long-standing abuse of overtime payments brought to light by whistleblowers at the Department of Homeland Security (DHS). I appreciate the Committee's interest in taking a closer look at this problem. I'd like to introduce Lynn Alexander, Johanna Oliver, and Nadia Pluta, attorneys in our Disclosure Unit, who had primary responsibility for these matters.

My statement today will focus on three areas: 1) the role of the Office of Special Counsel in whistleblower disclosures, 2) the specific procedures followed in the recently-concluded overtime case involving employees at the U.S. Customs and Border Protection (CBP), Commissioner's Situation Room, in Washington, D.C., and 3) our findings and ongoing areas of concern.

OSC's Role and Process

As an independent agency within the Executive Branch, the Office of Special Counsel provides a safe channel for federal employees to disclose allegations of waste, fraud, abuse; violations of law, rule, or regulation; and health or safety concerns. We evaluate disclosures to determine if there is a "substantial likelihood" that wrongdoing has been disclosed. If this substantial likelihood standard is met, I am required to send the information to the head of the appropriate agency. After a referral, the agency is required to conduct an investigation and to submit a written report to my office. OSC received approximately 1,150 disclosures from federal employees in Fiscal Year 2012, and just over three percent of the disclosures were referred for investigation.

After reviewing the agency's report of investigation and the whistleblower's comments on the report, I make two determinations. First, I determine whether the report contains the information required by the statute and second, whether the findings of the agency appear reasonable. My office then transmits the report, whistleblowers's comments, and my findings and recommendations to the President and congressional committees with oversight responsibility for the agency involved.

In addition to providing a safe channel for disclosures of government misconduct, OSC plays a critical oversight role in government investigations and often prompts corrective actions to address the reported wrongdoing. It was within this statutory framework that we received disclosures from whistleblowers throughout DHS concerning widespread abuse of overtime pay.

Procedural Case Chronology

In September 2012, OSC received a disclosure from Jose Ducos-Bello. Mr. Ducos-Bello alleged that DHS employees working in the CBP Situation Room in Washington, D.C., regularly abuse Administratively Uncontrollable Overtime (AUO), and that the Director and Assistant Director authorize and abet this improper use. According to Mr. Ducos-Bello, routine overtime payments to Situation Room employees functionally extend their daily shift by two hours, nearly every day, increasing pay by 25%. This practice is a violation of the regulations governing AUO.

According to regulations, AUO may only be used when an employee's hours cannot be scheduled in advance due to a substantial amount of irregular work. For example, AUO is appropriate when an employee's work requires responding to the behavior of suspected criminals and it would "constitute negligence" for the employee to leave the job unfinished. AUO may only be used for irregular and unpredictable work beyond an employee's normal shift. 5 C.F.R. Sec. 550.151-154.

The Situation Room employees in Mr. Ducos-Bello's disclosure were not receiving AUO as the result of any unpredictable or compelling law enforcement need. Rather, most claimed the overtime for administrative tasks that do not qualify for AUO. And, according to Mr. Ducos-Bello, many of these employees spent the extra two hours not working at all; they were surfing the internet, watching sports and entertainment channels, or taking care of personal matters.

After we determined that there was a substantial likelihood of a violation of law, rule, or regulation and gross waste of government funds, we referred these allegations to then-DHS Secretary Janet Napolitano for investigation. In April 2013, we received the agency's report, prepared by the CBP Office of Internal Affairs (OIA), which substantiated the allegations. The report concluded that previous warnings regarding proper use of AUO were disregarded, and it was "evident that the regular and consistent addition of two hours of AUO to the regularly scheduled eight-hour day implies hours of duty are controllable by management."

OSC Comments and Areas of Concern Regarding Custom and Border Protection's Findings

OIA's investigation confirmed most of Mr. Ducos-Bello's factual allegations and substantiated the concerns about AUO misuse. However, while CBP pledged to take corrective action in response to these findings, I remain concerned about whether the agency is ultimately willing or able to do so. As the rest of my testimony illustrates, the problem of AUO misuse is entrenched, particularly within CBP, and prior commitments to address these issues remain unfulfilled.

Over the past year, OSC has received disclosures from whistleblowers throughout DHS. In my October 31, 2013, letter to the President, which is attached to this testimony, I outlined

allegations of AUO abuse from six additional whistleblowers at five DHS offices. In addition to CBP, they include disclosures from employees at U.S. Citizenship and Immigration Services (USCIS) and Immigration and Customs Enforcement (ICE).

On Thursday, January 23, 2013, OSC received three additional reports from DHS. In these reports, CBP's Office of Internal Affairs substantiated the disclosures of AUO misuse at the CBP Office of Training and Development, CBP Laredo North Station, and CBP San Ysidro Asset Forfeiture Office. We are in the process of reviewing the details provided in these reports, and will provide the Committee with additional information on these confirmed instances of misconduct.

In addition, as public and congressional scrutiny of AUO misuse grew in response to our October letter, more whistleblowers stepped forward to report concerns. Since the fall, OSC has referred six additional AUO abuse cases to DHS for further investigation, bringing the total to 12 separate offices, and raising further concerns about the broad scope of AUO misuse, especially within CBP. These six new cases include:

- A whistleblower alleges that five Border Patrol Agents detailed to work as CrossFit instructors in El Centro, California routinely claim AUO, increasing their base pay by 15 percent every pay period.

- A whistleblower alleges that approximately 275 CBP employees in the Office of Internal Affairs (OIA) improperly claim AUO, up to two hours a day, every day, with the full knowledge and approval of the OIA leadership.[1]

- A CBP employee in El Paso, Texas alleges that approximately 440 employees are improperly receiving AUO. The employee specifically alleges that Supervisory Border Patrol Agents claim AUO hours when completing administrative tasks, and Border Patrol Agents claim AUO when assigned to "light" duty due to injury and when performing routine shift change activities.

- A CBP employee alleges that approximately 95 employees at the National Targeting Centers in Herndon and Reston, Virginia, including management, improperly claim AUO, up to two hours a day, every day, increasing their base pay by 25 percent.

- A whistleblower alleges that employees working in CBP Office of Border Patrol headquarters in Washington, D.C., claim AUO on a daily basis but fail to perform duties that qualify for AUO.

[1] As noted, OIA investigated and substantiated the previous AUO abuse cases referred by OSC. Although OIA conducted thorough investigations in each of these cases, the allegations concerning misuse within OIA raise questions about its ongoing ability to review OSC referrals. Accordingly, in consultation with OSC, the DHS Office of General Counsel determined that OIA will complete the pending CBP cases previously submitted to that office. However, the DHS Office of Inspector General will receive and investigate any new OSC referrals of AUO abuse, including those listed above.

- A whistleblower alleges that employees working in the ICE Enforcement and Removal Operations Office in Chattanooga, Tennessee routinely claim AUO, up to two hours a day, every day, with the full knowledge and approval of their supervisor but fail to either work any additional hours or perform duties that qualify.

Much of the AUO claimed at the locations identified by whistleblowers involves desk duty, training assignments, or even exercise classes, where compelling law enforcement reasons for staying on duty are unlikely to arise. For example, at the November 2013 House Oversight and Government Reform Committee hearing on AUO abuse, DHS whistleblower John Florence testified about his specific concerns at the CBP training facility in Glynco, GA. According to Mr. Florence, classroom instructors and as many as 50 headquarters managers in the Office of Training and Development routinely claim AUO. The recently-submitted report on the Office of Training and Development also confirms that Border Patrol Agents routinely claim AUO for performing the same duties as Customs and Border Protection Officers (CBPOs). CBPOs are not eligible for AUO and therefore do not receive AUO for completing the same tasks as the agents.

At the six facilities first identified by whistleblowers in disclosures to OSC, a conservative estimate of the cost of overtime abuse is nearly $9 million each year. The whistleblowers project that the cost nationwide is likely to reach tens of millions of dollars annually, and the more recent disclosures provide further evidence of the substantial, ongoing cost of improper AUO claims.

As I noted in my October 2013 communication to Congress and the President, identical concerns about overtime abuse were raised by a whistleblower in 2007, and CBP made similar promises about correcting them. Specifically, at that time, our agency received a disclosure that CBP employees in Blaine, Washington were improperly claiming AUO. In response, the agency confirmed the allegations, finding that employees were given blanket authorization to work overtime and managers improperly permitted excess overtime. Much of that overtime was controllable, and therefore it was improper to claim it as AUO.

At that time, CBP outlined a corrective plan, including the implementation of an agency-wide directive on AUO. Much of the agency's response to the 2007 complaint is mirrored in its response to the current round of allegations. Yet, to date, no directive has been issued.

In both the 2007 (Blaine, WA) and 2013 (Situation Room) reports, CBP cites a number of obstacles that will make it difficult to implement a directive to correct this problem, including collective bargaining obligations and the need for updated regulations from the Office of Personnel Management.

While I am hopeful that CBP and the Department will overcome these obstacles and take definitive action to correct this overtime abuse, I am also realistic. Based both on the magnitude of the problem and the history of ineffective solutions, it will require an immediate, serious and sustained commitment to make necessary changes.

According to DHS officials, in response to OSC's initial findings, a department-wide review of AUO practices is ongoing. AUO has reportedly been suspended at DHS Headquarters and within USCIS. These are positive steps. But, it remains unclear whether CBP – where the problem is most pervasive – has taken similar steps to control abuse. I note that in the most recent report CBP committed "to determine which of the 158 positions within CBP should continue to be eligible for AUO and which should be decertified."

I am also pleased that Congress and this Committee in particular have shown an interest in helping CBP find ways to solve this problem, including through legislative reform.

In conclusion, I want to applaud Mr. Ducos-Bello and the courageous DHS whistleblowers who are speaking out, often against their own financial self-interest. Had they not stepped forward, these problems would not have come to light, and the taxpayers would continue to foot the bill for these improper payments.

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

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

The Special Counsel

October 31, 2013

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

Re: OSC File No. DI-13-0002

Dear Mr. President:

I write to express deep concerns about long-standing abuse of overtime payments by the Department of Homeland Security (DHS). The enclosed report details one of six whistleblower cases currently before the Office of Special Counsel (OSC). Each of the six cases discloses misuse of a specific pay authority known as Administratively Uncontrollable Overtime (AUO). According to information provided by the whistleblowers, abuse of AUO at these six DHS offices alone costs the taxpayers approximately $8.7 million annually, a gross waste of government funds.

The enclosed report substantiates disclosures made by DHS employee Jose R. Ducos-Bello. The report confirms that employees in the Commissioner's Situation Room (Situation Room), an office within Customs and Border Protection (CBP) in Washington, D.C., violate the federal AUO regulation by claiming two hours of AUO pay nearly every day. The report also confirms that the Situation Room Director and Assistant Director "authorize and abet" the improper use of AUO. OSC recently referred to the Secretary of Homeland Security five additional AUO cases – a strong indication that DHS has a profound and entrenched problem.

AUO is intended to be used only when an employee's hours cannot be scheduled in advance due to a substantial amount of irregular work. For example, under the governing regulation, AUO is appropriate if an employee's work hours depend on responding to the behavior of suspected criminals and it would "constitute negligence" for the employee to leave the job unfinished. CBP and other DHS components have the authority to use AUO to effectively secure the borders, which may require irregular and unpredictable work beyond an employee's normal shift. See 5 C.F.R. § 150.151--154. Despite this definition, thousands of DHS employees routinely file for AUO, claiming up to two hours a day, nearly every day, even in headquarters and training assignments where no qualifying circumstances are likely to exist.

The attached report confirms that Situation Room employees in Washington, D.C., claim to have worked two hours of AUO following their assigned shift 89 percent of the time. These routine AUO payments to Situation Room employees "functionally [extend] their daily shift by two hours each day," but are not the result of any unpredictable or compelling law enforcement need. Most of the claimed overtime work is "administrative in nature, often consisting of Headquarters or local taskings" that do not qualify for AUO. Mr. Ducos-Bello alleged that the

employees who "work" overtime frequently watch sports and entertainment channels during their claimed AUO periods, or spend the two additional hours at their duty station relaxing, joking, surfing the internet, and taking care of personal matters.

This case is not an isolated occurrence. Rather, it is part of a persistent pattern of AUO allegations raised by DHS employees. Some of these whistleblowers are authorized to receive AUO. They are disclosing information against their own financial self-interest due to concerns about the ethics of the practice and the resulting impact on the federal budget. While DHS officials have acknowledged AUO abuse when confronted with specific allegations, they have taken insufficient steps to correct the problem.

For example, on February 20, 2008, OSC referred a whistleblower's allegations of AUO abuse at the Office of Border Patrol in Lynden, WA (OSC File No. DI-08-0663). The DHS report in response to those disclosures confirmed that employees in Lynden routinely abused AUO and that senior managers also benefited from improperly approved AUO. At the time, CBP promised to implement "an Agency-wide AUO policy directive [to] bring conformity to the policies and practices" – a step that would cease the practices in Lynden and prevent misuse throughout the agency.[1]

That commitment was made more than five years ago. In the current report on AUO abuse in the Situation Room, CBP repeats its desire "to work towards a unified and simplified agency-wide directive on AUO." The report adds an additional, minor commitment by CBP to show a video to all employees to reinforce rules on proper AUO use and administration.

Much of the language regarding the Situation Room AUO abuse and proposals for corrective action is taken directly from the 2008 Lynden report. Roughly one-quarter of the 2013 report is identical to the concerns cited in the 2008 report. The lack of progress in implementing plans first outlined five years ago raises questions about the agency's willingness or ability to confront this important problem.

CBP cites an array of obstacles to full implementation of an agency-wide AUO directive, including collective bargaining obligations and the need for updated regulations from the Office of Personnel Management. DHS and CBP must overcome these challenges and move quickly to reform AUO practices. OSC is currently processing five additional AUO cases, each of which met the high "substantial likelihood" standard for investigative referral by OSC to DHS. These cases include:

- A whistleblower at the CBP Office of Training and Development in Glynco, GA, alleged that agents routinely abuse AUO by claiming two hours of AUO daily while failing to perform any qualifying duties. The fact that AUO is claimed at a training facility – where compelling law enforcement reasons for staying on duty are unlikely to arise – raises concerns about the propriety of its use by these employees. According to the

[1] In 2012, OSC resolved a whistleblower case brought by another employee in Washington, who alleged retaliation for disclosing evidence of AUO abuse to his superiors.

whistleblower, CBP pays out nearly $5 million annually to employees in the Office of Training and Development, including to 50 managers at Headquarters. DHS is required to submit a report to OSC in response to these allegations by January 2, 2014.

- A whistleblower at the U.S. Citizenship and Immigration Services headquarters facility in Washington, D.C., alleged abuses of AUO in 2010 while the whistleblower worked in the Office of Security and Integrity (OSI). The whistleblower alleged that everyone in OSI claimed 10 hours of AUO every week, even though no employee performed work that qualified. This whistleblower requested that her position be made ineligible for AUO and also advised supervisors that AUO was being routinely misused. The whistleblower was initially told she could not be decertified from AUO because it would draw unwanted attention to the office. While the whistleblower was eventually decertified, the AUO abuse by others has not stopped. DHS is required to submit a report in response to these allegations by November 13, 2013.

- A whistleblower at the Immigration and Customs Enforcement (ICE) facility in Houston, TX, alleged that ICE supervisors authorize and abet the improper use of AUO. The whistleblower disclosed that employees are directed to stay beyond their normal duty hours to complete routine administrative tasks that are not time-sensitive or investigative in nature. These employees are instructed to certify the time as AUO. OSC received an inadequate report from ICE on September 11, 2013, and will seek a supplemental report.

- Two whistleblowers at the CBP facility in San Ysidro, CA, allege that Border Patrol Agents at the Asset Forfeiture Office routinely claim two hours of AUO each day, but fail to perform duties that qualify for AUO payments. The whistleblowers further alleged that employees work on routine administrative matters during the claimed AUO periods or are not even present for the AUO time they claim. DHS is required to submit a report to OSC in response to these allegations by November 6, 2013.

- Finally, a report issued by CBP in response to a whistleblower's disclosures at the CPB facility in Laredo, TX, confirms that AUO is being used for routine shift change activities in violation of rules and regulations. OSC requested additional information from CBP on the Laredo activities.

These additional cases indicate that AUO problems are ongoing and pervasive throughout DHS. Indeed, according to CBP's own data, during one three-month period in 2013 agents at Border Patrol Headquarters in Washington, D.C., averaged 1.99 AUO hours per day, or 20 hours per pay period. This is one of the highest AUO rates of any CBP duty station, including many duty stations in border areas. One whistleblower noted to OSC that if all AUO claims by agents in the field were excluded, and only AUO claims by agents in office jobs were examined, "the dollar amount of AUO abuse would be in the tens of millions per year."

Such abuse of overtime pay is a violation of the public trust and a gross waste of scarce government funds. It is incumbent upon DHS to take effective steps to curb the abuse. It is up to the administration and Congress to develop a revised pay system, if warranted, that ensures fair compensation for employees who are legitimately working overtime.

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The allegations regarding AUO abuse at the CSR were referred to former DHS Secretary Janet Napolitano on January 2, 2013, for an investigation and report.[2] On April 17, 2013, James F. Tomshek, Assistant Commissioner, Office of Internal Affairs (IA), submitted a report based on the results of an investigation conducted by CBP's IA. On May 3, 2013, a copy of the report was forwarded to Mr. Ducos-Bello, who provided comments in response to the report on May 5, 2013.

The report contains all of the information required by statute. However, there remain serious questions about the agency's ability or willingness to adequately address the AUO abuse issue. Therefore, I find the report unreasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency report and Mr. Ducos-Bello's comments to the Chairman and Ranking Member of the Senate Committee on Homeland Security and Governmental Affairs and the Chairman and Ranking Member of the House Committee on Homeland Security. I have also filed a copy of the report and the whistleblower's comments in our public file, which is now available online at www.osc.gov, and closed the matter.

Respectfully,

Carolyn Lerner

Carolyn N. Lerner

Enclosures

[2] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). If the Special Counsel determines that there is a substantial likelihood that the disclosures are accurate, she is required to advise the appropriate agency head and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel solicits comments from the whistleblower and reviews the agency's report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2).

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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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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

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

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:

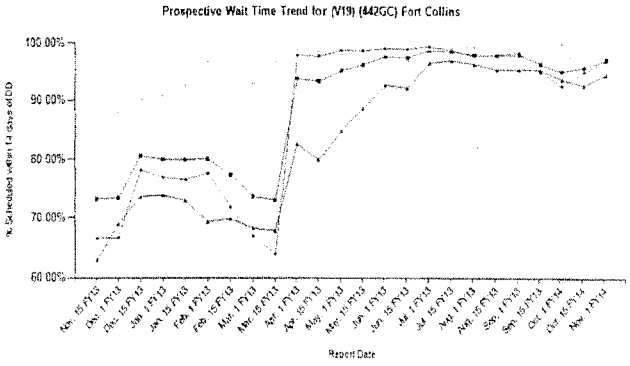
- A shortage of providers caused the facility to frequently cancel appointments for veterans. After cancellations, providers did not conduct required follow-up, resulting in situations where "routine primary care needs were not addressed."

- 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
1730 M Street, N.W., Suite 300
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.

Testimony of Carolyn Lerner, Special Counsel
and Ana Galindo-Marrone, Chief, Hatch Act Unit
U.S. Office of Special Counsel

U.S. House of Representatives
Committee on Oversight and Government Reform

"White House Office of Political Affairs: Is Supporting Candidates and Campaign Fund-Raising an Appropriate Use of a Government Office?"

July 16, 2014, 10:00 A.M.

Chairman Issa, Ranking Member Cummings, and Members of the Committee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC), and our enforcement of the Hatch Act. I am joined today by Ana Galindo-Marrone, Chief of OSC's Hatch Act Unit.

OSC's primary mission is to protect the merit system and provide a safe and secure channel for government whistleblowers who report waste, fraud, abuse, and threats to public health and safety. The agency also protects veterans and service members from discrimination under the Uniformed Services Employment and Reemployment Rights Act (USERRA). Finally, OSC enforces the Hatch Act, which was enacted in 1939 to restrict the partisan political activity of federal employees and certain employees of state and local governments.

This is the fourth time I have had the opportunity to testify before the Oversight Committee, including a few weeks ago in June. My testimony in May 2012 provided the Committee with recommendations for strengthening and modernizing the Hatch Act. Our discussions and your subsequent successful legislative efforts resulted in the first significant modifications to the Hatch Act in two decades.

The Hatch Act Modernization Act of 2012 (P.L. 112-230), sponsored by Ranking Member Cummings, Representative Chaffetz, Congresswoman Norton, and others, largely removed the Hatch Act's prohibition on state and local employees running for partisan elective office. This important reform reduced unnecessary federal involvement in state and local elections, and has allowed OSC to better allocate its scarce resources toward more effective Hatch Act enforcement. The Modernization Act also promotes fairness by providing for a range of penalties in federal sector Hatch Act cases and allows District of Columbia employees to run as independents in partisan local elections. I thank the Committee for its efforts to pass this important law and for its ongoing interest in OSC's Hatch Act enforcement efforts.

Our testimony today will focus on: (1) OSC's recent enforcement actions, (2) education and outreach efforts, and (3) the White House Office of Political Strategy and Outreach.

Significant Enforcement Actions

Our testimony provides a summary of recent enforcement actions, both to highlight the importance of the law and to serve as a reminder to federal employees of the Hatch Act's restrictions on certain partisan political activity.

In general, the Hatch Act prohibits all federal employees from soliciting, accepting, or receiving political contributions from any person and, with limited exceptions, engaging in any political activity while on duty or in the federal workplace. Federal employees, including high-ranking officials, may not engage in political activity in their official capacity or otherwise use their official authority for the purpose of interfering with or affecting the result of an election. Some federal employees are further restricted under the Hatch Act, meaning they may not take an active part in partisan political management or partisan political campaigns.

Recent cases that illustrate these restrictions include the following:

- In June 2014, OSC entered into a settlement agreement with an Internal Revenue Service (IRS) employee. The employee agreed to a 100-day unpaid suspension for violating the Hatch Act. The agreement resolved a formal Hatch Act complaint OSC filed with the Merit Systems Protection Board (MSPB) in April 2014. OSC's complaint alleged that, when fielding taxpayers' questions on an IRS customer service help line, the employee repeatedly urged taxpayers to reelect President Barack Obama in 2012 by delivering a chant based on the spelling of the employee's last name. In the settlement agreement, the IRS employee acknowledged that he had used his authority and influence as an IRS customer service representative for a political purpose and did so while at work.

- In May 2014, the MSPB granted OSC's request to remove a U.S. Postal Service (USPS) employee from federal service for violating the Hatch Act. Specifically, OSC's complaint alleged that the employee twice ran in partisan elections for a seat in the U.S. House of Representatives. In addition, he solicited political contributions for his campaigns. OSC and USPS repeatedly warned the worker that his actions violated the Hatch Act and requested that he comply with the law either by withdrawing from the elections or ending his federal employment. Despite these repeated warnings, the employee refused to comply with the law. This was the first MSPB decision under the Hatch Act Modernization Act, which took effect in early 2013.

- Under an April 2014 settlement agreement with OSC, an attorney at the Federal Election Commission (FEC) agreed to resign and is barred from employment within the federal executive branch for two years after admitting to violations of the Hatch Act. The FEC referred to OSC evidence that the employee posted dozens of partisan political tweets, including many soliciting campaign contributions to President Obama's 2012 reelection campaign and other political campaigns. The employee also participated in an internet broadcast via webcam from an FEC facility, criticizing the Republican Party and presidential candidate Mitt Romney. Following a joint investigation between OSC and the FEC Office of

Inspector General, the employee admitted to violating the Hatch Act and resigned.

- Under an April 2014 settlement agreement with OSC, a federal civilian employee with the U.S. Air Force agreed to serve a 40-day suspension without pay for repeatedly violating the Hatch Act's prohibitions against engaging in political activity while on duty and in the workplace, despite warnings to stop his behavior. The employee sent numerous partisan political e-mails in opposition to then-candidate President Obama using a government account to a list of as many as 60 federal employees. The employee sent each e-mail while on duty in the months leading up to the 2012 election. The employee admitted knowing about the Hatch Act's restrictions, and even after receiving warnings from his supervisors, persisted in sending more e-mails.

- Under an April 2014 settlement agreement with OSC, an IRS tax advisory specialist in Kentucky served a 14-day suspension for promoting her partisan political views to a taxpayer she was assisting during the 2012 presidential election season. The employee told a taxpayer she was "for" the Democrats because "Republicans already [sic] trying to cap my pension and . . . they're going to take women back 40 years." She continued to explain that her mom always said, "'If you vote for a Republican, the rich are going to get richer and the poor are going to get poorer.' And I went, 'You're right.' I found that out." The employee's supervisor had advised her about the Hatch Act's restrictions just weeks before the conversation. The employee told the taxpayer, "I'm not supposed to voice my opinion, so you didn't hear me saying that." In the settlement agreement, the employee admitted to violating the Hatch Act's restrictions against engaging in political activity while on duty and in the workplace and using her official authority or influence to affect the result of an election.

In addition to these recent actions, in September 2012, in response to a Hatch Act complaint filed by Chairman Issa and others, OSC sent findings to President Obama from its investigation of improper political activity by Secretary of Health and Human Services Kathleen Sebelius. OSC concluded that Secretary Sebelius violated the Hatch Act when she made extemporaneous partisan remarks in a speech delivered in her official capacity on February 25, 2012. The Hatch Act allows federal employees, including officials appointed by the President and confirmed by the Senate, to make partisan remarks when speaking in their personal capacity, but not when using their official title or when speaking about agency business.

After the event in question, the Department of Health and Human Services (HHS) reclassified the trip from official to political and issued a statement to that effect. The Democratic National Committee reimbursed the U.S. Treasury for all costs and expenses associated with Secretary Sebelius's travel to the event. OSC found no evidence that Secretary Sebelius made any other political statements in her official capacity. Nevertheless, this was the first time OSC found a sitting cabinet secretary in violation of the Hatch Act. It again serves as a reminder to employees, at all levels, of the importance of adhering to the Hatch Act's restrictions.

Education and Outreach

To better educate the federal workforce and prevent Hatch Act violations from occurring in the first place, OSC conducts training and outreach sessions for employees. During fiscal year 2014, OSC has been working, with limited resources, to ensure that federal, state, D.C., and local government employees understand their rights and responsibilities under the Hatch Act by: (1) conducting trainings at federal agencies and national conferences; (2) updating our website, including maintaining a comprehensive list of frequently asked questions and select OSC advisory opinions; and (3) using a listserv to quickly inform federal agency ethics officials of recent Hatch Act decisions, developments, enforcement actions, and guidance.

In this fiscal year alone, OSC has conducted 21 outreach presentations to diverse federal populations. This includes rank and file employees, senior officials and political appointees, and union groups. As we move closer to the 2014 mid-term elections, we expect to increase the number of outreach and training events nationwide. The number conducted to date is already more than double the number of events in 2013. OSC also works with Federal News Radio and other media outlets to promote Hatch Act education and compliance.

In addition, OSC provides technical assistance to agencies, employees, and the public at large through its nationwide advisory program. We provide Hatch Act information and assistance to congressional offices, cabinet members, the media, and local, state, and federal government officials. To assist with this effort, OSC maintains telephone and email Hatch Act advisory hotlines, and responds to over a thousand formal and informal inquiries annually.

Over the course of several administrations, it also has been OSC's practice to brief White House lawyers on the Hatch Act, who in turn conduct Hatch Act trainings for White House staff. Our meetings typically occur at the start of a new administration. We provide updates as needed during the election season. OSC is also available to White House personnel to provide technical assistance or informal advisory opinions in response to specific questions or concerns.

Consistent with this practice, on March 20, 2014, OSC conducted an outreach session for White House lawyers to provide guidance on a number of pertinent Hatch Act topics. At the session, OSC discussed our latest guidance on "use of official authority" restrictions. This includes rules on use of official title at partisan events, guidelines for speeches given in an employee's official capacity, and answering campaign questions at official events. In addition, OSC covered rules on solicitation, reminding employees that speaking at fundraisers is permissible, while soliciting donations at events or hosting fundraisers is not. OSC discussed the limitation on political activity on duty or in the federal workplace. Only commissioned officers in the White House may engage in a limited amount of political activity on duty or in a federal building. All other employees are barred from such activity. OSC updated White House staff on social media restrictions and discussed the distinction between official and personal social media accounts. Finally, OSC discussed rules concerning official versus political travel, including OSC's latest advisory opinion on this issue.

White House Office of Political Strategy and Outreach

OSC received copies of correspondence between Chairman Issa and the White House concerning the establishment of the Office of Political Strategy and Outreach (OPSO). The White House did not consult with OSC about establishing the OPSO. However, based on our review of the White House correspondence to the Committee, it appears that the White House adhered to OSC guidance in determining the scope of activity for the office. To the extent that OPSO's activities are limited to those described in the White House correspondence, OPSO appears to be operating in a manner that is consistent with Hatch Act restrictions.

OSC will continue to fulfill the dual advisory and enforcement role assigned to it by Congress under the Hatch Act. If the White House seeks additional guidance or clarification on any activities of the OPSO, we will provide advisory assistance to ensure compliance with Hatch Act restrictions. If OSC is presented with credible evidence of a violation, OSC would initiate an investigation to determine if any activity exceeds permissible Hatch Act boundaries.

We thank you again for the opportunity to testify today, and would be happy to answer the Committee's questions.

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Carolyn N. Lerner, Special Counsel

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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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

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

Ana Galindo-Marrone, Chief, Hatch Act Unit

Ana Galindo-Marrone began her employment at OSC in 1998, and in 1999 she joined the prosecution division. She has been chief of the Hatch Act Unit since 2000. The Unit enforces compliance with the Act by investigating complaint allegations and litigating Hatch Act cases before the Merit Systems Protection Board. In addition, the Unit is responsible for a nationwide program that provides Hatch Act advisory opinions to federal, state, and local officials, as well as the public at large.

Ms. Galindo-Marrone has been a frequent presenter at conferences and forums on the Hatch Act and OSC's enforcement program. She has been a guest on several radio shows, including The Kojo Nnamdi Show, FEDtalk, Federal Drive, and In Depth. She also has testified or served as a technical consultant before several congressional committees considering Hatch Act reform, including the June 21, 2011, House Committee on Oversight and Government Reform hearing, "The Hatch Act: The Challenges of Separating Politics from Policy."

Prior to joining OSC, Ms. Galindo-Marrone was a staff attorney for the School Board of Miami-Dade County, Florida. Ms. Galindo-Marrone, who is a native of Miami, Florida, received her law degree, cum laude, from the University of Miami School of Law.

Testimony of the Honorable Carolyn N. Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. House of Representatives Committee on Oversight and Government Reform
Subcommittee on Federal Workforce, U.S. Postal Service and the Census

"Examining the Administration's Treatment of Whistleblowers"

September 9, 2014, 2:00 PM

Chairman Farenthold, Ranking Member Lynch, and Members of the Subcommittee:

Thank you for inviting me to testify today about the U.S. Office of Special Counsel (OSC) and its role in protecting whistleblowers in the federal government.

I. OSC's Role and Jurisdiction

OSC is an independent investigative and prosecutorial agency tasked with protecting the merit system and ensuring accountability and fairness for over 2.1 million civilian federal employees. Although my testimony today will focus primarily on OSC's role in investigating and prosecuting violations of prohibited personnel practices (PPPs) with respect to whistleblowers, we also enforce the merit system in several other ways. We serve as a safe and secure channel for federal employees to disclose government wrongdoing, specifically waste, fraud, abuse, mismanagement, and health and safety issues; we protect federal employees from all 13 PPPs, including reprisal for blowing the whistle, hiring offenses, and discrimination; we enforce the Hatch Act, which keeps partisan politics out of the federal workplace; and we support service members by enforcing the Uniformed Services Employment & Reemployment Rights Act (USERRA).

We serve the federal government and taxpayers with a staff of approximately 120 employees and one of the smallest budgets of any federal law enforcement agency. Still, even though we face the significant challenges of an ever-rising caseload, I am proud to say that we are more effective and efficient than ever before. By the close of fiscal year 2014, we expect to have received over 5,000 cases of all types for the first time in our agency's history, a 15 percent increase from last year and double the number of cases from ten years ago. This will include over 1,400 retaliation cases and over 1,500 whistleblower disclosures, an almost 30 percent increase from last year. In the past two years, we have obtained 333 favorable actions for federal employees, a threefold increase from five years ago. Importantly, we have achieved these results while at the same time reducing the cost to resolve each case by 41 percent over the past six years.

We receive cases from across the government. Our work often results in systemic changes that make government more efficient, cost effective, and safer for our citizens. Some recent examples are indicative of our work. In the past year, we addressed dozens of disclosures of fraud and waste in the payout of Administratively Uncontrollable Overtime at the Department of Homeland Security's (DHS) agencies. OSC's work with DHS whistleblowers has already

resulted in changed practices that will save over $20 million a year. More recently, we have received hundreds of cases from Department of Veterans Affairs (VA) employees. These cases include disclosures of scheduling improprieties and threats to public health and safety, as well as complaints of whistleblower retaliation, which I will discuss later.

Finally, it is important to clarify that OSC's jurisdiction regarding whistleblower retaliation cases extends to many—but not all—current or former federal civilian employees or applicants for federal civilian employment. OSC does not, for example, have jurisdiction over active military personnel. Nor does OSC have jurisdiction over whistleblowers from intelligence agencies, such as the Federal Bureau of Investigation, the Central Intelligence Agency, or the National Security Agency. *See* 5 U.S.C. § 2302(a)(2)(C)(ii). However, on October 10, 2012, President Obama issued a Presidential Policy Directive that prohibits retaliation against whistleblowers in the Intelligence Community and requires intelligence agencies to establish a review process for claims of retaliation consistent with the procedures in the Whistleblower Protection Act (WPA).

With that introduction, I will discuss three main issues: (1) how we protect whistleblowers, (2) the effect of the Whistleblower Protection Enhancement Act of 2012 (WPEA) on our enforcement authority, and (3) our 2302(c) Certification Program and education and outreach efforts.

II. How OSC Protects Whistleblowers

When a federal employee or applicant for federal employment believes they have faced reprisal for blowing the whistle, they have the option to file a complaint with OSC. When reviewing a whistleblower retaliation complaint, OSC analyzes the following four legal elements:

(1) did a protected disclosure of information occur;
(2) was a personnel action taken, not taken, or threatened;
(3) did those involved in the personnel action have actual or constructive knowledge of the protected disclosure; and
(4) was the protected disclosure a contributing factor in the personnel action.

If these four elements are met, the agency must show—by the high bar of clear and convincing evidence—that it would have taken the same action absent the whistleblower's disclosure. To assess this, we look at the strength of the agency's evidence in support of the personnel action, the existence and strength of the agency's motive to retaliate, and the treatment of similar agency employees who are not whistleblowers, as well as other factors.

If OSC's Complaints Examining Unit preliminarily determines that the complaint meets the four elements above, the matter is referred to our Investigation and Prosecution Division for further investigation. When appropriate, the complainant and the relevant agency may be given the option of mediation, which I will discuss in more detail below.

The law requires that OSC give the agency the opportunity to correct a prohibited personnel practice before we pursue a formal complaint. And as we investigate, agencies often do

informally settle cases and take corrective action, restoring the *status quo ante*. These informal resolutions usually occur before OSC presents the case to the Merit Systems Protection Board (MSPB or Board), an administrative court in the executive branch that hears complaints regarding the federal merit system. But, if an agency does not take this opportunity, OSC may then file a complaint with the MSPB, which can order the agency to take corrective action.

Where warranted, an agency can also take disciplinary action against officials who have retaliated against a whistleblower. If the agency fails to do so, OSC can seek disciplinary action against the official by filing a complaint with the Board.

An Example of OSC's Work: The Port Mortuary Cases

An important matter early in my tenure as Special Counsel highlights how OSC can work with whistleblowers to shine a light a light on wrongdoing while protecting them from retaliation.

Three civilian Air Force employees at the Dover Port Mortuary disclosed to OSC that the mortuary mishandled the remains of fallen service members who died overseas. The whistleblowers also alleged that Air Force officials retaliated against them in response to their disclosures. OSC investigated and found that Air Force officials reprised against the whistleblowers, who faced removal, placement on extended administrative leave, suspensions, significant changes in duties and working conditions, and lowered performance appraisals after blowing the whistle.

When OSC presented its findings to the Air Force, the Air Force ultimately did the right thing. The whistleblowers were provided with full corrective action, and the officials responsible for retaliation were disciplined. The Air Force also reformed its mortuary operations and trained its employees on whistleblower protections. By working in collaboration with the Air Force, OSC was able to obtain relief for the whistleblowers and systemic changes without the need for litigation.

OSC's Ongoing Efforts to Help VA Whistleblowers

Cases from the VA comprise a large portion of OSC's workload, and I would like to briefly discuss our efforts regarding allegations of whistleblower retaliation at the VA.

OSC currently has about 125 active investigations of complaints from VA employees who allege retaliation 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. To illustrate the growing number of VA cases, OSC has received over 80 new VA whistleblower retaliation cases related to patient health and safety just since June 1, 2014.

As our VA caseload rose rapidly this year, we reallocated OSC staff and resources and implemented a priority intake process. OSC representatives also personally met with numerous high-level VA officials, including the then-Acting Secretary, to emphasize the importance of these issues and discuss ways to work together on obtaining prompt relief for whistleblowers

who suffered retaliation. OSC representatives also traveled to Phoenix to meet with a number of VA whistleblowers at the epicenter of the scandal. In addition, we have obtained several "stays," or delays, of disciplinary action against whistleblowers while we continue our investigations of these cases. Finally, OSC has coordinated with the VA to assist the agency in its efforts to educate and train its employees about whistleblower rights and protections.

The VA's leadership has been responsive and has worked with OSC to establish an expedited process to consider and settle meritorious whistleblower cases in order to provide these whistleblowers with relief as quickly as possible. In several cases, OSC has reached agreements in principle with the VA to provide whistleblowers with significant corrective action, and we are optimistic that we will be able to announce more good news soon.

OSC's Power to Delay Proposed Personnel Actions

OSC is able to protect complainants by seeking to stay proposed adverse personnel actions by filing formal requests with the MSPB. These stays provide temporary relief to federal employees while OSC investigates their claims. In addition, agencies can, and often do, agree to informal stay requests.

During the first two full years after my appointment as Special Counsel in 2011, OSC dramatically increased the use of informal stays. In 2012 and 2013, OSC obtained approximately 55 informal stays. In contrast, in the preceding five years (2007 to 2011), OSC obtained a total of 39 informal stays. When informal stays are not possible, OSC has also been more active in seeking formal stay requests with the MSPB.

For example, last month OSC obtained two formal stays from the MSPB in cases involving complainants at the Department of Agriculture and the Small Business Administration. In 2013, for the first time, OSC obtained stays on behalf of six former federal employees based on a novel theory of post-employment harassment. The employees claimed that they had been constructively discharged by their agency. None of the whistleblowers wanted to return to their old jobs. However, each wanted relief from the agency's continued efforts to force the employees to reimburse previously paid relocation bonuses. OSC requested an order from the MSPB to protect these former employees from this debt collection. Based on OSC's request, the Board granted the request for several of the employees and prevented the agency from seeking repayment of the bonuses.

Also, last year, OSC for the first time obtained a stay on behalf of an employee who faced retaliation for refusing to obey an order that would have violated the law. Specifically, the employee refused to follow an order to enter classified information into an unsecured computer network. The agency then placed the employee on a six-month detail out of the country, a decision that would cause the employee personal hardship and which the employee believed to be retaliatory. After OSC obtained an order from the MSPB to stay the detail, the agency agreed to discontinue the detail.

OSC's Alternative Dispute Resolution Program

As briefly mentioned earlier, OSC also refers selected prohibited personnel practice and USERRA complaints to mediation, a type of alternative dispute resolution (ADR). Under my tenure, OSC has greatly expanded our ADR program, which has been highly successful at resolving complaints to the mutual satisfaction of both agencies and complainants. For instance, in 2012, three employees of the Bureau of Alcohol, Tobacco, and Firearms who blew the whistle on Operation Fast and Furious resolved their cases through OSC's mediation program.

In fiscal year 2014, the settlement rate for mediated cases was approximately 75 percent. This is in addition to a high rate of corrective actions that are investigated and prosecuted at OSC, which result in corrective actions about 50 percent of the time.

In addition to producing a high rate of corrective action, mediation also provides agencies and complainants with an opportunity to participate in the resolution of complaints. By taking on this productive role and working together to find solutions, the parties are more likely to have a higher compliance rate with the settlement—and, as importantly, work more productively together in the future. There is also a benefit to OSC when parties agree to mediate their cases. When cases settle through mediation, it obviates the need to investigate and prosecute meritorious claims, thereby saving OSC's limited resources.

III. Effect of the Whistleblower Protection Enhancement Act on OSC's Authority

The WPEA, which this committee worked hard to enact, has strengthened OSC's ability to protect whistleblowers. The WPEA's mandates include: a significant expansion of OSC's jurisdiction; a requirement to conduct investigations in hundreds of whistleblower cases that previously would have been dismissed; a direction from Congress to initiate more formal litigation and disciplinary actions against agency managers; and training requirements for all other government agencies. The WPEA also provides OSC with the authority to file *amicus* briefs in federal court cases that involve whistleblower protection issues.

One of the WPEA's changes is the creation of a thirteenth prohibited personnel practice, which prohibits agencies from imposing non-disclosure agreements that do not explicitly allow for whistleblowing. OSC has already successfully resolved at least two cases related to this new PPP, with relief that included supplemental training and removal of a reprimand.

The WPEA also clarified that a disclosure is not excluded from protection simply because it was made during the employee's normal course of job duties. As a result of this enhanced protection, OSC was able to obtain relief on behalf of an employee with the Department of the Army who was subjected to a retaliatory removal. The employee reported what she believed were violations of the Army's rules pertaining to the use of a government purchase card to her chain of command. Her report was made in the course of her duties. Shortly thereafter, the technician was fired. Prior to the WPEA, and as a result of Federal Court decisions, her report would have been excluded from protection as whistleblowing because it was made in the course of regular duties.

The WPEA, however, overturned these decisions and OSC was able to pursue the case. As a result of OSC's investigation and report, the Army agreed to reinstate the employee with full back pay and benefits. It also convened a disciplinary review of the subjects responsible for the retaliatory discharge and is in the process of proposing disciplinary action.

The WPEA significantly improved OSC's ability to pursue disciplinary actions and we are taking action as a result. For example, in April, OSC filed complaints with the MSPB seeking disciplinary action against three Customs and Border Protection (CBP) officials. Our complaints accuse the three of discriminating for and against applicants based on political affiliation and granting illegal preferences or advantages to the preferred candidates. The complaints are currently pending before the Board. These disciplinary actions are OSC's first complaints against management officials for political discrimination in over 30 years.

As mentioned, the WPEA also expanded OSC's authority to file *amicus curiae* briefs in cases related to federal whistleblower retaliation. Prior to the WPEA, OSC had limited ability to file *amicus* briefs in whistleblower retaliation cases. Since receiving this expanded authority, OSC has filed three *amicus* briefs in federal appeals courts, including one this past month.

OSC first exercised its new *amicus* authority in *Kaplan v. Conyers*, arguing that the Federal Circuit Court of Appeals' decision threatened to undermine the enhanced whistleblower protections passed by Congress.

Then, in 2013, OSC filed an *amicus* brief with the Ninth Circuit in *Kerr v. Jewell*. OSC argued that the WPEA should be applied to cases pending before its enactment because: (1) it clarifies existing law by overturning prior decisions that unduly limited whistleblower protections; (2) Congress expressly intended the WPEA to apply to pending cases; and (3) applying the WPEA to pending cases promotes government efficiency and accountability. In its ruling, the Ninth Circuit determined that portions of the original Whistleblower Protection Act had been misapplied since its inception and that the WPEA simply clarified the protections Congress intended to confer in the statute.

This August, OSC filed an *amicus* brief with the Federal Circuit in *Clarke v. Dep't of Veterans Affairs*. OSC urged the court to reverse the MSPB's decision because it erected unnecessary procedural barriers for whistleblowers to meet in order to have their cases heard by the MSPB. This matter is pending.

Finally, OSC is currently considering filing an *amicus* brief with the U.S. Supreme Court later this month in *MacLean v. Dep't of Homeland Security*. This would follow the *amicus* brief we filed in Mr. MacLean's case with the MSPB in August 2011. Our concern in this case is that agencies might use regulations to create categories of disclosures exempt from whistleblower protections, contrary to the plain meaning and intent of the Civil Service Reform Act of 1978.

Our *amicus* briefs are meant to help courts interpret the contours of whistleblower laws, and we are optimistic that over time this will lead to a more pro-whistleblower body of jurisprudence.

IV. OSC's 2302(c) Certification Program

Government functions best and can address problems most effectively when employees feel comfortable and confident that they can blow the whistle at their agencies without retaliation. Creating this environment requires employees at all levels to be educated about their rights and responsibilities.

Federal agencies now have a statutory obligation to inform their workforces about the rights and remedies available to them under the WPA, the WPEA, and related civil service laws. OSC's 2302(c) Certification Program helps agencies meet this obligation through the following simple steps: agencies must place informational posters at agency facilities; provide information to new and existing employees and train supervisors about PPPs, the WPA, and the WPEA; and display a link to OSC's website on the agency's website or intranet.

To strengthen and expand whistleblower protections for federal government personnel, the Administration mandated participation in OSC's certification program under the White House's second National Action Plan on Open Government. Many agencies have contacted our office to begin the 2302(c) Certification Program process, and we keep an up-to-date list of all compliant agencies on our publicly accessible website. I am particularly encouraged that large agencies like the VA, the Energy Department, the Department of Health and Human Services, and NASA have taken steps to begin the certification progress.

Since my tenure as Special Counsel began, OSC has expanded its education and outreach efforts. In FY 2014, for example, we conducted 90 training sessions throughout the federal government. This compares with 33 sessions just three years ago. To help expand our education efforts in the federal workforce, we are also developing a new, online training quiz for federal employees that covers prohibited personnel practices, whistleblower disclosures, and the merit system principles. This quiz will allow us to educate a far larger portion of the federal workforce than in-person trainings alone. Better education can also help prevent retaliation from occurring in the first place.

Finally, OSC interacts with the federal community we serve through our website, which I am proud to announce we re-launched in July. We can now more easily communicate with federal employees. Filing complaints, making disclosures, and accessing information on our website is now easier. While we are pleased with the results so far, we are working to make further improvements. For example, we have been hard at work on a new online complaint filing system, which is designed to make it even easier for employees to report wrongdoing and ask for our help.

V. Reauthorization

An issue for the subcommittee's consideration is the fact that OSC has not been formally reauthorized since 2007. Reauthorization provides Congress with an opportunity to evaluate OSC's authorities and responsibilities and make any necessary adjustments. At the Senate's request, we have provided recommendations for a range of legislative changes and would be pleased to provide this information to this Committee, as well.

Thank you for the opportunity to testify today. I look forward to answering your questions.

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Carolyn N. Lerner
Special Counsel

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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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

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

Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

"Addressing Continued Whistleblower Retaliation Within the VA"

April 13, 2015, 4:00 P.M.

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

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

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

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

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

The current VA leadership has shown a high level of engagement with OSC and a genuine commitment to protecting whistleblowers. As many VA officials and Members of this Committee have repeatedly stated, culture change in an organization the size of the VA is

difficult and will take time. But, if the current number of whistleblower cases is an indication of employees' willingness to speak out, then things are moving in the right direction.

I. Whistleblower Retaliation – Collaboration with the VA to Provide Expedited Relief to VA Employees

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

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

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

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

- **Damian Reese, Phoenix VAMC** – Mr. Reese is a Phoenix VAMC program analyst. He voiced concerns to Phoenix VAMC management about the amount of time veterans had to wait for primary-care provider appointments and management's efforts to characterize long wait times as a "success" by manipulating the patient records. After making this disclosure, Mr. Reese had his annual performance rating downgraded by a senior official

with knowledge of his email. Mr. Reese agreed to settle his claims with the VA for mutually agreed upon relief.

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

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

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

- **Charles Johnson, Columbia VAMC** – Mr. Johnson, a technologist in the radiology department at the VA Medical Center in Columbia, South Carolina, disclosed that a doctor ordered him to hydrate a patient using a new, unfamiliar method in February 2014. Due to his concerns about the new hydration method, Mr. Johnson consulted with two physicians about the method, neither of whom would verify the method's safety. Mr. Johnson then contacted his union, which suggested he send an email seeking clarification of the method under the VA's "Stop The Line For Patient Safety" policy. In July 2014,

Mr. Johnson was issued a proposed five-day suspension by the same doctor whose hydration method Mr. Johnson had questioned. In October 2014, at OSC's request, the VA agreed to stay Mr. Johnson's suspension. In February 2015, Mr. Johnson and the VA settled his case, under which the VA will, among other things, rescind the proposed suspension and evaluate the hydration method.

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

- **Debora Casados, Denver, CO** – Ms. Casados is a nurse in the VA Eastern Colorado Health Care System. In August 2014, she reported that a coworker sexually assaulted two other VA staff members and made inappropriate sexual comments to her. Human resources told Ms. Casados and the other staff that they were not permitted to discuss the allegations and threatened them with disciplinary action if they did so. In October, human resources removed Ms. Casados from her nursing duties at the clinic and reassigned her to administrative tasks. In January 2015, she was moved again, this time to a windowless basement office to scan documents. In February, her superior denied Ms. Casados leave to care for her terminally ill mother. On April 3, 2015, the VA agreed to OSC's request for an informal stay on behalf of Ms. Casados, returning her to nursing duties at another clinic while OSC investigates her whistleblower reprisal claims to determine if additional corrective action and disciplinary action are appropriate.

Including these cases, in 2014 and 2015 to date, OSC has secured either full or partial relief for over 45 VA employees who have filed whistleblower retaliation complaints. OSC is on track to help nearly twice as many VA employees in 2015 as in 2014. These positive outcomes have been generated by the OSC-VA expedited settlement process, OSC's normal investigative process, and OSC's Alternative Dispute Resolution program. OSC is currently examining about 110 pending claims of whistleblower retaliation at the VA involving patient health and safety, scheduling, and understaffing issues. These pending claims involve VA facilities in 38 states and the District of Columbia. We look forward to updating the Committee as these cases proceed.

II. Whistleblower Disclosures and the Office of Medical Inspector

In my July 2014 testimony, I raised concerns about the VA's longstanding failure to use the information provided by whistleblowers as an early warning system to correct problems and prevent them from recurring. I summarized a series of cases in which the Office of Medical Inspector (OMI) identified deficiencies in patient care, such as chronic understaffing in primary care units, and the inadequate treatment of mental health patients in a community living center. In each case, OMI failed to grasp the severity of the problems, attempted to minimize concerns, and prevented the VA from taking the steps necessary to improve the quality of care for veterans.

In response to our concerns, the VA directed a comprehensive review of all aspects of OMI's operations. Overall, we believe this review has resulted in positive change. A recent whistleblower case is demonstrative.

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

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

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

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

III. Training Initiatives and Areas of Ongoing Concern

A. OSC's 2302(c) Certification Program

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

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

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

B. Investigation of Whistleblowers

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

There are two main problems with this approach. First, by focusing on the individual whistleblower, the systemic problem that has been raised may not receive the attention that it deserves. And second, instead of creating a welcoming environment for whistleblowers to come

forward, it instills fear in potential whistleblowers that by reporting problems, their own actions will come under intense scrutiny.

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

C. Accessing Whistleblowers' Medical Records

A final, related issue of ongoing concern is the unlawful accessing of employee medical records in order to discredit whistleblowers. In many instances, VA employees are themselves veterans and receive care at VA hospitals. In several cases, the medical records of whistleblowers have been accessed and information in those records has apparently been used to attempt to discredit the whistleblowers. We will aggressively pursue relief for whistleblowers in these and other cases where the facts and circumstances support corrective action, and we will also work with the VA to incorporate these additional forms of retaliation into our collaborative training programs.

IV. Conclusion

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

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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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. Senate
Committee on the Judiciary

Accountability and Oversight of Juvenile Justice Grants

April 21, 2015, 10:00 A.M.

Chairman Grassley, Ranking Member Leahy, and Members of the Committee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC). OSC is an independent federal investigative and prosecutorial agency. Our primary mission is to safeguard the merit system by protecting employees from prohibited personnel practices (PPPs), especially reprisal for whistleblowing. OSC also provides federal employees with a secure channel for disclosing wrongdoing in government agencies. My testimony today will focus on our process for receiving and evaluating whistleblower disclosures, and the critical role that these disclosures play in promoting government accountability.

As stated, OSC provides a safe channel through which federal employees may allege violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety. Unlike its role in retaliation and other PPP cases, OSC does not have investigative authority in disclosure cases. Rather, OSC evaluates disclosures of information to determine whether there is a "substantial likelihood" that wrongdoing has been disclosed. In making this determination, OSC reviews the information, interviews the whistleblower, and assesses their credibility and the reliability of their information, among other factors. If, based on this review, OSC makes a "substantial likelihood" determination, I transmit the information to the head of the appropriate agency. The agency head, or their designee, is required to conduct an investigation and submit a written report on the investigative findings to my office.

Upon receipt of the agency's report, I am required by law to determine whether the report contains the information required by the statute and whether the findings of the agency head appear reasonable. I will determine the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the whistleblower's comments on the report. I then transmit the report with my office's determination and the whistleblower's comments to the President and the congressional committees with oversight responsibility for the agency involved. OSC is also required to place the report and whistleblower comments in a public file.

Through this process, Congress has tasked OSC with a critical oversight role in reviewing allegations of potential government misconduct. The system is beneficial to improving government operations in three key ways. First, if an agency is reluctant to investigate possible wrongdoing raised internally by a whistleblower, OSC can compel the agency to conduct an investigation. Second, OSC provides an important accountability and quality control function in the investigative process. The whistleblowers, who are commonly the experts on the subject

matter of the allegations, are allowed to comment on the quality of the investigation and corrective actions. OSC also maintains a dialogue with the investigating agency throughout the process to make sure that the actions taken are reasonable and address the concerns raised by the whistleblowers. Finally, the process is transparent. At the conclusion, OSC posts the results on our website, creating a public record of all cases which have been referred for investigation.

In recent years, the OSC disclosure process has prompted significant changes in government operations. Our cases have saved lives and millions of taxpayer dollars. For example, whistleblowers at the Air Force's Port Mortuary in Dover, Delaware disclosed misconduct regarding the improper handling of human remains of fallen service members. After OSC reviewed the allegations and made recommendations, the Air Force took important, wide-scale corrective action. OSC's work helped to ensure that problems were identified and corrected, and the Air Force is now better able to uphold its sacred mission on behalf of fallen service members and their families.

In addition, OSC's work with whistleblowers at the Department of Homeland Security (DHS) exposed the department's longstanding failure to manage hundreds of millions of dollars in annual overtime payments. The lack of adequate safeguards in these overtime payments resulted in a significant waste of taxpayer dollars over many years. Repeated investigations in response to OSC referrals confirmed that overtime payments were routinely provided to individuals who were not eligible to receive them. This work resulted in a series of reforms within DHS, multiple congressional hearings, and bipartisan support for legislation to revise the pay system for Border Patrol agents that will result in $100 million in annual cost savings at the Department of Homeland Security—an amount roughly five times the size of OSC's annual appropriation.

Finally, in a report to the President and Congress last year, OSC documented severe shortcomings in Department of Veterans Affairs' (VA) investigations of threats to patient care at VA hospitals. This work with VA whistleblowers led to an overhaul of the VA's internal medical oversight office, drastically improving the reports now issued in response to OSC referrals. Just recently, a VA report confirmed an egregious threat to the health and safety of veterans at a medical center in Beckley, West Virginia. In order to meet budget goals, the facility altered prescriptions for veterans over the objections of their mental health providers, with no medical reason for the substituted drugs, in violation of VA policies. The VA investigated, determined that the substitutions created medical risks for the impacted veterans, and recommended both corrective steps to be taken and disciplinary actions for those responsible. It is this type of accountability that the OSC disclosure process promotes.

The number of whistleblower disclosures received by OSC has increased tremendously. The number of disclosures received by OSC has more than doubled in the last five years, and more than quadrupled in the last ten. OSC carefully reviews each disclosure received, and refers only a small percentage for investigation. The number of formal referrals to agency heads for investigation varies by year, and is generally between 40 and 60 cases, or approximately five percent of disclosures received.

In 2014 and 2015, OSC referred two cases involving the Office of Juvenile Justice and Delinquency Prevention (OJJDP) to the Attorney General for investigation under the provisions of 5 U.S.C. § 1213. The cases generally involve allegations that OJJDP failed to properly ensure that states and localities complied with the requirements of the Juvenile Justice and Delinquency Prevention Act of 1974. Notwithstanding documented noncompliance, states continue to receive grants, in further violation of the Act.

OSC referred the cases to the Justice Department on September 16, 2014 and January 13, 2015, respectively. The Justice Department's Office of Inspector General (OIG) is conducting the investigations on behalf of the Department. The reports are due to OSC on May 12, 2015. However, based on our communications with the OIG, we anticipate that the OIG will likely request an extension. OSC will grant an extension request where an agency demonstrates that it is conducting a good faith investigation that will require more time to successfully complete.

OSC is concurrently reviewing allegations that an employee was retaliated against for reporting related concerns about OJJDP.

Because these cases are ongoing, I cannot say more about them at this time, without compromising the ongoing investigation, my oversight of the OIG investigation and Department response, or prejudicing our determinations in the reprisal case. I acknowledge and appreciate the efforts of Committee staff, who I understand have communicated these limitations to the Members of the Committee.

I thank you for the opportunity to testify.

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Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. Senate
Committee on Appropriations
Subcommittee on Military Construction, Veterans Affairs, and Related Agencies

"Review of Whistleblower Claims at the Department of Veterans Affairs"

July 30, 2015, 10:30 A.M.

Chairman Kirk, Ranking Member Tester, and Members of the Subcommittee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our work with whistleblowers at the Department of Veterans Affairs (VA). Since April 2014, our office has seen a dramatic increase in the number of whistleblower cases from VA employees. These cases fall into two categories, retaliation complaints and disclosures of misconduct.

In response to retaliation complaints, we have secured relief for dozens of VA whistleblowers, helping courageous employees restore successful careers at the VA. The number of victories for whistleblowers is increasing steadily, with improved cooperation from the VA and our expedited review process for retaliation complaints. In 2015, we will more than double the total number of favorable outcomes for whistleblowers achieved in 2014.

Our work with whistleblowers in disclosure cases has improved the quality of care for veterans throughout the country and promoted accountability. The VA has disciplined or proposed discipline for 40 employees as a result of the wrongdoing identified by whistleblowers in disclosures to OSC. These actions include the termination of employees who failed to properly safeguard patient information and the suspension of four employees who improperly handled and restocked expired prescription drugs.

This statement describes our process for investigating retaliation complaints and reviewing whistleblower disclosures. It provides updated statistical information on case numbers and outcomes, and summarizes recent cases in which OSC secured relief for whistleblowers. Finally, it highlights areas of concern from the investigation and review of hundreds of these claims.

OSC Investigations of Whistleblower Retaliation Complaints

A. Process

OSC investigates allegations of whistleblower retaliation, one of the thirteen "prohibited personnel practices" that federal employees may challenge with our office. After receiving a retaliation complaint, we conduct an investigation to determine whether the employee has been fired, demoted, suspended, or subjected to some other personnel action because the employee blew the whistle. If OSC can demonstrate that a personnel action was retaliatory, we work with the agency to provide relief to the employee. Relief can include reinstatement, back pay, and

other remedies, including monetary damages. OSC also commonly works with the agency involved to implement systemic corrective actions, such as management training on whistleblower protections. Frequently, we resolve cases through alternative dispute resolution, including mediation. If the agency does not agree to provide the requested relief to the employee, either through mediation or based on our investigative findings, we have the authority to initiate formal litigation on behalf of the whistleblower before the Merit Systems Protection Board (MSPB). In egregious cases, we can also petition the MSPB for disciplinary action against a subject official.

B. VA Retaliation Complaints, by the Numbers

Government-wide, OSC is on track to receive over 3,800 prohibited personnel practice complaints in 2015. Over 1,300 of these complaints, or approximately 35%, will be filed by VA employees. In 2014, for the first time, the VA surpassed the Department of Defense in the total number of cases filed with OSC, even though the Defense Department has twice the number of civilian employees as the VA.

We have taken a number of steps to better respond to this tremendous surge in VA complaints. We reallocated a significant percentage of our program staff to work on VA cases. I assigned our deputy special counsel to supervise investigations of VA cases, and we hired an experienced senior counsel to further coordinate our investigations of VA cases. We prioritized the intake and initial review of all VA health and safety related whistleblower complaints and streamlined procedures to handle these cases. And, we established a weekly coordinating meeting on VA complaints with senior staff and case attorneys.

Although we have dedicated more staff and resources to these investigations, the volume of incoming VA complaints remains overwhelming. As I noted in testimony before the House Committee on Veterans' Affairs (HVAC) last year, the number and "severity of these cases underscores the need for substantial, sustained cooperation between the VA and OSC as we work to protect whistleblowers and encourage others to report their concerns." I am pleased to report that we are receiving that cooperation from VA leadership.

Working with the VA's Office of General Counsel (OGC), we implemented an expedited review process for whistleblower retaliation cases. This process allows OSC to present strong cases to the VA at an early stage in the investigative process, saving significant time and resources. To date, we have obtained 22 corrective actions for VA whistleblowers through this process, including a landmark settlement on behalf of Dr. Katherine Mitchell, who testified today, and two other Phoenix VA Medical Center (Phoenix VAMC) employees. The Phoenix VAMC cases were the first to be settled through the expedited program. My April 2015 testimony before HVAC summarized a number of the other cases we resolved in collaboration with the VA through the expedited process. I have attached that statement for reference.

Last week, OSC announced the resolution of three additional VA whistleblower complaints. These cases are summarized here:

Ryan Honl – Mr. Honl was a secretary in the mental health unit at the Tomah VA Medical Center in Tomah, Wisconsin. In addition to other concerns, he disclosed the alleged excessive prescription of opiates to patients. On the same day he made a disclosure to the VA Office of Inspector General, the VA stripped Mr. Honl of his job duties, locked him out of his office, and isolated him from co-workers. Shortly thereafter, he resigned. The VA and Mr. Honl settled his complaint with Mr. Honl receiving several corrective actions, including the removal of negative information from his personnel file and monetary damages.

Joseph Colon Christensen – Mr. Colon is a credentialing support specialist with the VA Caribbean Health System in San Juan, Puerto Rico. Mr. Colon reported concerns relating to patient care at his facility and information about alleged improper conduct by the director of his facility. In September 2014, two days after a newspaper called the facility's director asking for comment on a story about the director's conduct, the facility's chief of staff issued Mr. Colon a notice of proposed removal. In late December, the VA replaced the proposed removal with a three-day suspension and detailed him to a different position. Prior to his disclosures, Mr. Colon had an unblemished disciplinary history at the VA and had received "outstanding" performance reviews. The VA and Mr. Colon settled his retaliation complaint with Mr. Colon receiving several corrective actions, including the repeal of his suspension, a return to his position, and compensatory damages.

Troy Thompson – Mr. Thompson is a food services manager with the Philadelphia VA Medical Center. In 2012, Mr. Thompson reported management inaction on disciplinary issues and several violations of VA sanitation and safety policies, including a fly and pest infestation in facility kitchens. On the same day he made these disclosures to his supervisor, the supervisor detailed Mr. Thompson to the VA's Pathology and Lab Service pending an investigation into him for eating four expired sandwiches worth a total of $5. His new job mostly consisted of janitorial work, including sanitizing the morgue and handling human body parts. Mr. Thompson already had admitted that he ate and gave away the sandwiches instead of disposing of them per VA practice. After the VA investigation concluded he had stolen government property (the sandwiches), he was issued a proposed removal and fined $75. Mr. Thompson spent over two years on the detail and was under the pending removal for most of that time. The VA ultimately took positive steps to address his case by reassigning him to his previous position and rescinding the proposed removal. OSC determined, however, that the VA also owed Mr. Thompson compensatory damages, which the VA has agreed to provide as part of a settlement.

These are important victories for employees who risked their professional lives to improve VA operations and patient care. In addition to cases resolved through the expedited relief program, we are steadily increasing the number of corrective actions in all VA cases. In 2014 and 2015 to date, OSC has secured either full or partial relief 99 times for VA employees who filed whistleblower retaliation complaints, including 66 in fiscal year 2015 alone. These positive outcomes are generated by the OSC-VA expedited settlement process, OSC's normal

investigative process, and OSC's Alternative Dispute Resolution, or mediation, program. In addition, OSC is also currently reviewing the retaliatory conduct of six managers in three locations for possible disciplinary action.

OSC currently has 316 active VA whistleblower retaliation cases in 43 states, the District of Columbia, and Puerto Rico. Approximately 100 of these pending cases allege retaliation for blowing the whistle on a patient health or safety concern. We will continue to update the Committee as we resolve additional cases in the coming months.

Whistleblower Disclosures

A. Process

In addition to protecting employees from retaliation, OSC also provides federal workers a safe channel to disclose violations of law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific threat to public health or safety. Unlike our role in retaliation complaints, OSC does not have investigative authority in disclosure cases. Rather, OSC plays a critical oversight role in agency investigations of alleged misconduct.

After receiving a disclosure from a federal employee, OSC evaluates the information to determine if there is a "substantial likelihood" that wrongdoing exists. If OSC makes a "substantial likelihood" determination, we transmit the information to the head of the appropriate agency. The agency head, or their designee, is required to conduct an investigation and submit a written report on the investigative findings. The whistleblower is given the opportunity to comment on the agency report. After we review the agency report and the whistleblower comments, we transmit them with our analysis to the President and Congress and place the information on our web site.

This process promotes accountability and is transparent. We require agencies to investigate difficult subjects. And, the process empowers whistleblowers, most often the subject matter experts in the issues they have raised, to assess the quality of the agency investigation. In recent years, the OSC disclosure process has prompted significant changes in government operations, including an effort to modernize the pay structure for Border Patrol Agents, an action that saves taxpayers approximately $100 million a year—an amount over four times the size of OSC's annual budget.

At the VA, our work with whistleblowers led to an overhaul of the VA's internal medical oversight office, the Office of the Medical Inspector (OMI), and has prompted positive changes throughout the department. For reference, I have attached my July 2014 testimony before HVAC, which provides a detailed summary of OSC's prior efforts to promote accountability through our disclosure program.

B. VA Disclosure Cases, by the Numbers

Government-wide, OSC will receive nearly 2,000 whistleblower disclosures from federal employees in 2015.[1] At current levels, approximately 750, or 37.5%, of these disclosures will be filed by VA employees.

Through OSC's disclosure channel, VA whistleblowers have identified and set in motion corrective action plans to address significant threats to the health and safety of veterans. For example, numerous whistleblowers at the Jackson, Mississippi VAMC helped to remedy chronic under-staffing in the Primary Care Unit, improper prescriptions of narcotics, and unsanitary medical equipment. A whistleblower at a Brockton, Massachusetts VA community living center exposed extreme shortcomings in the care provided to long-term mental health patients. And, two whistleblowers at a VA clinic in Fort Collins, Colorado, were among the first to identify VA efforts to manipulate data on patient wait times. These efforts all led to positive changes at the facility involved, leaving leaving the hospital, clinic, and living center better able to provide quality care to veterans.

As stated above, I have attached my prior testimony to the Veterans Affairs' Committee, which provides more extensive summaries of these cases and others. The reports are also available in the public file on OSC's website. https://osc.gov/Pages/Resources-PublicFiles.aspx.

These employees' efforts not only improve the care provided to veterans, they also promote accountability and help to deter future misconduct. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct identified by whistleblowers in disclosures to OSC. Some of these actions include:

- Four pharmacy employees were suspended for the improper handling of prescription drugs as identified by a whistleblower in West Palm Beach, Florida.

- Six employees were disciplined for pressuring employees to manipulate scheduling and wait time data in a case brought to light by two whistleblowers in Fort Collins, Colorado and Cheyenne, Wyoming. (One of the six, a high-level employee, retired pending a proposed removal.)

- Two employees were disciplined, including one receiving a notice of proposed removal, for not properly reporting an alleged sexual assault, as disclosed by a whistleblower in Syracuse, New York.

[1] Each year, OSC receives a number of cases that are inadvertently filed by federal employees as disclosures of wrongdoing, and properly should have been filed as retaliation complaints because the employee is seeking to remedy a personnel action. OSC is in the process of modernizing its online complaint filing system to make it more user-friendly and intuitive. With a smarter, more user-friendly interface for federal employees, the new system will greatly diminish the historical problem of wrongly-filed disclosure forms. By diminishing the number of wrongly filed disclosure cases, the new system will provide a more accurate, but lower number of disclosure cases received in FY2016 and beyond. The changes may increase the number of retaliation complaints.

- A manager was disciplined for misrepresenting time spent in counseling sessions with veterans. The VA is currently reviewing the regional leadership's responsibility for lack of oversight on this issue in a case brought to OSC by a whistleblower in Federal Way, Washington.

- A physician received a reprimand and ultimately resigned after a whistleblower in Montgomery, Alabama, exposed that the physician had cut and pasted medical records and vital signs, rather than taking current readings. OSC has requested that the VA review the appropriateness of the level of disciplinary action taken in this case.

- Five employees received disciplinary actions, including two terminations, for failing to safeguard patient information, as disclosed by a whistleblower in Jackson, Mississippi.

- A total of 12 employees in multiple locations have been disciplined for improperly accessing a whistleblower's medical records.

OSC is in the process of reviewing the VA reports generated in response to disclosures made by Drs. Mitchell and Nee, who you heard from today. After our review and the whistleblowers' have the opportunity to comment, we will formally transmit the information to the Veterans Affairs Committees and the President.

I cannot go into detail on the content of these reports at this time. However, I can say that Dr. Mitchell and Dr. Nee exemplify the courage and tenacity that is necessary to overcome obstacles to change in an organization like the VA. While work still needs to be done, their efforts will lead to improved emergency care in Phoenix and improved cardiology care at Hines.

Indeed, we were delighted to present Dr. Mitchell with OSC's "Public Servant of the Year" award at a ceremony last year. At the event, VA Deputy Secretary Sloan Gibson commented on the importance of whistleblowers in prompting change. About Dr. Mitchell, he specifically noted, "[W]hile we still have vast work to do, I believe that it's because of Dr. Katherine Mitchell that access to care in Phoenix is beginning to improve." I can certainly add that it is because of Dr. Lisa Nee that cardiology care is beginning to improve at Hines. I applaud both of these heroes.

Areas of Ongoing Concern

In my April 2015 testimony, I highlighted several ongoing areas of concern in our investigation and review of VA whistleblower cases. As stated, my April 2015 statement is attached here for reference. I want to add detail today on two of the issues I identified in April, accessing employees' medical records and retaliatory investigations. Also, I will discuss our concern about the pace of culture change within the local facilities and regional levels of the VA.

A. Accessing Whistleblowers' Medical Records

An ongoing concern is the accessing of employee medical records in order to discredit whistleblowers. In many instances, VA employees are themselves veterans and receive care at VA hospitals. In several cases, the medical records of whistleblowers have been accessed by those who had no legitimate reason for doing so, in some instances with the apparent motive of using the information contained in those records to discredit the whistleblowers. We have pursued and will continue to pursue relief for these whistleblowers and discipline for those who improperly access medical records. In February of this year, in a referral of a whistleblower disclosure, I notified the VA that it should consider system-wide corrective action to avoid these types of breaches.

We have started to look more closely at this important issue. While we are not experts on record-keeping systems, our review of multiple cases in which an employee alleged improper access of their records leads us to believe that certain systemic changes could deter the retaliatory, accidental, and curiosity-fueled searches of whistleblowers' records.

First, the VA should implement an IT fix to its records-keeping systems to make it more difficult for an employee to access a fellow employee's medical records. The VA should determine the most cost-effective way to both deter improper access to records while still ensuring that those with a legitimate need to access the records can do so easily. Quite simply, it is too easy right now for a mischief-minded employee to enter the medical record system and access information on his or her coworkers. That should not be the case. A better "lock" on the system would potentially eliminate, and certainly reduce, this problem.

Second, a broader problem seems to exist within VistA—the Veterans Health Information Systems and Technology Architecture—or, the VA's Health IT system. VA employees routinely access the VistA system in order to obtain administrative and personnel information for employees. This use of a health information system to obtain both employment and medical information is problematic because it causes unnecessary searches of the medical records system, often to receive demographic information such as an employee's mailing address. In multiple investigations of improper access of medical records, the VA's justification for the searches was to access employee data, not medical information. Even where these searches are justified by VA procedures, there is a clear threat to an employee's privacy when medical records are accessed every time demographic or employment information is needed by HR or a manager. I understand that the VistA system may be undergoing a modernization effort. We believe the VA should address how to better segregate medical records from personnel or administrative information as part of this modernization effort.

B. Retaliatory Investigations

From a whistleblower protection standpoint, there are limitations in OSC's ability to address retaliatory access of medical records and other forms of retaliatory investigations. I should note that the VA has fully cooperated with our investigations and requests for review of improper records searches. However, a policy change may be appropriate to better equip OSC to address this unique form of retaliation.

The whistleblower law allows OSC to seek relief in cases where there has been a concrete personnel action, such as a termination, demotion, suspension, or a decision concerning pay. Congress has not included "an investigation" as a personnel action that we can stop or fix, even if the reason for launching the investigation is retaliation for whistleblowing. There are obviously competing interests at stake. An agency needs to be able to conduct investigations of its employees, and managers should not feel chilled from investigating misconduct because it could lead to a whistleblower complaint. At the same time, current law leaves a gap in coverage for whistleblowers who are subjected to retaliatory investigations, including medical records searches.

It is important to address these more subtle forms of retaliation, which have a negative effect on the whistleblower and their employment, and may chill others from blowing the whistle. However, under the current state of the law, it can be very difficult to challenge these less concrete retaliatory tactics. We will continue to investigate these actions as appropriate, but closing the statutory gap in our enforcement power may ultimately require a legislative fix.

C. Culture Change within the VA

Another ongoing concern is that the cooperation and commitment we are seeing at VA headquarters has not consistently filtered down to the regions. For example, regional counsels do not necessarily have a clear understanding of what constitutes appropriate treatment of whistleblowers. In many cases, the regional counsel is the person who signed off on the very same retaliatory action that OSC challenges, and therefore should not be handling the individual case, or advising managers about their legal responsibilities.

We think that the VA General Counsel's recent efforts to re-orient and sensitize regional counsel through training and other clear directives are extremely helpful and should be continued and expanded. We are particularly pleased that the General Counsel asked OSC staff to meet with VA regional counsels from all over the country this past April, and hope that we can continue such efforts. Also, OSC provided several high-level officials within the VA with in-person "train the trainers" training on whistleblower issues. Those officials can now act as force multipliers to go out and train others throughout the VA.

It is worth noting that no other agency in the federal government, much less one the size of the VA, has taken such a proactive approach to training managers on whistleblower protections. The VA deserves recognition for this important initiative.

Conclusion

We appreciate the Committee's attention to the issues we have raised and your interest in our efforts to protect and promote VA whistleblowers. I thank you for the opportunity to testify, and am happy to answer your questions.

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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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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Attachment 1

Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. House of Representatives
Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations

"Addressing Continued Whistleblower Retaliation Within the VA"

April 13, 2015, 4:00 P.M.

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

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

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

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

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

The current VA leadership has shown a high level of engagement with OSC and a genuine commitment to protecting whistleblowers. As many VA officials and Members of this Committee have repeatedly stated, culture change in an organization the size of the VA is

difficult and will take time. But, if the current number of whistleblower cases is an indication of employees' willingness to speak out, then things are moving in the right direction.

I. Whistleblower Retaliation – Collaboration with the VA to Provide Expedited Relief to VA Employees

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

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

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

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

- **Damian Reese, Phoenix VAMC** – Mr. Reese is a Phoenix VAMC program analyst. He voiced concerns to Phoenix VAMC management about the amount of time veterans had to wait for primary-care provider appointments and management's efforts to characterize long wait times as a "success" by manipulating the patient records. After making this disclosure, Mr. Reese had his annual performance rating downgraded by a senior official

with knowledge of his email. Mr. Reese agreed to settle his claims with the VA for mutually agreed upon relief.

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

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

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

- **Charles Johnson, Columbia VAMC** – Mr. Johnson, a technologist in the radiology department at the VA Medical Center in Columbia, South Carolina, disclosed that a doctor ordered him to hydrate a patient using a new, unfamiliar method in February 2014. Due to his concerns about the new hydration method, Mr. Johnson consulted with two physicians about the method, neither of whom would verify the method's safety. Mr. Johnson then contacted his union, which suggested he send an email seeking clarification of the method under the VA's "Stop The Line For Patient Safety" policy. In July 2014,

Mr. Johnson was issued a proposed five-day suspension by the same doctor whose hydration method Mr. Johnson had questioned. In October 2014, at OSC's request, the VA agreed to stay Mr. Johnson's suspension. In February 2015, Mr. Johnson and the VA settled his case, under which the VA will, among other things, rescind the proposed suspension and evaluate the hydration method.

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

- **Debora Casados, Denver, CO** – Ms. Casados is a nurse in the VA Eastern Colorado Health Care System. In August 2014, she reported that a coworker sexually assaulted two other VA staff members and made inappropriate sexual comments to her. Human resources told Ms. Casados and the other staff that they were not permitted to discuss the allegations and threatened them with disciplinary action if they did so. In October, human resources removed Ms. Casados from her nursing duties at the clinic and reassigned her to administrative tasks. In January 2015, she was moved again, this time to a windowless basement office to scan documents. In February, her superior denied Ms. Casados leave to care for her terminally ill mother. On April 3, 2015, the VA agreed to OSC's request for an informal stay on behalf of Ms. Casados, returning her to nursing duties at another clinic while OSC investigates her whistleblower reprisal claims to determine if additional corrective action and disciplinary action are appropriate.

Including these cases, in 2014 and 2015 to date, OSC has secured either full or partial relief for over 45 VA employees who have filed whistleblower retaliation complaints. OSC is on track to help nearly twice as many VA employees in 2015 as in 2014. These positive outcomes have been generated by the OSC-VA expedited settlement process, OSC's normal investigative process, and OSC's Alternative Dispute Resolution program. OSC is currently examining about 110 pending claims of whistleblower retaliation at the VA involving patient health and safety, scheduling, and understaffing issues. These pending claims involve VA facilities in 38 states and the District of Columbia. We look forward to updating the Committee as these cases proceed.

II. Whistleblower Disclosures and the Office of Medical Inspector

In my July 2014 testimony, I raised concerns about the VA's longstanding failure to use the information provided by whistleblowers as an early warning system to correct problems and prevent them from recurring. I summarized a series of cases in which the Office of Medical Inspector (OMI) identified deficiencies in patient care, such as chronic understaffing in primary care units, and the inadequate treatment of mental health patients in a community living center. In each case, OMI failed to grasp the severity of the problems, attempted to minimize concerns, and prevented the VA from taking the steps necessary to improve the quality of care for veterans.

In response to our concerns, the VA directed a comprehensive review of all aspects of OMI's operations. Overall, we believe this review has resulted in positive change. A recent whistleblower case is demonstrative.

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

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

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

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

III. Training Initiatives and Areas of Ongoing Concern

A. OSC's 2302(c) Certification Program

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

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

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

B. Investigation of Whistleblowers

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

There are two main problems with this approach. First, by focusing on the individual whistleblower, the systemic problem that has been raised may not receive the attention that it deserves. And second, instead of creating a welcoming environment for whistleblowers to come

forward, it instills fear in potential whistleblowers that by reporting problems, their own actions will come under intense scrutiny.

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

C. Accessing Whistleblowers' Medical Records

A final, related issue of ongoing concern is the unlawful accessing of employee medical records in order to discredit whistleblowers. In many instances, VA employees are themselves veterans and receive care at VA hospitals. In several cases, the medical records of whistleblowers have been accessed and information in those records has apparently been used to attempt to discredit the whistleblowers. We will aggressively pursue relief for whistleblowers in these and other cases where the facts and circumstances support corrective action, and we will also work with the VA to incorporate these additional forms of retaliation into our collaborative training programs.

IV. Conclusion

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

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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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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

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

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:

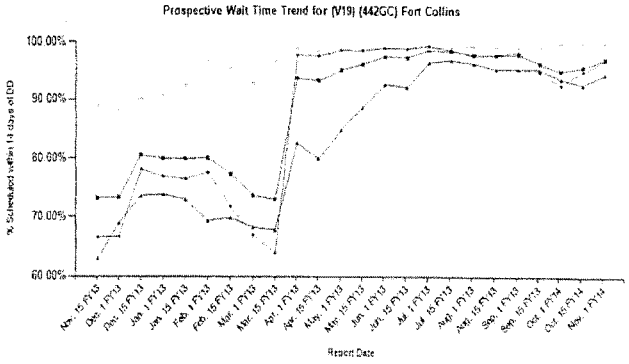
- A shortage of providers caused the facility to frequently cancel appointments for veterans. After cancellations, providers did not conduct required follow-up, resulting in situations where "routine primary care needs were not addressed."

- 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
1730 M Street, N.W., Suite 300
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.

The Special Counsel

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 Lerner

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.

Testimony of Carolyn Lerner, Special Counsel
U.S. Office of Special Counsel

U.S. Senate
Committee on Homeland Security and Governmental Affairs

"Improving VA Accountability: Examining First-Hand Accounts of Department of Veterans Affairs Whistleblowers"

September 22, 2015, 9:30 A.M.

Chairman Johnson, Ranking Member Carper, and Members of the Committee:

Thank you for the opportunity to testify today about the U.S. Office of Special Counsel (OSC) and our work with whistleblowers at the Department of Veterans Affairs (VA). Since April 2014, our office has seen a sharp increase in the number of whistleblower cases from VA employees. These cases fall into two categories: retaliation complaints and disclosures of wrongdoing.

In response to retaliation complaints, and working in cooperation with the VA, we have secured relief for dozens of whistleblowers, helping courageous employees restore successful careers at the VA. The number of victories for whistleblowers is increasing steadily. In 2015, we will more than double the total number of favorable outcomes for whistleblowers achieved in 2014. OSC recently settled a retaliation complaint filed by Joseph Colon, who testified on the first panel. We are actively reviewing the retaliation complaints and whistleblower disclosures filed by Brandon Coleman and Shea Wilkes, who also testified today.

In disclosure cases, OSC's work with whistleblowers improves the quality of care for veterans. Whistleblower disclosures also can play a pivotal role in promoting accountability. The VA has disciplined or proposed to discipline 40 employees as a result of wrongdoing whistleblowers identified in disclosures to OSC. This is substantial progress. However, as detailed below, our review of disciplinary actions in response to recent whistleblower disclosures indicates that discipline is being inconsistently imposed.

This statement describes our process for investigating retaliation complaints and reviewing whistleblower disclosures. It provides updated statistical information on case numbers and outcomes, and it summarizes recent cases in which OSC secured relief for whistleblowers. Finally, it highlights ongoing challenges and issues the Committee may want to consider to strengthen OSC's ability to investigate whistleblower retaliation complaints.

OSC Investigations of Whistleblower Retaliation Complaints

A. Process

OSC investigates allegations of whistleblower retaliation, one of the thirteen "prohibited personnel practices" that federal employees may challenge with our office. After receiving a retaliation complaint, we conduct an investigation to determine whether the employee has been fired, demoted, suspended, or subjected to another personnel action for blowing the whistle. If

OSC can demonstrate that a personnel action was retaliatory, we work with the agency to provide relief to the employee. This can include reinstatement, back pay, and other remedies, including monetary damages. OSC also commonly works with the agency involved to implement systemic corrective actions, such as management training on whistleblower protections. Frequently, we resolve cases through alternative dispute resolution, including mediation. If the agency does not agree to provide the requested relief to the employee, either through mediation or based on our investigative findings, we have the authority to initiate formal litigation on behalf of the whistleblower before the Merit Systems Protection Board (MSPB). In egregious cases, we can also petition the MSPB for disciplinary action against a subject official.

B. VA Retaliation Complaints, by the Numbers

Government-wide, OSC is on track to receive over 4,000 prohibited personnel practice complaints in 2015. Over 1,400 of these complaints, or approximately 35 percent, will be filed by VA employees. In 2014, for the first time, the VA surpassed the Department of Defense in the total number of cases filed with OSC, even though the Defense Department has twice the number of civilian employees as the VA.

We have taken a number of steps to respond to this tremendous surge in VA complaints. We reallocated a significant percentage of our program staff to work on VA cases. I assigned our deputy special counsel to supervise investigations of VA cases, and we hired an experienced senior counsel to further coordinate our investigations of VA cases. We prioritized the intake and initial review of all VA health and safety related whistleblower complaints and streamlined procedures to handle these cases. And, we established a weekly coordinating meeting on VA complaints with senior staff and case attorneys.

Working with the VA's Office of General Counsel (OGC), we implemented an expedited review process for whistleblower retaliation cases. This process allows OSC to present strong cases to the VA at an early stage in the investigative process, saving significant time and resources. To date, we have obtained approximately thirty corrective actions for VA whistleblowers through this process.

In July, OSC announced the resolution of Mr. Colon's case, as well as the retaliation complaint filed by Ryan Honl of the Tomah, Wisconsin VAMC, which I know has been of great interest to the Chairman, Senator Baldwin, other members of this Committee, and Mr. Kirkpatrick's family. These cases are summarized here:

> **Ryan Honl** – Mr. Honl was a secretary in the mental health unit at the Tomah VA Medical Center in Tomah, Wisconsin. In addition to other concerns, he disclosed the alleged excessive prescription of opiates to patients. On the same day he made a disclosure to the VA Office of Inspector General, the VA stripped Mr. Honl of his job duties, locked him out of his office, and isolated him from co-workers. Shortly thereafter, he resigned. The VA and Mr. Honl settled his complaint through the expedited process with Mr. Honl receiving several corrective actions, including the removal of negative information from his personnel file and monetary damages.

Joseph Colon Christensen – Mr. Colon is a credentialing support specialist with the VA Caribbean Health System in San Juan, Puerto Rico. Mr. Colon reported concerns relating to patient care at his facility and information about alleged improper conduct by the director of his facility. In September 2014, two days after a newspaper called the facility's director asking for comment on a story about the director's conduct, the facility's chief of staff issued Mr. Colon a notice of proposed removal. In late December, the VA replaced the proposed removal with a three-day suspension and detailed him to a different position. Prior to his disclosures, Mr. Colon had an unblemished disciplinary history and had received "outstanding" performance reviews. The VA and Mr. Colon settled his retaliation complaint through the expedited process with Mr. Colon receiving several corrective actions, including the repeal of his suspension, a return to his position, and compensatory damages.

These are important victories for employees who risked their professional lives to improve VA operations and the quality of care provided to veterans. Additionally, in the last two weeks, in cooperation with the VA, OSC resolved two additional significant retaliation claims, summarized below:

Philo Calhoun – Dr. Calhoun was a surgeon at the VA Roseburg Health Care System in Oregon. He raised numerous patient care issues with senior VA officials, the press, and Congress, both while he served as chief of surgery and after he stepped down from that post in 2013. In August of 2014, Dr. Calhoun reported that the new chief of surgery was performing colonoscopies incorrectly. A subsequent review by the chief of gastroenterology concluded that, out of the 80 colonoscopies reviewed, the new chief performed more than 90 percent incorrectly. After Dr. Calhoun reported these results to VA officials, the chief of surgery retaliated against him by taking away his surgical duties, giving him a lowered performance evaluation, and blocking his reassignment to another facility where he could maintain his surgical skills. OSC settled Dr. Calhoun's case through the expedited process. At Dr. Calhoun's request, the VA reassigned him to the Portland, Oregon VA Health Care System and reissued his 2014 Proficiency Report with an "outstanding" rating, consistent with his previous evaluations.

Bradie Frink – Mr. Frink is a disabled Army veteran who was hired at the Baltimore Regional Office (BRO) of the Veterans Benefits Administration in February 2013. VA policy required the BRO to transfer Mr. Frink's benefits claims folder to another VA facility for processing. However, the VA lost Mr. Frink's claims folder. Despite several requests to the VA to locate his claims folder, it remained lost. Mr. Frink sent a request for assistance to Senator Barbara Mikulski. The Senator's office contacted the BRO about Mr. Frink's claim. Shortly thereafter, the VA terminated Mr. Frink during his probationary period. OSC settled the complaint through the expedited process. The VA provided full corrective action for Mr. Frink, including reemployment with the VA, back pay for the months of unemployment, and compensatory damages for emotional distress. OSC further recommended that the VA consider disciplinary action against two of Mr. Frink's supervisors.

In addition to cases resolved through the expedited relief program, we are steadily increasing the number of corrective actions in all VA cases. In 2014 and 2015 to date, OSC has secured either full or partial relief 116 times for VA employees who filed whistleblower retaliation complaints, including 84 in fiscal year 2015 alone. These positive outcomes are generated by the OSC-VA expedited settlement process, OSC's normal investigative process, and OSC's Alternative Dispute Resolution, or mediation, program. In addition, OSC is currently reviewing the retaliatory conduct of six managers in three locations for possible disciplinary action.

OSC currently has 279 active VA whistleblower retaliation cases in 44 states, the District of Columbia, Puerto Rico, and VA hospitals abroad. Approximately 100 of these pending cases allege retaliation for blowing the whistle on a patient health or safety concern. We will continue to update the Committee as we resolve additional cases in the coming months.

Whistleblower Disclosures

A. Process

In addition to protecting employees from retaliation, OSC also provides federal workers a safe channel to disclose violations of law, rule, or regulation; gross mismanagement; a gross waste of funds; an abuse of authority; or a substantial and specific danger to public health or safety. Unlike our role in retaliation complaints, OSC does not have investigative authority in disclosure cases. Rather, OSC plays a critical oversight role in agency investigations of alleged misconduct.

After receiving a disclosure from a federal employee, OSC evaluates the information to determine if there is a "substantial likelihood" that wrongdoing exists. If OSC makes a "substantial likelihood" determination, we transmit the information to the head of the appropriate agency. The agency head, or their designee, is required to conduct an investigation and submit a written report on the investigative findings. The whistleblower is given the opportunity to comment on the agency report. After we review the agency report and the whistleblower comments, we transmit them with our analysis to the President and Congress and place the information on our web site.

This process promotes accountability and is transparent. We require agencies to investigate complex wrongdoing. And, the process empowers whistleblowers, the subject matter experts in the issues they have raised, to assess the quality of the agency investigation and provide comments on the agency's report.

In recent years, the OSC disclosure process has prompted significant changes in government operations and saved taxpayer dollars. For example, whistleblower disclosures to OSC about rampant overtime abuse in the Department of Homeland Security (DHS) prompted a successful legislative effort to modernize the pay structure for Border Patrol Agents. The pay reform, spearheaded by Members of this Committee after hearings with DHS whistleblowers and OSC, saves taxpayers $100 million a year—an amount over four times the size of OSC's annual budget.

At the VA, our work with whistleblowers led to an overhaul of the VA's internal medical oversight office, the Office of the Medical Inspector (OMI), and has prompted positive changes throughout the department. VA whistleblowers identified and set in motion corrective action plans to address significant threats to the health and safety of veterans. For example, numerous whistleblowers at the Jackson, Mississippi VAMC helped to remedy chronic under-staffing in the Primary Care Unit, improper prescription of narcotics, and unsanitary medical equipment. A whistleblower at a Brockton, Massachusetts VA community living center exposed extreme shortcomings in the care provided to long-term mental health patients. And, two whistleblowers at a VA clinic in Fort Collins, Colorado, were among the first to identify manipulation of data on patient wait times. These efforts all led to positive changes at the facility involved, leading to better care for veterans.

B. Inconsistent Application of Discipline in VA Whistleblower Cases

Government-wide, OSC will receive nearly 2,000 whistleblower disclosures from federal employees in 2015.[1] At current levels VA employees will file, approximately 774, or 38 percent, of these disclosures.

As I noted in recent testimony before the Senate Appropriations Committee, whistleblower disclosures not only improve the care provided to veterans, but also help to promote accountability and deter future misconduct. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct identified by whistleblowers in disclosures to OSC.

This is substantial progress toward greater accountability and deterring future misconduct, and I applaud the VA for taking these important steps. Unfortunately, as explained below, our review of several recent disclosure cases indicates that disciplinary actions are being inconsistently imposed. The failure to take appropriate discipline, when presented with clear evidence of misconduct, can actually undermine accountability, impede progress, and discourage whistleblowers from coming forward.

I highlighted my concerns about the disciplinary action process in a September 17, 2015 letter to the President and the Chairmen of the Veterans' Affairs Committees (attached). I raised specific concerns about the lack of accountability in response to confirmed mismanagement at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (Hayden VAMC), and other locations. I provided the following examples:

- At the Hayden VAMC, not a single nurse in the emergency department (ED) had completed a nationally-recognized, comprehensive triage training regimen. Only 11 of 31

[1] Each year, OSC receives a number of cases that are inadvertently filed by federal employees as disclosures of wrongdoing, and properly should have been filed as retaliation complaints because the employee is seeking to remedy a personnel action. OSC is in the process of modernizing its online complaint filing system to make it more user-friendly and intuitive. With a smarter, more user-friendly interface for federal employees, the new system will greatly diminish the historical problem of wrongly-filed disclosure forms. By diminishing the number of wrongly filed disclosure cases, the new system will provide a more accurate, but lower number of disclosure cases received in FY2016 and beyond. The changes may increase the number of retaliation complaints.

Phoenix ED nurses received any triage training at all. The in-house training completed by these 11 nurses omitted critical educational content. ED nursing supervisors nevertheless required nurses with inadequate or no training to triage incoming patients. This resulted in at least 110 cases that the whistleblower identified in which ED patients were improperly triaged and experienced dangerous delays in care. OMI concluded that the lapses in ED triage "constitute a significant risk to public health and safety" of veterans. Despite these findings, the VA has taken no disciplinary action against responsible officials.

- In Federal Way, Washington, the manager of a VA clinic falsified government records, repeatedly overstating the amount of time she spent counseling veterans. Regional leaders were aware of the manager's misconduct, yet failed to take action to address it. Although OMI substantiated both sets of allegations, the manager and regional leaders received only a reprimand, the lowest form of available discipline.

- The director of a VA outpatient clinic within the Martinsburg, West Virginia VAMC system improperly monitored witness interviews through a video feed to a conference room during an OMI investigation of patient care problems. The manager also approached a witness after the employee provided testimony to OMI and was not candid when interviewed about his actions. The director's actions create a chilling effect on the willingness of employees to participate in OMI and other investigative processes that promote better care for veterans. The director received only a written counseling.

- Officials at the Beckley, West Virginia VAMC attempted to meet cost savings goals by requiring mental health providers to substitute prescriptions for veterans, requiring them to prescribe older, cheaper, and less effective antipsychotic medications. These actions violated VA policies, undermined effective treatment of veterans, and placed their health and safety at risk. To date, no one has been disciplined.

- In Montgomery, Alabama, a staff pulmonologist copied and pasted prior provider notes for veterans, including the patients' chief complaint, physical examinination findings, vital signs, diagnoses, and plans of care, resulting in inaccurate recordings of patient health information and in violation of VA rules. An investigation confirmed that the pulmonologist copied and pasted 1,241 separate patient records. Yet the physician received only a reprimand. While the VA explained that managers attempted to issue a 30-day suspension, management apparently did not provide the appropriate information to human resources, which only approved a reprimand.

These cases stand in stark contrast to disciplinary actions taken against VA whistleblowers. My September 17, 2015 letter summarizes seven additional cases in which the VA attempted to fire or suspend whistleblowers for minor indiscretions or for activity directly related to the employee's whistleblowing. OSC has worked with VA headquarters to rescind the disciplinary actions in these cases. Nevertheless, the severity of the initial punishments chills other employees from stepping forward to report concerns.

I have encouraged VA leadership to review the cases identified and determine whether systemic changes to the disciplinary action processes in the VA would correct the inconsistent imposition of penalties. Based on the VA leadership's positive response to my prior recommendations, I am optimistic that the VA will work to appropriately address this problem.

In fact, just last week, Deputy Secretary Sloan Gibson issued a memorandum setting forth a new process for responding to OSC referrals of whistleblower information. The new process will route all OSC referrals through the VA Executive Secretariat, ensuring the highest level review of all whistleblower allegations and corresponding investigations. I am hopeful that this centralized, high-level review will address the concerns expressed in my September 17 letter and promote better and more consistent outcomes in whistleblower disclosure cases.

Additional Areas for Congressional Consideration

In prior testimony, I highlighted several ongoing areas of concern in our investigation and review of VA whistleblower cases. I previously discussed the improper accessing of whistleblowers' medical records, retaliatory investigations, and the role of regional counsel in whistleblower investigations. I would be happy to provide additional detail on each of these subjects.

Today, I want to focus on some specific measures that Congress could take to assist OSC in its investigations. OSC has not been formally reauthorized since 2007. While this does not prevent OSC from receiving appropriations, reauthorization provides Congress with an opportunity to evaluate OSC's authorities and responsibilities and make any necessary adjustments. While the Committee may want to consider any number of issues in connection with OSC reauthorization legislation, I would like to focus on two of particular importance.

First, Congress may want to clarify OSC's authority to seek information from other government agencies to assist OSC in its independent investigations of whistleblower retaliation and prohibited personnel practice claims. It would be helpful to provide OSC with direct, statutory authority to gain access to all agency information, much like the authorities Congress has provided to Inspectors General and the Government Accountability Office. Currently, OSC's authority to request documents is regulatory. Office of Personnel Management (OPM) regulation directs agencies to comply with document requests from OSC. While agencies typically comply with our OPM civil service rule 5.4 requests, we have had some difficulty in VA investigations with the timeliness and completeness of responses. Direct statutory authority would better ensure that OSC obtains all relevant facts during investigations.

Second, in light of our steadily increasing workload, especially in the number of VA whistleblower cases, Congress may want to consider the procedural requirements imposed on OSC in all prohibited personnel practice cases as a possible area for revision. Changes to section 1214 of title 5 would allow OSC to spend its limited resources on the investigation and prosecution of meritorious cases, providing OSC with the ability to generate more positive outcomes on behalf of whistleblowers, the merit system, and the taxpayers. Section 1214 currently requires OSC to provide an employee with repetitive status reports, a detailed, fact-based letter, the reason for terminating the investigation, and an opportunity to comment before OSC may close a complaint file, regardless of the merits of the complaint. In light of our

skyrocketing caseloads, these requirements require us to devote significant resources to closing non-meritorious complaints, instead of focusing on prosecuting and resolving meritorious cases. These requirements are unique to OSC.

Conclusion

We appreciate the Committee's attention to the issues we have raised and your interest in our efforts to protect and promote VA whistleblowers. I thank you for the opportunity to testify, and am happy to answer your questions.

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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. She previously served as the federal court appointed monitor of the consent decree in *Neal v. D.C. Department of Corrections*, a sexual harassment and retaliation class action.

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

Ms. Lerner earned her undergraduate degree from the University of Michigan, where she was selected to be a Harry S. 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.

Attachment

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

The Special Counsel

September 17, 2015

The President
The White House
Washington, D.C. 20510

Re: OSC File No. DI-14-2754

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at the Carl T. Hayden VA Medical Center in Phoenix, Arizona (Hayden VAMC). The Office of Special Counsel (OSC) reviewed the VA reports and provides the following summary of the whistleblower's allegations and my findings. The whistleblower, Dr. Katherine Mitchell, disclosed serious threats to the health and safety of veterans seeking care in the Hayden VAMC Emergency Department (ED). According to Dr. Mitchell, Hayden VAMC did not properly train ED nurses. Patients were harmed because nurses failed to conduct appropriate triage.

The VA's Office of the Medical Inspector (OMI) substantiated Dr. Mitchell's allegations. Specifically, at the time of OMI's investigation in 2014, the ED did not employ a single nurse who had completed a nationally-recognized, comprehensive triage training regimen. Only 11 of 31 Phoenix ED nurses had completed any triage training at all. The in-house training completed by these 11 nurses omitted critical educational content. ED nursing supervisors nevertheless required nurses with inadequate or no training to triage incoming patients. Dr. Mitchell identified at least 110 cases in which ED patients were improperly triaged and experienced dangerous delays in care, including a patient with a history of strokes waiting almost eight hours for treatment after presenting to the ED with low blood pressure. OMI concluded that the lapses in ED triage "constitute a significant risk to public health and safety" of veterans. In response to OMI's findings, Hayden VAMC initiated steps to implement comprehensive triage training protocols and improve ED staffing levels, something Dr. Mitchell first suggested in 2009, in correspondence and disclosures to senior Hayden VAMC officials.

The commitment to improve training in Phoenix is a positive and long-overdue step; however, I am concerned by the VA's decision to take no disciplinary action against responsible officials. The lack of accountability for Hayden VAMC leaders sends the wrong message to the veterans served by this facility, including those who received substandard emergency care. OSC sought additional information from the VA on its

decision not to impose discipline on any responsible officials, but the VA did not provide an adequate justification.

I have determined that the agency reports contain the information required by statute. However, the VA's failure to impose disciplinary action is troubling, given the seriousness of OMI's findings. A detailed analysis of Dr. Mitchell's disclosures, and the agency investigation and reports regarding patient care at the Hayden VAMC are included as an attachment to this letter.[1]

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As part of OSC's broader review of pending VA whistleblower disclosure cases, I have identified recent additional cases in which the VA confirmed serious misconduct brought to light by whistleblowers, yet failed to appropriately discipline responsible officials.

Similarly, in June 2014, I highlighted a pattern of deficient patient care at VA facilities nationwide, and the VA's resistance, and OMI's in most cases, to acknowledge and address the impact on the health and safety of veterans. In response to our concerns, the VA directed a comprehensive review of all aspects of OMI's operations. This review resulted in positive changes. With increasing consistency, patient care challenges, like those OMI identified in response to Dr. Mitchell's disclosures, are being acknowledged as threats to the health and safety of veterans, allowing the VA to consider and take the corrective actions needed to improve care for veterans.

The next and critical step is to hold officials accountable after lapses in care have been identified. Whistleblower disclosures, like those Dr. Mitchell submitted, can play a pivotal role in promoting accountability at the VA. Over the last two years, the VA has taken or proposed disciplinary actions against 40 officials who engaged in misconduct that whistleblowers identified. This is substantial progress. Nevertheless, as explained below, disciplinary action is being inconsistently imposed. The failure to take appropriate discipline, when presented with clear evidence of misconduct, can undermine accountability, impede progress, and discourage whistleblowers from coming forward.

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the anthority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The following examples are illustrative:

- In Federal Way, Washington, the manager of a VA clinic falsified government records, repeatedly overstating the amount of time she spent in face-to-face counseling sessions with veterans. Regional leaders were aware of the manager's misconduct, yet failed to take action to address it. OMI substantiated both sets of allegations, yet the manager and regional leaders received only a reprimand, the lowest form of available discipline.

- The director of a VA outpatient clinic within the Martinsburg, West Virginia VAMC system improperly monitored witness interviews through a video feed to a conference room during an OMI investigation of patient care problems. The manager also approached a witness after the employee provided testimony to OMI and was not candid when interviewed about his actions. The director's actions create a chilling effect on the willingness of employees to participate in OMI and other investigative processes that promote better care for veterans. Yet the director received only a written counseling.

- Officials at the Beckley, West Virginia VAMC attempted to meet cost savings goals by requiring mental health providers to substitute prescriptions for veterans, requiring them to prescribe older, cheaper, and less effective antipsychotic medications. These actions violated VA policies, undermined effective treatment of veterans, and placed their health and safety at risk. To date, no one has been disciplined.

- In Montgomery, Alabama, a staff pulmonologist copied and pasted prior provider notes for veterans, resulting in inaccurate recordings of patient health information and in violation of VA rules. The pulmonologist copied and pasted other physicians' earlier recordings, including the patients' chief complaint, physical examination findings, vital signs, diagnoses, and plans of care. An investigation confirmed that the pulmonologist copied and pasted 1,241 separate patient records. Yet the physician received only a reprimand. While the VA explained that managers attempted to issue a 30-day suspension, management did not provide the appropriate information to human resources, which only approved a reprimand.

The lack of accountability in these cases stands in stark contrast to disciplinary actions taken against VA whistleblowers. The VA has attempted to fire or suspend whistleblowers for minor indiscretions and, often, for activity directly related to the employee's whistleblowing. While OSC has worked with VA headquarters to rescind the disciplinary actions in these cases, the severity of the initial punishments chills other employees from stepping forward to report concerns. OSC has obtained corrective action, or is working to correct the actions taken against the following employees:

- At the Philadelphia VAMC, a food services manager who blew the whistle on VA sanitation and safety practices was fired after being accused of eating four expired sandwiches instead of throwing them away.

- In Puerto Rico, the VA sought to remove an employee who blew the whistle on the hospital director's misconduct. Puerto Rico officials claimed the employee made an "unauthorized disclosure of information." But the employee's communication was protected and related to his concerns about hiring violations at the facility. The VA also sought removal of a second Puerto Rico employee, the privacy officer, in part because she concluded that the whistleblower had not made an unauthorized disclosure, and refused management pressure to change her finding.

- A VA employee in Wisconsin sent an email expressing her concerns about ongoing improper disclosures of veterans' health information. The employee sent the email to an internal list of VA privacy and compliance officers, yet the VA fired the employee for sending the email because it contained personal information about a veteran.

- The VA fired an employee and disabled veteran in Baltimore for pretextual reasons after he petitioned Congress for assistance with his own VA benefits claim.

- In Kansas City, the VA fired an employee who blew the whistle on improper scheduling practices, claiming for the first time after her disclosures that she was acting "too slowly" in scheduling appointments for veterans.

- At the Wilmington, Delaware VAMC, a registered nurse blew the whistle on improper treatment of opiate addiction. The employee received a 14-day suspension for charging one colleague $5 for notary services, an event that occurred a year prior to his whistleblowing, and other minor allegations of misconduct.

In 2015, OSC received over 2,000 cases from VA employees. The large number of VA cases OSC has received and processed provides us with the ability to compare the actions taken against whistleblowers with those taken, or not taken, against officials who engage in substantive misconduct. I highlight these cases to demonstrate the disparity in punishments for whistleblowers and those who have engaged in misconduct that negatively impacts patient care.

I encourage VA leadership to review the cases identified and determine whether systemic changes to the disciplinary action processes in the VA would correct the inconsistent imposition of penalties.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the unredacted agency reports and Dr. Mitchell's comments to the Chairmen and Ranking members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports and Dr. Mitchell's comments in our public file, which is available at www.osc.gov.[2] OSC has now closed this file.

Respectfully,

Carolyn Lerner

Carolyn N. Lerner

Enclosures

[2] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.

Remarks of Carolyn Lerner, Special Counsel, U.S. Office of Special Counsel

I want to thank the Sunlight Foundation and the other members of the Advisory Committee on Transparency for organizing this event. I also want to thank Chairman Issa and Representative Quigley, the co-chairs of the Congressional Transparency Caucus, for sponsoring today's discussion.

This is my first public speaking engagement since being sworn in as Special Counsel about 6 weeks ago. So, it's especially meaningful to be here today.

Though I've only been on the job a short time, I feel some urgency to re-invigorate this important agency. I am beginning at a time when our country is in a fiscal crisis, and it is clear that as Congress tries to tighten the budget, OSC's role has never been more important.

OSC is a small agency with a large mission. We promote government accountability, efficiency and transparency by providing a safe channel for employees to report waste, fraud, abuse, or threats to public health or safety.

Government workers are in the best position to uncover wrongdoing. Study after study demonstrates that insiders – employees – are the single best source for identifying costly wrongdoing and harm. One recent study in the private sector showed that outside regulators and auditors uncovered corporate fraud in only one out of six cases. It is the people inside companies who are most likely to report wrongdoing - - because they are the ones who know about it.

And though these employees performed an important service, this same private sector study found that 80 percent of the whistleblowers regretted coming forward because of the negative consequences they suffered. At the OSC, we know that the experience of federal employees who have reported wrongdoing is all too similar. This is a culture that must change. And the federal government should be setting the pace.

Public servants need to feel confident that they can speak out without fear of retaliation… and when they do, we must make sure that the government is held accountable for correcting any misconduct they uncover.

Creating an environment inside the government where open dialogue about problems is accepted – and indeed encouraged – is one of my goals as Special Counsel. And the OSC is especially able to do this given its independence.

When it established the OSC, Congress understood that for the agency to be effective it must have full freedom to act on behalf of whistleblowers, even if that upsets other agencies or the White House. So while I was nominated by President Obama and confirmed by the Senate, I do not serve at the pleasure of either the President or Congress.

This unique status ensures that OSC is not subject to influence or pressure when we conduct investigations or make prosecution decisions. We are able to advocate on behalf of the lowest level employee against the highest ranking official at an agency.

OSC is also unique because - - unlike Inspectors General - - we are not tied to any one agency and, with few exceptions, we have the ability to hold any government agency accountable. Moreover, Congress has mandated that we make it a priority to help whistleblowers.

We are a small agency with a relatively small budget - - about 5% the budget of military bands - - Yet our work provides enormous value to American taxpayers: It is reflected in saved lives, improved government efficiency, and significant cost savings for the federal government.

For example, Federal Aviation Administration whistleblower disclosures to OSC led to safer flights for airline passengers, including better maintenance of aging aircraft, the cancelation of unsafe flight patterns, and correcting safety hazards air traffic control towers. As a result, OSC has helped to avoid costly tragedies that could result in the loss of hundreds of lives and billions of dollars of economic loss.

In 2005, Hurricane Katrina cost the federal government $127 billion dollars. But that didn't stop the Army Corps of Engineers from attempting to install an untested and potentially flawed flood protection system when a more reliable and less expensive option was available. If a whistleblower had not come forward to OSC,

the same devastation could easily have recurred the next time a hurricane hits the Gulf Coast.

In the health area, OSC's efforts have led to better care for veterans at VA hospitals, including protecting patients in psychiatric treatment, ensuring that surgical instruments were actually sterilized, and doctors were not performing procedures for which they had no expertise.

OSC's accomplishments are due to the hard work of the dedicated career staff that serves the agency. However, it is no secret that prior to my arrival the agency was racked by controversy and had been without Senate-confirmed leadership for 2 ½ years. It will take time to re-build this agency, and it will take collaboration with each of the agency's stakeholders to do so.

Everyone in this room has a interest in OSC's successful enforcement of the good government laws. As we move forward, I want to hear from you about how OSC can best serve the public interest.

For the congressional staff in the room, I encourage you to work with my office, and to refer your constituent's disclosures or concerns about retaliation. We want to be a resource and make sure these claims are handled quickly and well.

Finally, while there is much to be done, there are some very real limits on what the OSC can actually do under the present law. OSC is currently hampered by court interpretations of the whistleblower law. These interpretations have narrowed the protections intended by Congress and also dissuade OSC from seeking disciplinary action against wrongdoers. We look forward to working closely with many of you as Congress considers legislation to strengthen the Whistleblower Protection Act.

A stronger whistleblower law will allow employees to feel safe when coming forward and speaking out in the public interest. While no system of whistleblower protection will be 100% fool-proof, there is no question that, in the absence of such protection, the public loses the benefit of the surest source of information about waste, fraud and abuse: the government employee with the integrity and courage to reveal it.

In closing, I want to again thank the organizers of this event for giving me the opportunity to speak today. I look forward to hearing from the other panelists, and taking your questions.

September 19, 2011 Speech at National Whistleblower Assembly

Introduction

Thank you for including me on your program today. It is an honor to be here.

Saturday will be my 100th day in my new role. So I am particularly pleased to be here talking with you today. There is much to be done and a lot to learn - - and I know this audience in particular will help get me educated!

In my brief remarks today, I want to tell you about my road to the Office of Special Counsel and share with you some of my goals for the OSC. It's no secret that the OSC has been through some tough times, and I expect that many of you may have some skepticism about whether the OSC can change - - whether things will be any different with new leadership. So I want to start by telling you a little about my background and the perspective that I bring to OSC, and then share with you some of my goals for my term.

Before I was appointed by President Obama, I was an employment lawyer for 20 years, and for the 14 years before I became Special Counsel, I was a partner at Heller, Huron, Chertkof, Lerner, Simon & Salzman, an employment and civil rights firm that I helped to found. The firm primarily represents individuals – both federal and private sector workers – in employment discrimination and civil rights actions. Coincidentally, the firm is also a floor above my current office in the same building as the OSC. So when I was asked to consider putting my hat in the ring for this position, I took its location as a sign that invigorating this important agency was my calling.

One of my most satisfying recent cases was that of Melodi Navab Safavi, an Iranian-Swedish American. Melodi was a contract translator for the Voice of America, the U.S. government radio

station overseas. She was also part of a rock band which made a music video opposing the Iraq War. For this, and this alone, Melodi lost her job with Voice of America. We took Melodi's case to Court alleging, among other things, First Amendment violations against the Government. After her termination, Melody suffered tremendously, both personally and financially. So, I am keenly aware of the effect government actions can have on a person's life. And, I am pleased to report that after several years of litigation, Melody's case was recently – and happily - resolved.

Perhaps because I am so familiar with the frustrations and limits of litigation, over the years I developed a strong interest in mediation. I have taught mediation at George Washington University Law School, been a volunteer mediator for the U.S. District Court and the EEOC, and frequently used mediation as an advocate in my individual cases.

Special Counsel's Goals, and Steps Being Taken to Improve OSC's Effectiveness

In my first three months as Special Counsel, I have spent a lot of time listening to the dedicated career staff and meeting with a wide range of OSC stakeholders. OSC is already taking concrete steps to implement some of the terrific suggestions we have received, and I anticipate that efforts to improve OSC's effectiveness will be an ongoing process. I want to share with you some of the priorities :

Increasing our Commitment to Protecting Whistleblowers. We will ensure that OSC vigorously investigates complaints of whistleblower reprisal. We will secure relief for whistleblowers. And at this time of fiscal crisis, our role has never been more important. In just the last two years, whistleblower disclosures to our office saved the government over eight million dollars. Government workers are in the best position to uncover fraud, waste and unsafe practices. Study

after study demonstrates that insiders - employees – are the single best source for identifying costly wrongdoing and harm. One recent study in the private sector showed that outside regulators and auditors uncovered corporate fraud in only one out of six cases. It is the people inside companies who are most likely to report fraud - - because they are the ones who know about it. And though these employees performed an important service, this same private sector study found that 80 percent of the whistleblowers regretted coming forward because of the negative consequences they suffered. This is a culture that must change.

As the open government community fully understands, whistleblowing is central to efforts to make large institutions more accountable by improving transparency. And the federal government should be setting the pace.

Public servants need to feel confident that they can speak out without fear of retaliation... and when they do, we must make sure that the government is held accountable for correcting any misconduct they uncover.

Creating an environment inside the government where open dialogue about problems is accepted – and indeed encouraged – is one of my primary goals as Special Counsel.

My team and I already have ramped up the number of OSC employees who work on complaints of whistleblower reprisals. This week OSC is launching a Retaliation Pilot Project that will focus on investigating and prosecuting whistleblower retaliation cases. Several of the attorneys in the project are being detailed from other units at OSC. The commitment of additional resources to whistleblower retaliation cases should help reduce the backlog of cases and secure relief for whistleblowers more quickly.

And though it's only been 3 months, we're already making a difference. Three quick examples:

- An auditor with a federal agency disclosed that managers had issued flawed audit reports of government contractors. As a result of OSC's findings, the agency granted the auditor full corrective action, and took disciplinary action against the auditor's managers.
- A supervisor at Customs and Border Protection suffered retaliation for disclosing misconduct, management neglect, and abuses of overtime pay. OSC obtained relief from the agency and the employee is now an integral part of the management team.
- A supervisory financial analyst with the U.S. Forest Service disclosed that the Chief Financial Officer had misused his government travel card and then the analyst was not selected for a promotion because of his whistleblowing. After OSC's investigation, the agency agreed to settle the case.

Making OSC More Accessible to Federal Employees Three decades after OSC was created, many federal employees are still unaware of who we are. I am determined to improve OSC's outreach to federal employees and to make OSC more accessible. One concrete step that we will take is revamping the website. We want to improve the website to be a better resource for federal employees about their rights. We want to make it easier to file complaints. Recently, GAP and POGO provided very helpful recommendations for improvements to OSC's website. I am grateful for those suggestions and look forward to implementing many of them.

Improving Customer Service OSC must do a better job communicating with whistleblowers and ensuring that whistleblowers are heard. To that end, we've instructed the examiners in our Complaint Examining Unit to contact complainants earlier in the complaint examination stage to explain OSC's process for processing complaints and to request additional information and documents from complainants. Similarly, when a case is assigned for a full investigation, the investigator or attorney will contact a complainant early in the investigation to solicit suggestions as to who should be interviewed and which documents OSC should obtain from the agency. During the investigative phase of a PPP case, our staff will ramp up efforts to update whistleblowers on the status of an investigation and will give them an opportunity to respond to an agency's explanation for a personnel action.

Expediting Case Processing and Prioritizing Complaints. Having represented employees for more than two decades, I know how frustrating it is to wait for an agency to complete an investigation or to encounter delays in litigation, especially where an employee is out of work or is suffering ongoing retaliation or discrimination. And from the perspective of protecting the merit system, it is critical to obtain relief on an expedited basis to mitigate the chilling effect of whistleblower reprisal

There are, however, significant resource constrains that hinder OSC's ability to process all cases on an expedited basis. In FY 2010, OSC handled over 2,400 complaints alleging prohibited personnel practices, a majority concerning reprisal for whistleblowing. We also have responsibility for whistleblower disclosures, as well as USERRRA and Hatch Act cases.

Faced with that reality, we are experimenting with ways to prioritize cases. For example, a whistleblower complaint entailing a severe personnel action, such as proposed removal, should

be processed more quickly than a complaint arising from a less severe personnel actions, such as a low performance evaluation. And a case in which OSC obtains a stay of a personnel action must be investigated on an expedited basis.

Indeed, one of my first acts as Special Counsel was to obtain a stay of the firing of federal whistleblower so that OSC would have an opportunity to investigate the matter.

Expanding OSC's ADR Program Early mediation can help complainants obtain relief on an expedited basis, avoiding costly and protracted litigation. And successful resolution of cases allows OSC to use its limited resources to investigate and litigate other cases. I am working to expand OSC's capability to mediate more cases so that OSC can offer mediation to most complainants at the beginning of an investigation.

So in closing, I reiterate to you that my mission at OSC is to make this public service agency all that it was intended to be. We will listen, we will assess, we will be timely, we will resolve cases with justice. But we've got a big mission, and we know we can't do it alone. We need each and every one of us to join us in this effort. So please work with us. And please be patient, as all this may take some time. Finally, thank you for what you do and have done to advance this same, larger cause. I look forward to working with you.

Remarks to Wednesday Morning Breakfast – December 7, 2011

Good morning. Thanks very much for inviting me – I'm delighted to be here.

I'm guessing that many of you may not know what the Office of Special Counsel is – not many people do – I think it's one of government's best kept secrets.

We are an independent, non-partisan agency. Our primary role is handling whistleblower complaints – both when government employees need to report waste, fraud and abuse – and when they suffer retaliation for doing so.

For example, you may have seen recent news coverage about our report on the Port Mortuary at Dover Air Force base. Whistleblowers told us about misconduct there, including lost body parts. As the Secretary of the Air Force has said, we never would have found out about these problems if the Whistleblowers hadn't come forward.

We also play an important cost-savings role. Disclosures to our agency have saved the government millions of dollars – and potentially saved many lives, as well. Whistleblowers are in the best position to expose waste and wrongdoing in government – but they often experience retaliation when they do. So, our agency's investigation and prosecution division handles those claims.

OSC also protects service members through USERRA. USERRA stands for the Uniformed Services Employment and Reemployment Rights Act – in plain speak it means we protect the job rights of members of the military and guard.

Finally, we are responsible for enforcing the Hatch Act. The Hatch Act was passed in 1939 and it still has an important role – it keeps partisan politics out of the civil service. But it is also clear that this Act needs to be reformed.

Right now, the Hatch Act reaches into state and local elections by prohibiting anyone from running for partisan political office if they are in any way – no matter how trivially – tied to a source of federal funds.

I'll give you a few examples:

Recently, OSC told a paramedic in North Carolina that he could not run for coroner because he drives an ambulance, and some of the patients he transports receive Medicaid.

In another case, we had to tell a Pennsylvania police officer in a canine unit that he was not eligible to run for his local school board because his partner, a black Labrador, is paid for with federal funding.

And when a Deputy Sheriff wants to run for Sheriff, most of the time they can't – because their jobs are funded - at least in part - with federal money.

These results are absurd. And I think it's improper for the federal gov't to tell state and local officials they can't run in a local election.

So, I have called on Congress to reform the Hatch Act. My proposed legislation fits on one page. It's easy to understand, we don't know of any opponents, and - - as I expect this audience will appreciate - - it won't cost taxpayers a single dime.

The legislation does two simple things: First, it removes the prohibition on partisan candidacy by state and local officials. This would demonstrate respect for the independence of state and local elections, and would allow qualified candidates to serve their communities. The National Sheriffs Association has made this type of reform one of its top priorities because of how frequently their members are affected.

Second, my proposal would change the penalty structure in federal Hatch Act cases. Currently, termination is the only penalty allowed, no matter how trivial the violation. This can lead to unjust results, and may even deter agencies from referring potential violations because they don't want an otherwise good employee to be fired.

So, in a nutshell, these are the key revisions we're hoping Congress will pass. We believe these reforms will have bi-partisan support. And we're hopeful that it's the type of good government legislation that has a chance of passing.

Thank you again for having me here today - and I'd be happy to take some questions.

CIGIE SPEECH FEB. 21, 2012

Good morning. I'm delighted to be here among colleagues who share many of my agency's goals.

I was asked to speak to you today about the changes taking place at my agency. I will touch on many of them but I want to focus on what I hope is a shared mission: changing the federal government's culture for whistleblowers. And I want to hear from you about how we can work in partnership on these and other questions. Finally, I've asked Catherine McMullen, Disclosure Unit Chief, to talk specifically about disclosure referrals.

I began my five-year term as Special Counsel just last June. As many of you may know, the Special Counsel is appointed by the President to a five-year term. Our agency is not affiliated with any other government entity – we are truly independent. I know this audience understands why that is important.

We have four divisions – you are familiar with our disclosure unit that handles whistleblower allegations of wrongdoing. And you are familiar with the unit that handles Prohibited Personnel Practices. But we wear two other hats as well: We enforce the Hatch Act – for which we receive thousands of complaints annually – and we enforce USERRA - the Uniformed Services Employment and Reemployment Rights Act – USERRA protects veterans and members of the Reserves and the Guard and we enforce their employment rights.

It's no secret that this agency has been through some tough times and we're working hard to reinvigorate it. I'll address some initiatives in more detail but first want to briefly list three: First, we are reaching out to various stakeholders, such as managers, good government groups, veterans' groups, and listening to their concerns. Second, I've called for Hatch Act reform and sent draft legislation to Congress. Too often this law has the arm of the federal government reaching into state and local races where it doesn't belong. Third, we're strengthening the alternative dispute resolution program at our agency. I don't know if you're experiencing the increase in disclosures that we are – in 2010, for the first time, OSC received over 1,000 whistleblower disclosures. A revitalized alternative

dispute resolution program will get better and quicker results for employees and agencies, and will allow us to resolve many cases without resource-intensive litigation.

Now, as I said in opening, I want to talk to you today mainly about the two divisions which are central to OSC's identity and original mission: that of listening to and protecting whistleblowers.

RENEWING OUR COMMITMENT TO PROTECTING WHISTLEBLOWERS.

When Congress passed the Civil Service Reform Act, OSC's primary mission was intended to be investigating and prosecuting complaints regarding prohibited personnel practices, with a special emphasis upon protecting whistleblowers against reprisal. The Senate report is worth quoting briefly:

> *In the vast federal bureaucracy it is not difficult to conceal wrongdoing provided that no one summons the courage to disclose the truth. Whenever misdeeds take place in a federal agency, there are employees who know that it has occurred, and who are outraged by it. What is needed is a means to assure them that they will not suffer if they help uncover and correct administrative abuses. What is needed is a means to protect the Pentagon employee who discloses billions of dollars in cost overruns, the GSA employee who discloses widespread fraud, and the nuclear engineer who questions the safety of certain nuclear plants. These conscientious civil servants deserve statutory protection rather than bureaucratic harassment and intimidation.*

At a time when our country is in a fiscal crisis, the role of the IGs and the OSC in listening to and protecting whistleblowers is crucial. Government workers are in the best position to uncover waste, fraud, and unsafe practices. Whistleblower disclosures have accounted for billions of dollars in recoveries for the US Treasury, including disclosures to IGs, as a recent GAO report highlighted.

Whistleblowers aren't *the* silver bullet that will eradicate all wrongdoing, but they are a silver bullet...and because they are already on the job, on the inside and in the know, they provide the biggest good government bang for the taxpayer buck. Indeed, studies show that employees detect and disclose more fraud than auditors, internal compliance officers, and law enforcement agencies combined.

Yet, employees are often wary of coming forward. A majority of OSC's whistleblowers report experiencing retaliation after they make a disclosure. This retaliation takes the form of geographic transfers, undesirable internal reassignments, bad performance reviews, and worse.

This culture must change. MSPB's November report on whistleblowing found that 35 percent of employees who observed wrongdoing did not report the activity. The same report urged agencies to make the cultural shift to *praising* whistleblowers. Helping to creating an environment inside the government where open dialogue about problems is accepted – and indeed encouraged – is one of my primary goals as Special Counsel.

One of the concrete steps I've taken to strengthen OSC's ability to protect whistleblowers is starting a **Retaliation Pilot Project**. The Project focuses more resources on investigating and prosecuting whistleblower retaliation cases. This project also provides a benefit to our staff, since it allows attorneys to be detailed for six months from other units at the agency to our Investigation & Prosecution Division. This project is already beginning to help reduce the backlog and get results for whistleblowers more quickly.

WORKING WITH IGs

At OSC, we feel fortunate to have the Inspectors General as our colleagues. We may not have glamorous titles but our role is truly significant – that of imagining the government at its finest and pushing the government to be a role model for efficiency, safety and the merit system.

Often, whistleblowers approach both an IG and the Office of Special Counsel. We work collectively to resolve their issue. Frequently, we refer disclosures to you. Whatever the mechanics of it, we aspire to work in

collaboration with Inspectors General to maximize our effectiveness and our influence.

It has been noted that OSC itself has no IG and no mechanism for our own employees to file complaints, should they need to. I wanted this audience to be the first to hear that we hope to collaborate with an IG at another agency. If all goes as hoped, our employees could go to that outside entity with any disclosures or prohibited personnel practices they needed to report. I'm fully aware that someone's got to be watching the watchdog and I welcome it.

Of all the stakeholders, this room holds probably our most important ones. We do and we must work hand in hand. So I want to thank you again for your service and collaboration and I urge you to come to me and my staff with ideas or problems. Our collective task is to address government inefficiency so we should aspire to be highly efficient ourselves in doing so!

Special Counsel Carolyn N. Lerner's Remarks to
Office of Inspector General, Department of Defense, May 21, 2012

Good afternoon. Thank you for the invitation to join you here today. I'm delighted to be here among colleagues who share so many of our goals. I expect we also share many of the same challenges – so we have a lot to learn from each other.

I'd like to introduce two people who are here with me today. Shirine Moazed, as many of you know, is the Washington Field Office Chief of our Investigation and Prosecution Division – OSC's division that handles Prohibited Personnel Practices, or PPPs. Shirine will talk with you about our process for handling those cases in a moment.

Jason Zuckerman is also here. Jason is our Senior Legal Counsel. He joined the Office of Special Counsel with me last summer. He left a partnership at a private practice specializing in whistleblower litigation, so our agency is very lucky to have him on board.

As mentioned, I started as Special Counsel last summer so I am still somewhat new to this community. I was surprised to find that so many federal employees were not even aware that our agency existed - and those who were aware of it didn't always have, shall I say, the most positive views about it.

So one of our greatest challenges this past year has been getting the word out - both that we exist and that we are, in many ways, a new OSC.

First a bit of background about OSC and what we've been up to this past year.

We are a small agency with several large missions:

First, we enforce the Hatch Act, a law meant to keep partisan politics out of the federal workplace and prevent those in political power from abusing their authority.

Earlier this year, I sent Congress proposed legislation to reform the Hatch Act. We hope to change it to allow state and local employees run for office. We also want to change the penalty structure. Right now, termination is the only penalty – unless the MSPB unanimously rules to mitigate it to a 30 day suspension. Happily, bills have been introduced in both the House and Senate, and last week we had a hearing in House. There is bi-partisan support – so we are very hopeful it can pass.

Second, we enforce the Uniformed Services Employment and Reemployment Rights Act (USERRA). In a nutshell, this law protects members of the military and the reserves from employment discrimination. This past year we've been particularly busy with USERRA cases, as more service members return from Iraq and Afghanistan.

Third, a new initiative we started this past fall is an Alternative Dispute Resolution Unit. My background as a litigator, mediator and professor of mediation before coming to OSC made me a strong proponent of ADR. And we're already seeing that we're able to get quicker and better results for both complainants and agencies without resource-intensive litigation. With dramatically increasing caseloads, this has been vital to our agency.

Fourth, the Unit with which you are probably most familiar is our Disclosure Unit, which receives whistleblower disclosures of waste, fraud, abuse, gross mismanagement or health or safety violations.

And finally, our Investigations and Prosecution Division receives complaints of prohibited personnel practices (PPPs), the majority of which involve retaliation.

When Congress created the Office of Special Counsel, its purpose was primarily to investigate and prosecute PPP complaints, with a special emphasis on protecting whistleblowers against reprisal.

The Senate report from 1978 is worth quoting briefly:

In the vast federal bureaucracy it is not difficult to conceal wrongdoing provided that no one summons the courage to disclose the truth. Whenever misdeeds take place in a federal agency, there are employees who know that it has occurred, and who are outraged by it. What is needed is a means to assure them that they will not suffer if they help uncover and correct administrative abuses. What is needed is a means to protect the Pentagon employee who discloses billions of dollars in cost overruns, the GSA employee who discloses widespread fraud, and the nuclear engineer who questions the safety of certain nuclear plants. These conscientious civil servants deserve statutory protection rather than bureaucratic harassment and intimidation.

At a time when our country is in a fiscal crisis, OSC's and the Inspectors Generals' role in protecting whistleblowers has never been more important.

There is no question that government workers are in the best position to uncover waste, fraud, and unsafe practices.Whistleblowers aren't the silver bullet that will eradicate all wrongdoing, but they are a silver bullet...and because they are already on the job, on the inside and in the know, they provide the biggest good government bang for the taxpayer buck.

Indeed, studies show that employees detect and disclose more fraud than auditors, internal compliance officers, and law enforcement agencies combined. Yet, employees are often wary of coming forward. Concerns about retaliation prevent many employees from reporting serious problems. And our agency has found that in a majority of cases, whistleblowers report experiencing retaliation after they make a disclosure to our agency.

Changing the culture for whistleblowers is crucial. I hope that during my tenure, OSC can strengthen its partnerships with IG offices to help effect this cultural change. Some possible ways that we can work in partnership:

First is Outreach – Providing robust protection to whistleblowers, especially in a chain of command environment, can be a challenge. So it's important to try to help organizations understand that it's in their interest to protect whistleblowers. This is a message that we can mutually reinforce and deliver in tandem.

On this note, I want to commend DOD OIG for its vigorous § 2302 certification effort. It is a model of how agencies should train employees about PPP's.

Second, we can share best practices. Our agency struggles under the weight of rising caseloads with inadequate resources to process them. Case screening is vitally important – we refer less than 10% of PPP complaints for investigation, and an even smaller percentage of disclosures to agencies for investigation. Sharing best practices with IG offices has the potential to help us both.

Third, OSC has the ability to bring a complaint for corrective action and/or disciplinary action when an agency believes that there is a clear violation but may not be able to take the appropriate action. You can always refer matters to us for additional action.

Fourth is training. We can help train DOD IG investigators about the legal standards that apply in WB reprisal claims. We also prepare regular updates on MSPB decisions and whistleblower law, and can share this expertise.

Finally, there is an ongoing need to educate folks on the Hill about how IG offices and OSC serve a vital purpose. Especially at a time when there's a lot of interest in cost-cutting at every agency, the value that we provide to the government needs to be communicated.

So to conclude: I know that offices such as yours and ours make the government stronger. I look forward to working with the DOD OIG & continuing our missions together.

June 27, 2012 Public Servant of the Year Award Presentation

Good afternoon. I'm Carolyn Lerner, and on behalf of the Office of Special Counsel, welcome. Thank you for joining staff from the OSC and me for the Public Servant of the Year award ceremony.

I want to extend a special welcome and thank you to the entire Delaware Congressional delegation – Senator Tom Carper, Senator Chris Coons, and Representative John Carney, all of whom you'll be hearing from shortly.

Several distinguished guests are here from the Air Force. Brigidier General Eden Murrie. I also want to extend a warm welcome to Col. John Devillier, the new Commander of Air Force Mortuary Affairs at Dover Air Force Base. Col. Devillier took time out of a very busy inspection schedule this week to join us, and we truly appreciate it. Finally, I'm delighted that so many from the whistleblower and good government community could join us today.

Before turning to Delaware Delegation, just a few remarks about the award we are giving today and the people who are receiving it.

I am often asked, who are whistleblowers, and why do they come forward. The answer is simple: Whistleblowers are patriots. They possess unusual courage. They come forward because they are driven by conscience. When they see something that is not right, they speak. They know they may be unpopular for it. They do it anyway. As citizens, we all depend upon the personal bravery and integrity of these government servants.

The OSC's Public Servant of the Year recognizes employees who have made an especially important contribution to our nation in the previous year.

The three people we honor today -- Bill Zwicharowski, Mary Ellen Spera and Jim Parsons -- had both courage and conscience. They put their personal interest at risk because they believed the public interest required it.

In this particular case of whistleblowing, the public interest was profound and poignant. Dover has a sacred place in American life. The Air Force rightly has the highest standards for how the remains of our fallen are handled. These three

individuals knew that these standards had slipped and that they needed to help try to remedy that.

By speaking, Bill Zwicharowski, Mary Ellen Spera and Jim Parsons allowed the Air Force to do right by our service members and their families. And to its credit, the Air Force ultimately responded by making the Port Mortuary stronger and better than it had been. It has also renewed its commitment to listen to employees who speak out. So today we also salute and thank the U.S. Air Force.

I'd now like to recognize Rep. John Carney. Rep. Carney is Delaware's lone representative in the United States House of Representatives. He is serving his first term in Congress after a distinguished career in public service in Delaware, including twice being elected Lieutenant Governor. On a more personal note, I greatly appreciated Rep. Carney's interest and feedback as we conducted our work on the Port Mortuary cases. Rep. Carney, thank you for being here today, and we look forward to your remarks.

[Remarks by Rep. Carney].

Thank you Rep. Carney. I'd now like to introduce Senator Christopher Coons. Senator Coons is in his first term in the United States Senate after a decade of public service in New Castle County government. As I learned in our discussions about the Port Mortuary whistleblower cases, Sen. Coons' experience in government has given him great insight on the importance of whistleblowers in making government work better. He also understands the unique challenges faced by whistleblowers after they have exposed waste, fraud, and abuse. Sen. Coons, thank you for taking the time to be with us today.

[Remarks by Sen. Coons.]

Thank you Sen. Coons. Last but not least, I'd like to introduce Sen. Tom Carper. Unlike Rep. Carney and Senator Coons, Senator Carper is not serving his first term in the United States Congress. Sen. Carper has had a remarkable career in public service in the state of Delaware, serving in the House of Representatives, as Governor, and of course now in the United States Senate. Along the way, Senator Carper has established himself as a leader in promoting government efficiency

and sound financial management of federal government resources. Senator Carper, as the senior member of the Delaware delegation, I thank you for hosting OSC and the other members for discussions on the Port Mortuary cases, and for your sage advice on these matters. Sen. Carper, we're honored to have you here today.

[Remarks by Sen. Carper]

Thank you Sen. Carper. Before presenting the Special Counsel's Public Servant Award to the three whistleblowers from Port Mortuary, I'd like to ask the OSC staff who worked so hard on these cases to join me at the podium. Catherine McMullen, Shirine Moazed, Jennifer Pennington, Elizabeth McMurray, and Anne Glass, can you please join me now.

I thank you for your tireless work on behalf of these individuals, and for your dedication to the mission of this agency. Ask that you join me in presenting the Special Counsel's Public Service Award to Bill Zwicharowski, Mary Ellen Spera and Jim Parsons. Would you please join me at the podium at this time.

Mr. Zwicharowski, Ms. Spera, and Mr. Parsons, on behalf of the Office of Special Counsel, and in recognition of the military families who will benefit from your courageous public service, I present you with the Special Counsel's Public Servant Award.

Mr. Zwicharowski, I understand you've been elected to deliver some remarks on behalf of the group.

[Remarks by Mr. Zwicharowski]

This concludes today's ceremony. I want to again thank all of you for joining us. Please enjoy some light refreshments.

January 15, 2013 Speech to Chief Human Capital Officers

Good morning and I am so pleased to appear before you today and am excited to work with you to educate employees about whistleblower protections and to prevent prohibited personnel practices.

While you are familiar with OSC, let me briefly describe our mission:

First, we investigate complaints of prohibited personnel practices (PPPs), including retaliation and unlawful hiring practices. Lately, OSC has experienced a very substantial increase in PPP complaints. Despite this mounting caseload, in FY 12, OSC nearly doubled its favorable outcomes over FY 11.

Second, we enforce the Hatch Act. Third, we enforce the Uniformed Services Employment and Reemployment Rights Act. This past year we've been particularly busy with USERRA cases, as more service members return from Iraq and Afghanistan.

Fourth, our Disclosure Unit receives whistleblower disclosures of waste, fraud, abuse, gross mismanagement or health or safety violations. OSC now receives over one thousand disclosure complaints from federal whistleblowers annually, which result in millions of dollars in direct returns to the government. One disclosure identified contracting irregularities which led to a $1.6 million reimbursement due to the Department of the Army. At the Department of Homeland Security, a whistleblower alerted OSC that employees were improperly paid Administratively Uncontrollable Overtime. By stopping these improper payments, the government saved approximately $2 million.

When Congress created the Office of Special Counsel, its purpose was primarily to investigate and prosecute PPP complaints, with a special emphasis on protecting whistleblowers against reprisal. The Senate report from 1978 is worth quoting briefly:

> In the vast federal bureaucracy it is not difficult to conceal wrongdoing provided that no one summons the courage to disclose the truth. Whenever misdeeds take place in a federal agency, there are employees who know that it has occurred, and who are outraged by it. What is needed is a means to assure them that they will not suffer if they help uncover and correct

> administrative abuses. What is needed is a means to protect the Pentagon employee who discloses billions of dollars in cost overruns, the GSA employee who discloses widespread fraud, and the nuclear engineer who questions the safety of certain nuclear plants. These conscientious civil servants deserve statutory protection rather than bureaucratic harassment and intimidation.

At a time when our country is in a fiscal crisis, OSC's role in protecting whistleblowers has never been more important. There is no question that government workers are in the best position to uncover waste, fraud, and unsafe practices. Whistleblowers aren't the silver bullet that will eradicate all wrongdoing, but they are a silver bullet...and because they are already on the job, on the inside and in the know, they provide the biggest good government bang for the taxpayer buck.

Indeed, studies show that employees detect and disclose more fraud than auditors, internal compliance officers, and law enforcement agencies combined. Yet, employees are often wary of coming forward. Concerns about retaliation prevent many employees from reporting serious problems. And our agency has found that in a majority of cases, whistleblowers report experiencing retaliation after they make a disclosure to our agency.

Protecting whistleblowers not only enables management to learn about wrongdoing, but it also improves employee engagement. A recent MSPB study titled Blowing the Whistle: Barriers to Federal Employees Making Disclosures found that 64.7 percent of employees who reported feeling that they could disclose wrongdoing without fear of reprisal can be characterized as "engaged" employees. In contrast, only 18.5 percent of employees who felt dissuaded from making a disclosure were engaged. Engaged employees have a heightened connection to their work, their organization, or the people they work for or with that causes them to produce better results for the organization. The greater an employee's engagement, the more likely it is that the employee will go above and beyond minimum requirements and expend discretionary effort to provide excellent performance.

Changing the culture for whistleblowers is crucial and today I am asking for your continued assistance in that endeavor. As many of you are aware, the head of each agency is required by statute to educate employees about the rights and remedies available to them under the PPP and whistleblower protection provisions of Title 5. Recently, Congress enacted the Whistleblower Protection Enhancement Act, which requires OIGs to educate employees about whistleblower rights and protections. I am excited to work with you and the Inspectors General to ensure that all federal employees are encouraged to disclose waste, fraud and abuse, and are informed of the rights and remedies afforded to whistleblowers.

Today I have brought a two-page pamphlet titled "Know Your Rights When Reporting Wrongs," which is a plain English description of whistleblower rights and protections. OSC would like to distribute this pamphlet to all federal employees. In particular, I am asking agencies to include this pamphlet in the materials provided to new employees and email it to existing employees. The pamphlet is posted on the outreach page on OSC's website, which is at www.osc.gov.

OSC is also working with OPM and Chief Learning Officers to enhance training on whistleblower protections and OSC has posted on its YouTube channel a video providing an overview of whistleblower rights and protections. In addition, I will be working with the Chief Learning Officers Council to expand training on whistleblower rights and protections.

Finally, I encourage you to learn more about OSC's 2302(c) Certification Program, a voluntary program to help meet the obligation to inform employees about PPPs and whistleblower rights. A description of the program is posted on the outreach page of our website.

So to conclude: I know that offices such as yours and ours make the government stronger. I look forward to working with you and thank you in advance for your assistance.

October 18, 2013 Remarks to National Employment Lawyers Association

Thank you to Julie Strandlie for organizing this panel. It's an honor to be here with Susan Grundmann, David Lopez and Beth Slavet. Also want to acknowledge the excellent paper that OSC's Senior Legal Counsel Jason Zuckerman put together. I encourage you to read it to get a much more detailed description of how OSC protects whistleblowers. May be able to use it as a guide to practicing before OSC.

Prior to my appointment as Special Counsel, I was in private practice for 20 years, primarily representing employees in discrimination and employment cases. Of course, I was a member of NELA – so I feel very at home being with you today.

Since most of you are familiar with OSC's whistleblower work, I want to begin by giving just a brief overview of all that our agency does - and the ways we may be able to assist your clients.

OSC has four primary mandates:

First, OSC enforces the Hatch Act. The Hatch Act keeps partisan politics out of the federal workplace. And it prevents those in political power from abusing their authority for political goals.

As you may know, OSC recently advocated for legislative changes to the Hatch Act. And last year, Congress passed the Hatch Act Modernization Act which now allows for a range of penalties – not just termination. This brings the penalty structure in line with other types of offenses, and will provide more fairness for federal workers in cases of violations.

We were also pleased that Congress made the law more democratic by giving State and Local government workers the ability to run for local office, something the Hatch Act previously restricted.

The Second law OSC enforces is the Uniformed Services Employment and Reemployment Rights Act (or USERRA).

USERRA prevents discrimination based on military or reserve status. In other words, an employee can't lose ground or be at a disadvantage in their civilian job because they were called up for active duty.

If you have clients who are members of the reserves or guard and are having problems at work, you might consider whether there is a USERRA claim available.

Our third area of responsibility is to provide a secure channel for federal workers to blow the whistle on waste, fraud or abuse – or health and safety issues. We do this through our Disclosure Unit – which plays a critical role in promoting better, safer, and more accountable government.

For example, this summer OSC highlighted problems at VA Hospitals around the country that are endangering patient care. These reports prompted congressional hearings and led to the VA taking remedial measures.

The Disclosure Unit often works hand in hand with employees in our investigation and prosecution division, which is responsible for carrying out our fourth and final mandate: protecting employees from retaliation and other prohibited personnel practices, or PPPs.

PPPs also include claims for sexual orientation discrimination, irregularities in the hiring and recruitment process, and other forms of prohibited employment practices.

Role of Whistleblowers

As we move out of the latest fiscal crisis, it's worth taking a moment to emphasize just how critical this function continues to be, and why this conference is so important. There is no question that government workers and other insiders are in the best position to uncover waste, fraud, and unsafe practices.

But we know that employees are often wary of coming forward. Concerns about retaliation prevent many employees from reporting waste, fraud, abuse, health or safety concerns.

That's where OSC comes in. Through effective enforcement of the Whistleblower Protection Act, we help to create an environment inside the government where employees feel confident stepping forward to disclose evidence of government waste and other problems.

Creating a culture that values whistleblowers has been one of my primary goals as Special Counsel, and will continue to be throughout my tenure.

With that overview, I'd like to move on quickly to the specific questions raised in this panel.

I was asked to talk about Challenges OSC Faces in Protecting Whistleblower's -

Our Number One Challenge is our Growing Caseload with a corresponding Shrinking Budget

Our overall caseload has skyrocketed since I've been in office. In 2012, for the first time, OSC received over 1000 disclosures. Last year it was 1150. The numbers have doubled from 5 years ago. This year we expect to receive even more.

Also in 2012, Congress passed the Whistleblower Protection Enhancement Act which gives OSC additional mandates and more responsibilities. The law expands the types of cases in which OSC can conduct a full investigation, which is a good thing - - but we're now required to do more without the resources to support it.

In the first quarter after the bill was passed, OSC had the highest number of PPP case filings in the agency's 35 year history. We have 50% more cases now than we did five years ago, while our operating budget is smaller than it was three years ago. This trend is not sustainable and it is definitely our biggest challenge.

You've also asked me to discuss Innovative Approaches we've taken to Combat Retaliation

With rising caseloads and shrinking staff, we have needed to be creative in our approach to protecting whistleblowers. There are several ways in which we are doing so:

First, shortly after I started, we created a Pilot Project to train more OSC employees in retaliation law and to shift more staff resources into PPP investigations. The Pilot Project was highly successful and we have the results to show for it. In 2012, we had the highest number of corrective actions on behalf of whistleblower in in the agency's history, and in FY13 we beat that number.

Second, in addition to putting more staff resources into retaliation cases, we are taking full advantage of all available tools, concentrating on seeking stays, both informal and formal. Our numbers in this critical area are also at all-time highs.

Third, at every opportunity we do outreach to educate agencies about emerging issues in whistleblower law to prevent PPP's from happening in the first place. Created brochure – Know Your Rights When Reporting Wrongs to be distributed to every federal employee.

We have also worked with OMB to remind agencies about the prohibition on retaliatory surveillance or email monitoring, and the improper use of non-disclosure agreements.

Finally, we are focusing on alternative dispute resolution. I have long been a proponent of alternative dispute resolution - used it in private practice, taught it as professor at GW Law School, used it as a mediator for the US Courts. There is no question that mediation can get both better and quicker results for employees and agencies. OSC also benefits, allowing us to resolve many cases without resource-intensive litigation. It's also effective – 100% of USERRA cases mediated have settled and the settlement rate for PPP's is about 60%.

We've also been asked to discuss trends in protecting whistleblowers.

I earlier mentioned the Whistleblower Protection Enhancement Act – The WPEA eliminates obstacles to full enforcement of whistleblower law – and we want to keep it that way. After a 10-year struggle, it is critical that OSC play an active role in preserving the boundaries of the law that were established by the WPEA.

As Congress has instructed, we'll pursue disciplinary action prosecutions in appropriate cases– an integral aspect in deterring retaliation.

And, we will continue to use our new ability to file amicus briefs in important cases that may impact the scope of whistleblower protections.

Finally, we'll continue our education and outreach efforts to make sure that agency managers and employees understand their rights and responsibilities under the law.

CONCLUSION

The work OSC does – listening to employees when they report wrongdoing and working to correct it – makes the government stronger. Your representation of courageous government workers is an integral part of this process and I thank you for working with our office. I look forward to your questions.

December 5, 2013 Remarks to FAC-OSHA

Good afternoon. Thank you for inviting me to speak about whistleblower protections for federal employees. I'd like to first give you an overview of the Office of Special Counsel (OSC). I know we are still a bit of an unknown for many folks in the federal community. I will then talk about some best practices you can take back with you to your workplaces.

OSC is a small, independent federal agency. We have four divisions. First, we investigate complaints of prohibited personnel practices (PPPs), including retaliation and unlawful hiring practices. Second, we enforce the Hatch Act. Third, we enforce Uniformed Services Employment & Reemployment Rights Act. Fourth, and I believe the main topic of interest for today, is our Disclosure Unit.

The Disclosure Unit receives whistleblower disclosures of waste, fraud, abuse, gross mismanagement or health or safety violations. OSC now receives over one thousand disclosure complaints from federal whistleblowers annually.

We've had a number of prominent disclosure cases in the last couple years. Most recently, we reported on a significant case regarding the abuse of a type of overtime at DHS. Ten of millions of dollars of improper overtime are at issue.

This past spring we reported on five separate disclosures from the Jackson, Mississippi Veterans Affairs hospital. These disclosures included issues with improper sterilization of surgical instruments, failure to properly read radiology images or to inform the patients of this failure, prescribing narcotics in violation of state and federal law, and more.

We've also had prominent cases involving the mishandling of human remains at the Dover mortuary, and of problems within the Federal Aviation Administration.

And as may be of special interest to the OSHA community, we often receive disclosures involving workplace safety issues. Disclosures have included everything from harmful exposure to asbestos, legionella and radiation - - to unsafe bus fleets and boiler plants.

When Congress created the Office of Special Counsel, its primary purpose was to protect whistleblowers from retaliation. The Senate report from 1978 is worth quoting briefly:

> In the vast federal bureaucracy it is not difficult to conceal wrongdoing provided that no one summons the courage to disclose the truth. Whenever misdeeds take place in a federal agency, there are employees who know that it has occurred, and who are outraged by it. What is needed is a means to assure them that they will not suffer if they help uncover and correct administrative abuses. What is needed is a means to protect the Pentagon employee who discloses billions of dollars in cost overruns, the GSA employee who discloses widespread fraud, and the nuclear engineer who questions the safety of certain nuclear plants. These conscientious civil servants deserve statutory protection rather than bureaucratic harassment and intimidation.

There is no question that government workers are in the best position to uncover waste, fraud, and unsafe practices. Whistleblowers are vital because they are already on the job, on the inside and in the know. But we also know that much goes unreported, since employees are often wary of coming forward because of concerns about retaliation. Indeed, studies have found that in a majority of cases, whistleblowers report experiencing retaliation after they make a disclosure.

So, changing the culture for whistleblowers is crucial. Employees need to know their rights to make disclosures, and managers need to understand their responsibilities.

How best to do that? Here are some steps you and your agencies can take to implement best practices that will help create and reinforce a positive culture for whistleblowers:

First, become certified. OSC's 2302(c) Certification Program, a voluntary program to help meet the obligation to inform employees about PPPs and whistleblower rights. A description of the program is posted on the outreach page of our website. OSC will certify an agency's compliance with this statutory obligation if they do five things:

1. Place informational posters in agency facilities
2. Provide whistleblower information during new employee orientation
3. Provide whistleblower information to current employees
4. Train supervisors
5. Link OSC website on their website

Second, and related to the Certification process, make sure employees are being educated about their rights and remedies.

As many of you are aware, the head of each agency is required by statute to educate employees about the rights and remedies available to them under Title 5. Similarly, Congress recently enacted the Whistleblower Protection Enhancement Act, which requires OIGs to educate employees about whistleblower rights and protections - -and have an Ombudsman available as a resource for employees. Employees should know about the Ombudsman, and the IG office should be a source of information and support for employees and managers.

Third, work with OSC by distributing pamphlets and posters in your workplaces.

Today I have brought a two-page pamphlet titled "Know Your Rights When Reporting Wrongs," which is a plain English description of whistleblower rights and protections. We want to distribute this pamphlet to all federal employees. In particular, I am asking agencies to include this pamphlet in the materials provided to new employees and email it to existing employees. The pamphlet is posted on the outreach page on OSC's website, which is at www.osc.gov.

OSC is also working with OPM and Chief Learning Officers to enhance training on whistleblower protections and OSC has posted on its YouTube channel a video providing an overview of whistleblower rights and protections.

Fourth, make sure your workplaces are implementing appropriate non-disclosure policies.

Last year, we were notified that some departments and agencies were monitoring their employees' computer files, emails and other communications. While there

is no prohibition on monitoring per se, if it is done after an employee makes a protected disclosure, or in a targeted way, it could raise concerns about retaliation. It also undermines an employee's ability to make confidential disclosures.

In 2012, we issued a memorandum on this issue, which OMB distributed to all Executive Departments and Agencies. It explains that departments and agencies should carefully evaluate their monitoring policies and practices and take steps to insure employees are not being improperly targeted.

Fifth and finally, talk frequently with employees about the value of their observations and **let them know their communications are both protected and appreciated**.

When disclosures become valued for what they are - - sincere efforts to make our government work better and safer - - we will all benefit.

So to conclude, I look forward to working with you and thank you in advance for your assistance. I'm happy to take questions or to discuss any of these matters at greater length.

SPEECH TO EEO OFFICERS 1-14-14

Good morning.

Thank you Chair Berrien for your kind introduction and to Carlton Hadden for inviting me to be with you this morning.

I'm delighted to be here to discuss the important work our agencies collectively do in helping ensure fair employment practices for federal employees.

The role of agency EEO offices is so critical to this mission -- and our agencies are so closely aligned in protecting employment rights of federal workers. In fact, Chair Berrien and I will be signing a new Memorandum of Understanding this morning to formalize our partnership in enforcing findings of discrimination.

But before I talk about that new MOU and our areas of overlapping jurisdiction, I'd like to spend a few minutes describing the Office of Special Counsel more generally, as you are the folks who are often in the best position to refer matters to us for review.

Many federal employees still are not aware that OSC exists – or if they have heard of us they don't really know what we do. While OSC is often thought of as the agency that protects whistleblowers, our mandate is a bit broader:

We investigate complaints of prohibited personnel practices (PPPs), including retaliation, unlawful hiring practices and sexual orientation discrimination.

Second, we enforce the Hatch Act, which exists to keep partisan politics out of the federal workforce.

Third, we enforce the Uniformed Services Employment and Reemployment Rights Act. This past year we've been particularly busy with USERRA cases, as more service members return from Iraq and Afghanistan.

Fourth, our Disclosure Unit receives whistleblower disclosures of waste, fraud, abuse, gross mismanagement or health or safety violations.

I want to focus on the two areas that are probably most significant for you as EEO officers – first, disclosures of government wrongdoing and second, prohibited personnel practices, including discrimination on the basis of sexual orientation.

Starting with Disclosures - -

OSC receives over one thousand disclosure complaints from federal whistleblowers annually, which result in millions of dollars in direct returns to the government.

For example: One disclosure identified contracting irregularities which led to over a $1 million reimbursement due to the Department of the Army. At the Department of Homeland Security, a whistleblower alerted OSC that employees were improperly paid Administratively Uncontrollable Overtime. By stopping these improper payments, the government saved approximately $2 million. We have since heard from many more DHS whistleblowers about the same issue – Congress currently holding hearings to determine how to fix problem.

At a time when our country is in a fiscal crisis, OSC's role in protecting whistleblowers has never been more important. There is no question that government workers are in the best position to uncover waste, fraud, and unsafe practices. And because they are already on the job, on the inside and in the know, they provide the biggest good government bang for the taxpayer buck. Indeed, studies show that employees detect and disclose more fraud than auditors, internal compliance officers, and law enforcement agencies combined.

PPPs – ESPECIALLY B1s AND B10s

But despite the incredible importance of whistleblowers, many employees are often wary of coming forward because they are worried about retaliation. And, in fact, our agency has found that in a majority of cases, whistleblowers report experiencing retaliation after they make a disclosure to our agency - - which is perhaps a phenomena you are also familiar with when ee's come to you with discrimination complaints.

It is worth it for agencies to help prevent retaliation when employees come forward. Protecting whistleblowers not only enables management to learn about wrongdoing, but it also improves employee engagement.

A recent MSPB study titled Blowing the Whistle: Barriers to Federal Employees Making Disclosures found that 64% of employees who reported feeling that they could disclose wrongdoing without fear of reprisal can be characterized as "engaged" employees. In contrast, only 18% of employees who felt dissuaded from making a disclosure were engaged.

Engaged employees have a heightened connection to their work, their organization, and the people they work for. The greater an employee's engagement, the more likely it is that the employee will go above and beyond minimum requirements and provide excellent performance. So everyone wins when agencies create an environment that is open to employee reports of wrongdoing.

In addition to retaliation, I want to touch on two other prohibited practices because they are of particular importance when it comes to the relationship between my agency and the EEOC.

These PPPs are various types of discrimination covered by section 2302(b) of Title 5 of the U.S. Code. B1 of that section prohibits "illegal discrimination for or against any employee/applicant"

OSC has jurisdiction over these cases, but given the overlapping jurisdiction with the EEOC, most of the time OSC defers to EEOC, with two exceptions:

1. When discrimination is based on marital status and political affiliation since these types of discrimination are not covered in Title VII; and

2. A case in which the action of the subject official or officials is so egregious that it may be worthy of a stay or disciplinary action. Examples might be sexual harassment or excessive inappropriate conduct.

Part of the reason we would keep these cases is that we are able to do things EEOC can't: OSC can get a stay from the MSPB. We can also prosecute wrongdoers to impose disciplinary action. In addition, as you know EEO claims have a 45- day time limit. But, OSC does not have a statute of limitations.

Related to OSC's Ability to Prosecute EEO Matters, today the EEOC and OSC are re-entering into a memorandum of understanding regarding enforcement and disciplinary actions. In discrimination cases under Title VII, the Americans with Disabilities Act, Fair Labor Standards Act, or Rehab Act, the EEOC can refer the case to OSC so that we can pursue disciplinary or enforcement actions.

These referrals can happen when an agency refuses to comply with the Commission's order, and take appropriate remedial or disciplinary action.

In those situations, our Investigation and Prosecution Division will investigate the matter [under 5 U.S.C. 1214 or 1216] and determine if there is a basis for

initiating disciplinary action [under 1215]. If so, we can prosecute the case before the MSPB.

5 U.S. Code 2302 (b)(10) -- SEXUAL ORIENTATION DISCRIMINATION

The second PPP where there is significant overlap with EEOC is under 5 U.S. Code 2302b(10), which prohibits discrimination "on the basis of conduct which does not adversely affect the performance of the employee or applicant or the performance of others."

This PPP protects federal employees in the conduct of their private lives without the threat of discrimination when their personal conduct is unrelated to their job performance.

So, for example, before removing an employee based on off-duty conduct, the government must determine both that the employee actually committed the conduct complained of and that removal based on that conduct will promote the efficiency of the service.

Discrimination based on sexual orientation or gender identity discrimination is antithetical to the core merit system principle that employees should be judged by the work they do, not by who they are.

The EEOC may also have jurisdiction over claims of sexual orientation discrimination, such as a claim of discrimination for failing to conform to a gender stereotype.

The EEOC's April 2012 decision in Macy clarifies that "intentional discrimination against a transgender individual because that person is transgender is, by definition, discrimination 'based on . . . sex,' and such discrimination therefore violates Title VII."

Where an employee's claim is limited to sexual orientation discrimination (and not gender stereotyping), OSC is likely a better option that the EEO process.

And, as mentioned, OSC can seek a stay of a personnel action and can pursue disciplinary action against a supervisor or manager who engaged in a PPP.

All of this can be fairly complicated. And we know that federal employees often have a hard time understanding their rights and remedies – and knowing where to go with a claim.

My sense is that many file EEO complaints even when the Office of Special Counsel might be the more appropriate venue.

So, in closing, I'd like to ask that you help OSC get the word out, both about whistleblower rights AND the ways that we work with the EEOC.

Today I have brought a two-page pamphlet titled "Know Your Rights When Reporting Wrongs," which is a plain English description of whistleblower rights and protections. OSC would like to distribute this pamphlet to all federal employees.

In particular, I am asking agencies to include this pamphlet in the materials provided to new employees and email it to existing employees. The pamphlet is posted on the outreach page on OSC's website, which is at www.osc.gov.

We have a video on our YouTube channel providing an overview of whistleblower rights and protections.

Finally, I encourage you to learn more about OSC's 2302(c) Certification Program, a voluntary program to help meet the obligation to inform employees about PPPs and whistleblower rights. A description of the program is posted on the outreach page of our website, but it's a fairly 5 step program – includes posting informational posters, providing information about PPPs to new and current employees; training supervisors on PPPs and displaying a link to OSC's website on the agency's website.

So to conclude: I know that offices such as yours and ours make the government stronger. I look forward to working with you and thank you in advance for your assistance.

December 3, 2014 Public Servant of the Year Awards Ceremony

Good morning. I'm Carolyn Lerner, and on behalf of the Office of Special Counsel, welcome. Thank you for joining all of us at OSC for the Public Servant of the Year award ceremony.

I want to extend a special welcome and thank you to the VA's Deputy Secretary, Sloan Gibson, and the Chairman of the House Veterans Affairs Committee, Jeff Miller. You'll be hearing from them both shortly.

I'm also delighted that so many from the veteran's advocacy and good government community could join us.

A few remarks about the award we are giving today and the people who are receiving it.

I have the honor of leading a federal agency that has a crucial mission: The Office of Special Counsel protects government employees who report deficiencies in their workplace – issues of waste, fraud, abuse, and threats to public health and safety. Issues that - once corrected - will make our government better and our country safer.

I am often asked, who are whistleblowers, and why do they come forward. My answer is simple: Whistleblowers are patriots. They possess unusual courage. They come forward because they are driven by conscience. When they see something that is not right, they speak. They know they may be unpopular for it. They do it anyway. As citizens, we all depend upon the personal bravery and integrity of these conscientious public servants.

The OSC's Public Servant of the Year recognizes employees who have made an especially important contribution to our nation in the previous year.

The three people we honor today -- Doctors Katherine Mitchell,

Charles Sherwood, and Phyllis Hollenbeck -- had both courage and conscience. They put their personal interest aside because they believed the public interest required it.

By speaking up, Doctors Mitchell, Sherwood, and Hollenbeck turned the public spotlight on serious threats to patient health and safety at the Phoenix and Jackson, Mississippi VA Medical Centers. Because of their efforts, Veterans seeking care are now far more likely to receive the treatment they deserve.

As you all know, they are part of a much larger group of whistleblowers who have contributed to much needed reforms at the Veterans Health Administration.

And although there is still much work that needs to be done, the new leadership at the VA has swiftly taken corrective actions to improve access to care and to hold individuals accountable for causing these problems.

The VA has also renewed its commitment to listen to employees who speak out. So today we also acknowledge and thank the VA.

I'd now like to introduce the Chairman of the House Committee on Veterans Affairs, Congressman Jeff Miller. Chairman Miller is serving his eighth term as the representative for the 1st congressional district in Florida. He is a champion for veterans and has been a pivotal voice in spotlighting the concerns raised by VA whistleblowers.

Chairman Miller has doggedly sought and continues to seek accountability within the VA. We are honored that he has taken time from his busy schedule to be with us today.

I'd now like to recognize VA Deputy Secretary Sloan Gibson. Deputy Secretary Gibson served as President and CEO of the USO for five years. He is a veteran, graduating from West Point in 1975.

Deputy Secretary Gibson has been an important force for change within the VA and was Acting Secretary before Secretary Robert McDonald took the helm.

As both Acting Secretary and Deputy Secretary, Gibson has made strong statements making it clear that whistleblowers should be protected. Both he and Secretary McDonald have helped to change the tone towards whistleblowers – recognizing their value to the VA.

On a more personal note, I greatly appreciated Deputy Secretary Gibson's willingness to work with us at OSC as we continue progress on a large number of VA disclosure and retaliations cases. Deputy Secretary Gibson, thank you for being here today, and we look forward to your remarks.

Before Principal Deputy Special Counsel Mark Cohen presents the Special Counsel's Public Servant Award to the three whistleblowers from the VA, I'd like to recognize some of the OSC staff who worked so hard on these cases.

Catherine McMullen, Siobhan Bradley Smith, John Young, Sarah Black, Eric Bachman, Jane Juliano, Liz Brown, and Barbara Wheeler -- thank you for your tireless work on behalf of these courageous individuals, and for your dedication to the mission of this agency.

I ask that you join me in presenting the Special Counsel's Public Service Award to Katherine Mitchell, Charles Sherwood, and Phyllis Hollenbeck. Would you please join me at the podium at this time?

Mark will now introduce the whistleblowers.

UNITED STATES OFFICE OF
GOVERNMENT ETHICS

OCT 16 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Carolyn N. Lerner, who has been nominated by President Obama for the position of Special Counsel, Office of Special Counsel.

We have reviewed the report and have obtained advice from the agency concerning any possible conflict in light of its functions and the nominee's proposed duties. Also enclosed is an ethics agreement outlining the actions that the nominee will undertake to avoid conflicts of interest. Unless a date for compliance is indicated in the ethics agreement, the nominee must fully comply within three months of confirmation with any action specified in the ethics agreement.

Based thereon, we believe that this nominee is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,

David J. Apol
General Counsel

Enclosures REDACTED

October 9, 2015

Ms. Lisa V. Terry
General Counsel and
Designated Agency Ethics Official
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, DC 20036-4505

Dear Ms. Terry:

The purpose of this letter is to describe the steps that I will take to avoid any actual or apparent conflict of interest in the event that I am confirmed for the position of Special Counsel of the U.S. Office of Special Counsel.

As required by 18 U.S.C. § 208(a), I will not participate personally and substantially in any particular matter in which I know that I have a financial interest directly and predictably affected by the matter, or in which I know that a person whose interests are imputed to me has a financial interest directly and predictably affected by the matter, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. § 208(b)(2). I understand that the interests of the following persons are imputed to me: any spouse or minor child of mine; any general partner of a partnership in which I am a limited or general partner; any organization in which I serve as officer, director, trustee, general partner or employee; and any person or organization with which I am negotiating or have an arrangement concerning prospective employment.

Following confirmation I will retain my position as Trustee of a trust that was established under my late mother's will. I will not receive any fees for the services that I provide as Trustee during my appointment to the position of Special Counsel. I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the trust, unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1), or qualify for a regulatory exemption, pursuant to 18 U.S.C. §208(b)(2).

My spouse is currently a partner at the law firm of Zuckerman Spaeder, LLP. For as long as my spouse continues to work for Zuckerman, Spaeder, LLP., I will not participate personally and substantially in any particular matter that to my knowledge has a direct and predictable effect on the financial interests of the firm unless I first obtain a written waiver, pursuant to 18 U.S.C. § 208(b)(1). I also will not participate personally and substantially in any particular matter involving specific parties in which I know a client of my spouse is a party or represents a party, unless I am first authorized pursuant to 5 C.F.R. § 2635.502(d). In addition, for the duration of my appointment to the position of Special Counsel, my spouse has agreed not to communicate with the Office of Special Counsel on behalf of the firm or any client.

I understand that as an appointee I must continue to abide by the Ethics Pledge (Executive Order No. 13490) that I previously signed and that I will be bound by the requirements and

restrictions therein in addition to the commitments I have made in this and any other ethics agreement.

I have been advised that this ethics agreement will be posted publicly, consistent with 5 U.S.C. § 552, on the website of the U.S. Office of Government Ethics with ethics agreements of other Presidential nominees who file public financial disclosure reports.

Sincerely,

Carolyn N. Lerner

U.S. Senate Committee on Homeland Security and Governmental Affairs
Pre-hearing Questionnaire
For the Nomination of Carolyn Lerner to be
Special Counsel, Office of Special Counsel

I. Nomination Process and Conflicts of Interest

1. **Why do you believe the President nominated you to serve another term as Special Counsel for the Office of Special Counsel (OSC)?**

I believe the President nominated me to serve another term as Special Counsel based on my background and experience and because of my successful tenure at the Office of Special Counsel (OSC). Over the past four years, I have reinvigorated OSC after a difficult period for the agency.

By any statistical measure, OSC is now operating more efficiently and effectively than at any time in its history. Our results in individual, high impact cases demonstrate this office's ability to promote better and more efficient government. For example, our work with whistleblowers has prompted improvements at VA medical centers across the country, saved hundreds of millions of dollars in overtime payments at the Department of Homeland Security, and helped the Air Force better fulfill its sacred mission on behalf of fallen service members and their families.

2. **Were any conditions, expressed or implied, attached to your nomination? If so, please explain.**

There were no conditions, expressed or implied, attached to my nomination.

3. **If confirmed, are there any issues from which you may have to recuse or disqualify yourself because of a conflict of interest or the appearance of a conflict of interest? If so, please explain the procedures and/or criteria that you will use to carry out such a recusal or disqualification.**

In connection with the nomination process, I have consulted with OSC's General Counsel, who also serves as the Designated Agency Ethics Official to identify potential conflicts of interest. Any potential conflicts of interest will be resolved in accordance with the terms of an ethics agreement that I have entered into with OSC and that has been provided to the Committee. I am not aware of any other potential conflicts of interest.

4. **Have you made any commitments with respect to the policies and principles you will attempt to implement in another term as Special Counsel? If so, what are they, and to whom were the commitments made?**

I have not made any commitments with respect to the policies and principles I will attempt to implement in another term as Special Counsel.

II. Role and Responsibilities of the Special Counsel

5. What lessons have you learned in your first term as Special Counsel, and how will you apply those if you are confirmed?

Given the tremendous increase in OSC's caseload, I have learned that it is crucial to create efficiencies in our operations. Over the past four years, demand for OSC's services has far exceeded our small agency's resources. In response, we have found new and more efficient ways to approach resource management and increasing caseloads.

By taking the steps summarized below, I reduced OSC's cost to resolve a case by 45%, leading to record levels of productivity. In 2015, OSC resolved over 6,000 cases, a 55% increase from the year before I took office. At the same time, we increased effectiveness; the number of favorable actions on behalf of whistleblowers increased from 29 in 2007 to 268 in 2015.

My efforts to promote greater efficiencies have been large and small. I have focused on being a careful steward of taxpayer dollars and found better ways to manage our cases. For example, to avoid increased rent payments, we converted our library, which was largely underutilized, into workspaces for interns and new employees. I also discontinued or modified inefficient contracts. I switched our legal research provider and generated savings of nearly $50,000 annually. I discontinued outdated and unnecessary subscription services and saved an additional $32,000 annually. These types of savings add up in an agency of our size.

I have also implemented several policy initiatives to better manage our caseload.

First, I reinvigorated our alternative dispute resolution program. Mediation saves OSC, the employee, and the agency time and resources, while often resulting in better solutions for complainants and agencies alike. Advocates for whistleblowers and agency counsel have praised OSC's mediation program and its ability to bring about effective results. In recent testimony before this Committee, Government Accountability Project (GAP) Legal Director Tom Devine praised "[OSC's] re-birth of an Alternative Dispute Resolution (ADR) system that has set the global gold standard for effective results constructively resolving whistleblower disputes."

In addition, I have initiated new and innovative approaches to managing OSC's caseload. For example, I recently established a new project, the Retaliation and Disclosure Team (RDT), which implements a common sense and more efficient model for handling whistleblower cases. OSC's historical practice has been to assign several attorneys to review the same set of facts in cases in which an employee files both a whistleblower disclosure and a retaliation complaint. From an agency resources perspective, this is inefficient. The RDT model consolidates four OSC positions: intake examiner, disclosure attorney, investigative attorney, and mediator. It collapses the

process while producing better results, as one attorney has full access to the universe of case-related material, as opposed to having to track down another attorney's case file and piece together relevant information. The model also develops a highly skilled and cross-trained team of attorneys who are flexible to meet agency needs.

If confirmed for a second term, I will continue to look for ways in which OSC can be more efficient and effective.

6. **What is your view of the role of the Special Counsel and the OSC, and how, if at all, has that view changed after leading that office since 2011?**

The Special Counsel and OSC play a critical role in improving government and promoting accountability. After leading the office since 2011, I now fully appreciate its potential impact.

We have managed to generate the efficiencies described above without compromising the quality or effectiveness of OSC's work. For example, when evaluating the most important statistic for OSC – the number of favorable actions on behalf of whistleblowers and the merit system – we have consistently set records. In fact, in each year since my arrival, OSC has set a new record. In 2015, we secured 268 favorable actions for whistleblowers and other employees, up from 201 favorable actions in 2014. Prior to my tenure, the number of favorable actions had dropped to 29, and this total had never exceeded 100 in the agency's 35-year history. These "victories" for whistleblowers include reinstatement, back pay, and other remedies, such as stays of improper removals or reassignments, and disciplinary actions against those who retaliate. These actions are a key measure of OSC's success. Helping courageous public servants maintain successful careers after facing retaliation is a central role of the Special Counsel and OSC.

While I am proud of these accomplishments, our numbers don't tell the whole story. Statistics cannot capture the true impact and value of OSC's work. Our efforts to support whistleblowers often improve lives and spark reforms that prevent wasteful, inefficient, or unsafe practices.

For example, early in my tenure, whistleblowers at the Air Force's Port Mortuary in Dover, Delaware disclosed misconduct regarding the improper handling of human remains of fallen service members. After OSC reviewed the allegations and made recommendations, the Air Force took important, wide-scale corrective action. OSC's work helped to ensure that problems were identified and corrected, and the Air Force is now better able to uphold its sacred mission on behalf of fallen service members and their families.

In addition, OSC's work with whistleblowers at the Department of Homeland Security (DHS) exposed the department's longstanding failure to manage hundreds of millions of dollars in annual overtime payments. The lack of adequate safeguards in these overtime payments resulted in a significant waste of taxpayer dollars over many years. Repeated

investigations in response to OSC referrals confirmed that overtime payments were routinely provided to individuals who were not eligible to receive them. This work resulted in a series of reforms within DHS, multiple congressional hearings, and bipartisan support for legislation to revise the pay system for Border Patrol agents that will result in $100 million in annual cost savings at the Department of Homeland Security—an amount roughly five times the size of OSC's annual budget.

OSC's work with VA whistleblowers has improved the quality of care for veterans throughout the country and promoted accountability. For example, our reports prompted significant improvements in cardiology care at the Hines VA Medical Center in Chicago and also generated critical changes to the quality of training for triage nurses at the Phoenix VA medical center. In a report to the President and Congress last year, I documented severe shortcomings in VA internal investigations of threats to patient care at VA hospitals throughout the country. This led to an overhaul of the VA's internal medical oversight office, as well as other systemic changes at the VA.

In addition to our casework, OSC has worked with Congress to promote better and more efficient government. As an example, when I arrived at OSC, I reviewed each of our program areas, including OSC's Hatch Act program. I quickly realized the overreach of this otherwise important federal law. At its best, the Hatch Act keeps partisan politics out of the public workplace and prevents those in political power from abusing their authority to advance partisan political causes. This aspect of the Hatch Act must be vigorously enforced.

Nevertheless, I also realized that the Hatch Act was forcing my office, and thereby, the federal government to unnecessarily interfere with state and local elections hundreds of times each year. In response my legislative proposal, Senators Mike Lee and Daniel Akaka introduced and passed the Hatch Act Modernization Act of 2012. The Act promoted good government, demonstrated respect for the independence of states and localities, and has allowed OSC to better allocate its scarce resources toward more effective enforcement of the Hatch Act and other program areas. If confirmed, I will continue to look for opportunities to partner with Congress.

7. **Using your experience since becoming Special Counsel in 2011, how would you describe the respective roles of the OSC, Merit Systems Protection Board, Equal Employment Opportunity Commission, and the Office of Personnel Management in dealing with prohibited personnel practices, and are there any recommendations you would make to streamline and reduce duplication within the whistleblower/appeal processes?**

OSC, the Equal Employment Opportunity Commission, the Merit Systems Protection Board (MSPB) and Office of Personnel Management (OPM) each have distinct roles in dealing with prohibited personnel practices.

OSC investigates allegations of prohibited personnel practices and has the authority to litigate these cases before the MSPB.

Discrimination based on race, color, religion, sex, national origin, age, or handicapping condition is a prohibited personnel practice that OSC has jurisdiction to enforce. However, Congress did not intend that OSC duplicate the procedures established in the agencies and the Equal Employment Opportunity Commission (EEOC) for resolving such discrimination complaints. Therefore, it is OSC's general policy, with exceptions for particularly egregious allegations, not to take action on such allegations of discrimination as they are more appropriately resolved through the EEO process.

When employees file multiple complaints involving retaliation and discrimination, OSC has streamlined the process, creating efficiencies for agencies and employees, by frequently facilitating global settlements in appropriate cases of both EEO and reprisal complaints. This saves agencies, the EEOC, and OSC time and resources.

The Office of Personnel Management (OPM) refers to OSC allegations of prohibited personnel practices that arise from OPM audits and reviews of agency hiring programs and decisions. These referrals have led to numerous successful OSC investigations and disciplinary actions against government officials who committed prohibited personnel practices.

Finally, OSC often collaborates with the EEOC, OPM, and MSPB to provide better information and training to federal employees. If resources allowed, it would be beneficial to increase these efforts to more proactively prevent prohibited personnel practices and discrimination in the government.

8. What do you believe are the qualities of an effective manager?

Some of the most important qualities of an effective manager are the ability to listen; to problem solve; to set strategic direction for the agency while providing employees with the necessary freedom and flexibility to implement my priorities; to empower employees to perform their jobs; to delegate responsibility to appropriate personnel whenever appropriate; and to require accountability and the highest standards in performance and ethics for government employees.

a. How would you describe your management style?

I have implemented a results oriented approach at OSC, with high expectations for managers and employees to produce positive outcomes. Wherever possible, I have encouraged managers to eliminate processes that interfere with successful performance of our mission. For example, if we can achieve the same result with a shorter letter or one letter instead of two, I have directed managers to implement the more efficient approach.

I also try to empower managers and employees to take initiative and come up with new solutions. I am always looking for new ideas to improve OSC, both in terms of the important work that we do and our own work environment. I have an open door

policy to receive feedback --good or bad -- from any employee. An appointment is not necessary to meet with me. I also have regularly scheduled meetings with my immediate staff and senior agency career staff. I meet with program units and schedule regular visits to the field offices in order to hear from every OSC employee.

b. What are the most important lessons you have learned about management in this job and previous management positions you have held?

The most important lesson I have learned about management is that it is crucial to hire excellent people. Of the management decisions I have made at OSC, I am most proud of the people I have hired to join my management team. These decisions matter. While I am ultimately responsible for ensuring that our agency gets results for the federal employees and the American public we serve, I am only one person. I understand that OSC can only be successful if we have people who are very effective at their jobs, whether it is managing our general counsel functions, directing our intake review and procedures, or establishing programs to expedite the settlement process for VA whistleblowers.

c. What qualities do you look for in assembling a management team?

While OSC is primarily staffed by attorneys, I expect managers to be problem solvers, not litigators. Managers must have excellent judgment, and be able to manage and motivate people, not just write legal briefs. Managers must possess an appreciation of and commitment to OSC's mission. They must be able to give and receive constructive feedback. Finally, it is critical that they are willing to tell it to me straight. I believe that the only way to improve OSC is to know where problems may exist, and I have asked managers to provide direct and unfiltered feedback.

d. What is your approach to delegating work and responsibilities to others?

I believe my role is to establish the key priority areas for the agency, and then give employees the tools to accomplish the goals. I ask staff to recommend ideas and creative solutions, but I ultimately make the decision and am accountable for actions taken on initiatives or significant litigation. Where warranted, I will work closely with staff on particular projects, but generally I try to create an environment that will maximize their responsibility and potential.

9. How do you handle disciplinary issues at the OSC?

The need to take disciplinary action has been relatively rare. In instances where it has been necessary, I have acted in a way that recognizes it is in the agency's best interest to allow an employee to correct their conduct or performance and hold them accountable for doing so.

a. How do you respond to underperforming individuals within your office and the agency at large?

With our drastically increasing case levels, OSC's staff is working at full capacity, often going above and beyond to ensure timely and fair review of whistleblower and other claims. There is simply no room for underperforming individuals. To the extent individual employees have needed to improve their performance, I have instructed managers to give prompt feedback on areas that need improvement and provide the employee an opportunity to appropriately respond. Most of our employees are assigned a docket of cases, which facilitates effective supervision. On the rare occasions in which an employee is underperforming, this is identified and addressed through docket review. Fortunately, OSC is primarily staffed with dedicated public servants who care deeply about the agency's mission.

b. Please explain your views on putting an employee on paid administrative leave pending an investigation or disciplinary action. Have you ever done so?

Paid administrative leave should be used only when absolutely necessary, such as when an employee represents an immediate threat to the safety of others in the workplace, and then for as short a time as possible. I have not put any employee on administrative leave for investigation or discipline since becoming Special Counsel.

III. Policy Questions

10. What are the highest priority issues facing the OSC?

Managing our rapidly rising caseload is the highest priority issue facing the OSC. The number of new cases filed with OSC continues to rise, while OSC's budget has remained relatively flat. Simply put, OSC's resources have not kept pace with the demand for its services.

Whistleblower complaints and disclosures from VA employees continue to account for a disproportionate total of OSC's overall caseload. In response to retaliation complaints, OSC has secured relief for dozens of VA whistleblowers, helping courageous doctors, nurses, and other VA employees restore successful careers, while addressing ongoing threats to patient health and safety. The number of these victories for whistleblowers is increasing steadily, with improved cooperation from the VA and our expedited review process for retaliation complaints. In 2015, OSC more than doubled the total number of favorable outcomes for VA whistleblowers achieved in 2014. We project to further increase this total in FY 2016 and beyond.

The VA itself has acknowledged the critical role OSC plays in promoting accountability and restoring confidence at the VA. In testimony before this Committee, the VA noted that Congress may want to "fund OSC at a level that enables the office to hire more investigators" to increase our capacity to work on whistleblower retaliation cases. In addition, as Rep. Jeff Miller, Chairman of the House Committee on Veterans Affairs, noted in comments on the House floor, "Despite its small size, OSC's efforts are making a tremendous difference."

We will continue to work with the VA to provide expedited relief to employees and respond to whistleblower concerns about ongoing threats to patient care. But, the high volume of VA cases places an incredible strain on our already small budget. Government-wide, OSC received over 4,000 prohibited personnel practice complaints in 2015. Over 1,400 of these complaints, or approximately 35 percent, were filed by VA employees. In 2014 and 2015, the VA surpassed the Department of Defense in the total number of cases filed with OSC, even though the Defense Department has twice the number of civilian employees as the VA.

a. What steps are you taking to remediate those issues?

We have taken a number of steps to respond to this tremendous surge in complaints. We reallocated a significant percentage of our program staff to work on VA cases. I assigned our deputy special counsel to supervise VA cases, and we hired an experienced senior counsel to further coordinate our investigations and act as a liaison with the VA's Office of Accountability Review and Office of General Counsel (OGC). We prioritized the intake and initial review of all VA health and safety related whistleblower complaints and streamlined procedures to handle these cases. And, we established a weekly coordinating meeting on VA complaints with senior staff and case attorneys.

Working with the VA's OGC, we implemented an expedited review process for whistleblower retaliation cases. This process allows OSC to present strong cases to the VA at an early stage in the investigative process in order to resolve the matter without a full investigation; it also saves significant time and resources, and gets whistleblowers relief more quickly. To date, we have obtained over 30 corrective actions for VA whistleblowers through this process.

These VA-specific steps are in addition to other efforts to increase OSC's overall efficiency and effectiveness, such as establishment of the Retaliation and Disclosure Project, as discussed above.

b. If confirmed, what longer-term goals would you like to achieve in your next term as Special Counsel?

Given our resource constraints and our increasing caseload, OSC is limited in its ability to expand its outreach and training efforts. I believe that the more federal employees understand their rights and responsibilities under the law, the less need there will be for OSC's services in prosecuting prohibited personnel practices. We want to prevent retaliation before it occurs.

OSC's whistleblower and prohibited personnel practice certification program provides an important avenue for raising awareness about these rights and preventing violations. In 2015, I reassigned a senior OSC attorney to the newly created position of Director of Training and Outreach. This is the first time OSC has had a full-time

employee dedicated to these duties. The Director of Training and Outreach is responsible for increasing outreach and visibility as part of our efforts to prevent retaliation and increase awareness of whistleblower protections. If confirmed, and with additional resources, I would like to expand this program.

11. **When you took over the Special Counsel position in 2011, you noted that one of the most significant challenges you faced was publicizing the OSC and expanding participation. Please give your own assessment on your success in addressing that challenge.**

When I was first nominated as Special Counsel, I often remarked that OSC was the best kept secret in the federal government. If the number of cases filed is any indication of the federal community's awareness of OSC, then I believe we have been very successful in publicizing OSC's good work and expanding participation. In 2015, for the first time in the agency's history, we will exceed 6,000 cases filed across all program areas. This is a 50% increase from 2011, when I took office.

Perhaps more importantly, the increase in filings indicates that whistleblowers and other employees believe they will be able to make a difference by bringing a claim to us. There is renewed confidence in OSC. In response to surveys over the years, employees have indicated that the number one reason they choose to look the other way when they see waste, fraud or abuse is not because they fear retaliation. It's because they don't believe any good will come from their risk. If the number of whistleblower disclosures is any indication of employees' willingness to raise concerns – and I think it is – then we are definitely moving in the right direction.

12. **What measurements do you use to determine whether your office is successful? How do you believe your office measured against those standards since you took over as Special Counsel in 2011?**

As summarized above, by every statistical measure, OSC achieved more positive results on behalf of whistleblowers and the federal merit system than at any point in its history. OSC received nearly 6,000 cases in 2015, a first in agency history and a 1,000 case increase over FY 2014 levels. OSC resolved over 6,000 cases in 2015, an all-time high, and an increase of nearly 30% above 2014. As stated, in 2015, OSC secured 268 "favorable actions" for whistleblowers and other employees, an increase of nearly 300% from when I took office in 2011. By comparison, just seven years ago, the total number of favorable actions was 29.

OSC's cost to resolve a case has dropped to historic lows. In 2010, before I took over as Special Counsel, the cost to resolve a case was $5,174. In 2015, we dropped that metric to $3,696 per case, allowing us to review and process thousands of additional cases each year with comparable resources, and without compromising quality or results.

13. Do you believe that the OSC has the statutory authority necessary to effectively carry out its mission? If not, please explain what statutory authority you believe is lacking.

OSC has not been formally reauthorized since 2007. Reauthorization provides Congress with an opportunity to evaluate OSC's authorities and responsibilities and make any necessary adjustments. I have several specific recommendations to improve OSC's statutory authorities to help us more effectively carry out our mission.

I recommend that Congress strengthen OSC's ability to ensure that agencies take action to correct substantiated claims of wasteful, fraudulent or abusive conduct in OSC disclosure cases. Specifically, we ask that Congress require agencies to provide a reason for failing to take action, including disciplinary action, in the case of substantiated misconduct. OSC should have the statutory authority to request detailed follow-up information on any agency action that is planned, but not yet implemented. In addition, we should be required to provide Congress and the public with a list of agencies that failed to implement any action planned in response to substantiated misconduct.

Second, I recommend that Congress clarify OSC's authority to seek information from other government agencies to assist OSC in its independent investigations of whistleblower retaliation and other prohibited personnel practice claims and in our reviews of whistleblower disclosures. It would be helpful to provide OSC with direct, statutory authority to gain access to all agency information, much like the authorities Congress has provided to Inspectors General and the Government Accountability Office. Currently, OSC's authority to request documents is regulatory. Office of Personnel Management (OPM) regulation directs agencies to comply with document requests from OSC. While agencies typically comply with our civil service rule 5.4 requests, we have had some difficulty in VA investigations with the timeliness and completeness of responses. Direct statutory authority to access all agency information would better ensure that OSC obtains all relevant facts during investigations and reviews of whistleblower disclosures.

In addition, in light of OSC's steadily increasing workload, Congress should consider revising the procedural requirements imposed on OSC in all prohibited personnel practice cases. Changes to section 1214 of title 5 would allow OSC to spend its limited resources on the investigation and prosecution of meritorious cases, providing OSC with the ability to generate more positive outcomes on behalf of whistleblowers, the merit system, and the taxpayers. Section 1214 currently requires OSC to provide an employee with repetitive status reports, a detailed, fact-based letter, the reason for terminating the investigation, and an opportunity to comment before OSC may close a complaint file, regardless of the merits of the complaint. This requires us to devote significant resources to closing non-meritorious complaints, instead of focusing on prosecuting and resolving meritorious cases.

14. Do you believe the OSC has access to all agency documents it needs to effectively carry out its mission? Please explain.

See answer to Question 13 above.

15. Other than any statutory authorities identified above, what, if anything, do you believe Congress can do to assist the OSC and ensure it can effectively carry out its mission?

The increase in cases filed with OSC has been unprecedented and is unrelenting. OSC's jurisdiction covers the entire civilian workforce, with limited exceptions. We are responsible for enforcing four statutes, and we include education and outreach for each one of them among our critical duties. While we are performing more efficiently and effectively than ever, a budget that provides for 140 employees does not allow OSC to fully and effectively fulfill its many mandates. OSC has one of the smallest budgets of any federal law enforcement agency. Accordingly, Congress could provide more appropriate resources to OSC commensurate with its wide scope of responsibilities.

16. Do you believe federal employees receive sufficient training and information regarding their rights as a whistleblower? If not, do you have any recommendations for improving this outreach?

Federal employees should receive more training and information regarding their whistleblower rights and responsibilities as managers to prevent retaliation. The primary statutory authority for training federal employees about their rights and responsibilities under the whistleblower law is 5 U.S.C. § 2302(c). Congress enacted Section 2302(c) in response to reports of limited understanding in the federal workforce concerning employees' right to be free from prohibited personnel practices, especially retaliation for whistleblowing. Section 2302(c) requires agency heads to ensure, in consultation with OSC, that employees are informed of the rights and remedies available to them under the Whistleblower Protection Act (WPA) and related laws.

In 2002, OSC established a "2302(c) Certification Program" to provide agencies and agency components with a process for meeting this statutory requirement. In 2014, the White House directed agencies to take affirmative steps to complete OSC's program. In accordance with a February 2014 memorandum from the White House's Chief Technology Officer and the White House's 2013 second Open Government National Action Plan, agencies must establish a plan for completing OSC's 2302(c) Certification Program. Currently, three cabinet-level departments, the VA, Health and Human Services, and Housing and Urban Development, 17 additional agencies, 16 additional components, and 16 Offices of Inspector General have completed the plan, with approximately 20 additional agencies on track to complete the program this year.

During my tenure, I have taken several additional steps to increase outreach:

- I have personally addressed OSC stakeholders, including the Council of Inspectors General, the Chief Human Capital Officers, and numerous employee and management groups.

- My staff has collectively conducted over 100 outreach sessions at federal agencies in the past year, including a recent session for regional counsel at the VA.

- We have revamped our website to include easily accessible training materials and videos. We produced a pamphlet titled "Know Your Rights When Reporting Wrongs," which is posted on our website; and requested all agencies distribute it to their employees.

- We work closely with the Inspectors General's whistleblower ombudsman program.

- We routinely present to congressional investigators on how to work with whistleblowers and OSC.

- We developed and issued government-wide policy guidance on electronic surveillance of government workers and the Whistleblower Protection Enhancement Act's restrictions on non-disclosure agreements in government employment.

- And, as stated, this past year, for the first time, OSC designated a senior, full-time employee as Director of Training and Outreach.

Each of these measures has increased the number of individuals who hear directly about their rights and responsibilities under the Whistleblower Protection Act. However, I have been limited in my ability to assign more dedicated staff to training and outreach because that necessarily means fewer people to work on cases.

I strongly believe that educating the federal workforce about rights and responsibilities under the Whistleblower Protection Act can help prevent retaliation from occurring in the first place. And while OSC has made great strides in getting the word out about whistleblower rights, there is much more that we could do if we had the resources to commit more staff time.

17. **What policies and procedures, if any, are in place for OSC regarding "re-opening" an inquiry?**

Requests for reconsideration (RFRs) are most common in the case of decisions made by OSC's intake, or Complaints Examining Unit (CEU). CEU requests are handled by an OSC Senior Examiner. The Senior Examiner discusses each RFR with the head of CEU prior to issuing a final determination. While there is no deadline to request reconsideration from OSC, we promptly notify the complainant that filing such a request does not toll the time for filing an Individual Right of Action (IRA) appeal with the MSPB. OSC has a "standard language paragraph" (SLP) for CEU requests for reconsideration. It states:

You asked about having our final determination reconsidered. Please include your file number and address your written Request for Reconsideration to:

Senior Attorney
Complaints Examining Unit
U.S. Office of Special Counsel
1730 M Street, NW, Suite 218
Washington, DC 20036
Fax: 202-254-3711

Please note that such requests are not time sensitive, i.e., there is no deadline to request reconsideration from the Office of Special Counsel of your complaint. Note also, however, that filing a Request for Reconsideration with our Office does not toll the time for filing an Individual Right of Action (IRA) appeal with the Merit Systems Protection Board.

OSC's Disclosure Unit (DU) also receives some requests for reconsideration. Generally, whistleblowers are permitted to make two RFRs. The RFR is reviewed by the assigned case attorney with oversight from the Deputy Chief on the first RFR and the Chief of the unit on the second RFR. After receiving and reviewing the request, the assigned attorney contacts the whistleblower to determine if any additional information has been provided that would modify the previous finding. Attorneys are instructed to resolve requests for reconsideration within 90 days. If the decision is reversed, the case proceeds as a referral under section 1213 of title 5. If there is no information presented that reverses the initial determination, the case is closed.

OSC's Investigation and Prosecution Division (IPD) receives fewer requests for reconsideration than CEU and DU. Generally, IPD RFRs from OSC headquarters cases are reviewed by OSC's SES Associate Special Counsel for headquarters (IPD-HQ) and RFRs from an OSC Field Office are reviewed by OSC's SES Associate Special Counsel for the field offices (IPD-FO). The Associate Special Counsels will re-open an investigation, based on an RFR, if the request presents new and material evidence that was not available at the time the decision to close the case was made, or if the request demonstrates significant legal error on the part of OSC.

IV. Assistance

18. Are these answers your own? Have you consulted with OSC or any other interested parties? If so, please indicate which entities.

These answers are my own. I have consulted with staff from the OSC on a number of questions.

Chairman Ron Johnson
Supplemental Pre-hearing Questionnaire
For the Nomination of Carolyn Lerner to be
Special Counsel, Office of Special Counsel

1. **Do you agree without reservation to comply with any request or summons to appear and testify before any duly constituted committee of Congress if you are confirmed?**

   Yes.

2. **Do you agree without reservation to make any subordinate official or employee available to appear and testify before, or provide information to, any duly constituted committee of Congress if you are confirmed?**

   I am responsible, with input from my senior staff, for directing OSC policy and am ultimately responsible for our work on individual cases. Accordingly, my senior staff and I are generally in the best position to respond to requests for information and to appear and testify before Congress. If a need arises to receive information from a lower-level employee, I will work with the Committee to ensure that its informational needs are met.

3. **Do you agree without reservation to comply fully, completely, and promptly to any request for documents, communications, or any other agency material or information from any duly constituted committee of the Congress if you are confirmed?**

   Yes.

Ranking Member Tom Carper
Supplemental Pre-hearing Questionnaire
For the Nomination of Carolyn Lerner to be
Special Counsel, Office of Special Counsel

1. **Do you agree without reservation to respond to any reasonable request or summons to appear and testify before any duly constituted committee of Congress if you are confirmed?**

   Yes.

2. **Do you agree without reservation to reply to any reasonable request for information from any duly constituted committee of the Congress if you are confirmed?**

   Yes.

I, Carolyn Lerner, hereby state that I have read the foregoing Pre-Hearing Questionnaire and that the information provided therein is, to the best of my knowledge, current, accurate, and complete.

Carolyn Lerner
(Signature)

This 13th day of November, 2015

Post-Hearing Questions for the Record
Submitted to Carolyn Lerner
From Senator Ron Johnson

Nomination Hearing to Consider
Michael J. Missal to be Inspector General, Department of Veterans Affairs
and
Carolyn N. Lerner to be Special Counsel, U.S. Office of Special Counsel
January 12, 2015

1. The Committee's analysis of Federal Employee Viewpoint Surveys from 2012 to 2015 has shown a consistently downward trend in OSC employees' faith in leadership, morale, and belief that they can report wrongdoing. How do you plan to address this issue?

OSC takes the Federal Employee Viewpoint Survey (FEVS) results seriously. Each year since 2012— the first year that OSC participated in the viewpoint survey— I have taken steps to address issues identified in survey results. These steps include: (1) increased promotional opportunities for employees; (2) an interagency agreement with the National Science Foundation Inspector General, which provides OSC employees an outside, independent channel through which they can make disclosures or report prohibited personnel practices (PPPs); (3) ongoing efforts to inform employees of their right to make disclosures and report PPPs; (4) increased professional development training opportunities; (5) more frequent communication to employees from the Immediate Office of the Special Counsel; and (6) and my personal outreach to employees, both through meetings with organizational units and individual employees.

This year, we are engaged in a more intensive effort to obtain input from every OSC employee. I convened an employee engagement working group, which is currently developing an action plan based on employee feedback. I would be pleased to update the Committee on additional steps taken when completed.

Further, based on the feedback received this year, we believe morale has been impacted by external factors, most notably, the extraordinary increase in OSC's caseload. Many OSC employees now carry a docket that is more than double, and in some cases, triple the historic norm. Also, our participation rate in FEVS dropped significantly in 2015, down from 90 percent participation in 2012 to 61 percent in 2015. Next year, we will focus on increasing the level of participation to make sure that the results reflect the views of the entire workforce. Together with the steps described above, we believe we will reverse the trend you described.

Post-Hearing Questions for the Record
Submitted to Carolyn Lerner
From Senator Claire McCaskill

Nomination Hearing to Consider
Michael J. Missal to be Inspector General, Department of Veterans Affairs
and
Carolyn N. Lerner to be Special Counsel, U.S. Office of Special Counsel
January 12, 2015

In your prepared statement, you talk about the efficiencies that you have achieved by improving and streamlining some of OSC's internal policies and procedures. However, I'm concerned that the gains and benefits for whistleblowers by having a faster process may be offset by moving too quickly to dismiss potentially meritorious cases. The number of favorable actions for whistleblowers has gone up dramatically during your tenure, and you should be proud of that. But the number of cases has also gone up dramatically.

1. Please provide the following information for the past 5 years, broken down by year:

   a. The total number of cases that have been received;

      OSC Prohibited Personnel Practice (PPP) Cases:

      FY2008 – 2089
      FY2009 – 2453
      FY2010 – 2415
      FY2011 – 2580
      FY2012 – 2960
      FY2013 – 2930
      FY2014 – 3356
      FY2015 – 4051

   b. The percentage of cases that have resulted in favorable outcomes for the employee;

      FY2008 – 1.6% (33 favorable case outcomes / 58 favorable actions overall)[1]
      FY2009 – 2.2% (53 favorable case outcomes / 62 favorable actions overall)
      FY2010 – 3.1% (76 favorable case outcomes / 96 favorable actions overall)
      FY2011 – 2.5% (65 favorable case outcomes / 84 favorable actions overall)
      FY2012 – 4.3% (128 favorable case outcomes / 159 favorable actions overall)[2]
      FY2013 – 4.2% (124 favorable case outcomes / 173 favorable actions overall)
      FY2014 – 4.9% (165 favorable case outcomes / 201 favorable actions overall)
      FY2015 – 5.2% (212 favorable case outcomes / 278 favorable actions overall)

[1] Some cases may include multiple favorable actions, such as 1) a stay of a personnel action followed by 2) a settlement that permanently resolves the retaliatory personnel action, and 3) a disciplinary action against the manager who engaged in retaliation.
[2] FY2012 was the first full fiscal year for Special Counsel Carolyn Lerner.

Please note, approximately 15 percent of PPP claims each year involve allegations of discrimination under 5 U.S.C. § 2302(b)(1), matters that OSC generally closes after initial review, to not duplicate the well-established processes for addressing claims of discrimination through the EEOC. In addition, the same employee may file multiple cases that are resolved through one favorable action. When these and other factors are considered, the percentage of favorable actions may increase.

c. The percentage of cases that have resulted in successful mediation over the past 5 years;

FY2008 – 4 cases resulted in settlement, 57% of those cases mediated.
FY2009 – 4 cases resulted in settlement, 36% of those cases mediated.
FY2010 – 3 cases resulted in settlement, 50% of those cases mediated.
FY2011 – 10 cases resulted in settlement, 77% of those cases mediated.
FY2012 – 18 cases resulted in settlement, 60% of those cases mediated.
FY2013 – 29 cases resulted in settlement, 62% of those cases mediated.
FY2014 – 30 cases resulted in settlement, 79% of those cases mediated.
FY2015 – 21 cases resulted in settlement, 81% of those cases mediated.

d. The percentage of cases that result in a negative preliminary determination.

By statute, OSC issues a negative preliminary determination letter in cases where we cannot seek a favorable action or have not secured a mediated resolution.

You state that you have achieved a 45 percent reduction in OSC's cost to resolve a case.

2. In addition to the increase in the pursuit of mediation, what are the other primary drivers of that reduction?

My efforts to promote greater efficiencies have been large and small. I have focused on being a careful steward of taxpayer dollars and found better ways to manage our cases. For example, to avoid increased rent payments, we converted our library, which was largely underutilized, into workspaces for interns and new employees. I also discontinued or modified inefficient contracts. I switched our legal research provider and generated savings of nearly $50,000 annually. I discontinued outdated and unnecessary subscription services and saved an additional $32,000 annually. These types of savings add up in an agency of our size, allow us to use more of our limited resources for program work, and lead to the efficiencies cited in the question.

I have also implemented several policy initiatives to better manage our caseload. First, as referenced, I reinvigorated our alternative dispute resolution program. Mediation saves OSC, the employee, and the agency time and resources, while often resulting in better solutions for complainants and agencies alike. Advocates for

whistleblowers and agency counsel have praised OSC's mediation program and its ability to bring about effective results. In recent testimony before this Committee, Government Accountability Project (GAP) Legal Director Tom Devine praised "[OSC's] re-birth of an Alternative Dispute Resolution (ADR) system that has set the global gold standard for effective results constructively resolving whistleblower disputes."

Consistent with our approach to mediation, I have also instructed and empowered employees in our Complaints Examining Unit (CEU) to pursue stays and corrective actions on behalf of employees. We are increasingly achieving positive resolution of cases at the intake level, securing relief for whistleblowers without the need for a formal referral to our investigation division, and the time associated with that process. In FY 2015, CEU secured 81 corrective actions, including numerous cases in which intervention by CEU required an agency to repeal an unlawful non-disclosure agreement issued to a whistleblower.

In addition, I recently established a new project, the Retaliation and Disclosure Team (RDT), which implements a common sense and more efficient model for handling whistleblower cases. OSC's historical practice has been to assign several attorneys to review the same set of facts in cases in which an employee files both a whistleblower disclosure and a retaliation complaint. From an agency resources perspective, this is inefficient. The RDT model consolidates four OSC positions: intake examiner, disclosure attorney, investigative attorney, and mediator. It collapses the process while producing better results, as one attorney has full access to the universe of case-related material, as opposed to having to track down another attorney's case file and piece together relevant information. The model also develops a highly skilled and cross-trained team of attorneys who are flexible to meet agency needs.

These and other efforts have all contributed to a 45 percent reduction in OSC's cost to resolve a case since I've been in office. We have managed to generate the efficiencies described above without compromising the quality or effectiveness of OSC's work. As noted above, both the number and percentage of favorable outcomes have increased during my tenure.

I am concerned that the changes you have made at OSC, while commendable, are covering up a considerable lack of adequate resources. You said in your written statement that OSC's caseload has gone up 50 percent since you first took office in 2011.

3. How much has OSC's budget increased since that time?

In 2011, OSC received 4,027 cases across all program areas. In 2015, OSC received 6,140 cases, a 52.4 percent increase.

In 2011, OSC's budget was $18.592 million. In 2015, OSC's budget was $22.939 million, an increase of 23.3 percent. When adjusted for inflation, the increase is 15.8 increase.

The OSC website indicates that 80 percent of complainants hear from an examiner within 60 to 90 days.

4. Does that mean that after someone submits information to OSC, the first time that person is contacted is 2-3 months later?

   Within 15 days of receiving a complaint, OSC strives to send a written acknowledgement letter to the complainant that contains the name of the assigned examiner, a contact number, and general information on how a PPP complaint is processed. We are able to meet this goal in about 96 percent of cases.

5. What is the average length of time it takes for OSC to reach a preliminary determination in a case that is not resolved through mediation?

   If OSC's Complaints Examining Unit (CEU) determines that there are reasonable grounds to believe that a PPP occurred, CEU may seek corrective action at the intake level, refer the complaint for mediation, or refer the complaint for further investigation. Our goal is to make a determination on a PPP complaint within 90 days or less. For FY2015, we resolved 3,643 PPP complaints. The average length of time it took to reach a final determination was approximately 119 days.

6. What would it take to get this time frame down to 1 month?

   CEU currently has a staff of 16 full-time examiners. To reduce the resolution time frame to 30 days would require a staff of at least 25 examiners.

7. What do you think is an ideal size for OSC to be able to adequately handle the caseload you're seeing?

   If current trends continue, OSC projects annual case growth of 14 percent through FY2018. To simply keep pace with this increase and to keep our backlog at its current level of approximately 2,200 cases, we would need to grow our staff from its current level of 140 employees to approximately 182 employees by 2018.

   However, significantly more resources would be required to make meaningful reductions to the backlog, take on more disciplinary action cases and litigation, reduce our FOIA response time, and enhance information security and technology capabilities, among other competing priorities.

In your prepared statement, you indicate that OSC received and resolved over 6,000 cases in 2015, a 50% increase from 2011.

8. What do you think is driving this increase?

When I was first nominated as Special Counsel, I often remarked that OSC was the best kept secret in the federal government. If the number of cases filed is any indication of the federal community's awareness of OSC, then I believe we have been very successful in publicizing OSC's good work and expanding participation. As you note, in

2015, for the first time in the agency's history, we will exceed 6,000 cases filed across all program areas. This is a 50 percent increase from 2011, when I took office.
Perhaps more importantly, the increase in filings indicates that whistleblowers and other employees believe they will be able to make a difference by bringing a claim to us. There is renewed confidence in OSC.
In response to surveys over the years, employees have indicated that the number one reason they choose to look the other way when they see waste, fraud, or abuse is not because they fear retaliation. It's because they don't believe any good will come from their risk. If the number of whistleblower disclosures is any indication of employees' willingness to raise concerns—and I think it is—then we are definitely moving in the right direction.
I believe our work on a number of significant cases, involving the Air Force, the Federal Aviation Administration, the Food and Drug Administration, and the Department of Homeland Security, among others, helped to demonstrate the ability of OSC to promote better and more accountable government. More recently, OSC has worked with Department of Veterans Affairs whistleblowers from across the country to improve the care provided to veterans. With each positive outcome, we signal to another employee that they can blow the whistle without fear of retaliation, and their efforts and risk will make a difference.

I want to get a better understanding of where the core of the problem lies because I think our civil service system is badly in need of reform on several fronts. The increase in OSC complaints is clearly a symptom of larger issues.

9. Do you have a breakdown of the types of employees that are the subjects of the complaints – what percentage are political appointees versus career managers or SES?

OSC is currently upgrading and modernizing its case management system. Our current system does not allow us to breakdown the types of employees who are subjects of complaints by the criteria listed above. However, we would be happy to provide anecdotal evidence to Sen. McCaskill and the Committee. We share your concerns about diagnosing the problem, and are committed to working with you and the Committee on any reforms that will prevent further retaliation against federal employees.

Over the past 10 years, OSC and Congressional stakeholders have supported federal Inspectors General in their efforts to conduct whistleblower reprisal investigations. However, recently, there has been a string of complaints about IG offices themselves. Sources tell my staff that the Defense Department Office of Inspector General alone has ten reprisal complaints about senior leadership, investigative staff, and security officials in the IG's office.

10. What is your view on how the IG community is handling reprisal complaints within their own offices?

OSC has received numerous whistleblower disclosures and retaliation complaints from employees of Offices of Inspectors General (OIGs), including the Defense Department OIG. Fortunately, the string of complaints from OIG employees appears to be

decreasing. One factor in the decreased number of complaints may be that OIGs have taken the lead in completing OSC's whistleblower certification program under 5 U.S.C. § 2302(c). To date, 18 OIGs have completed the certification process, and five additional OIGs are registered to complete the program. OSC has also conducted training and outreach sessions with the IG community and is an active participant in the OIG Whistleblower Ombuds Working Group.

11. Do you have a sense of when these DOD IG reprisal investigations might be resolved?

The DOD IG reprisal and disclosure cases are a priority for OSC, are under active investigation and review, and will be resolved as soon as possible. We will continue to keep your staff updated on our progress as the cases proceed.

G·A·P
WHISTLEBLOWER.ORG

GOVERNMENT ACCOUNTABILITY PROJECT
1612 K Street, NW, Suite #1100
Washington, DC 20006
(202) 457-0034 | info@whistleblower.org

January 6, 2015

Chairman Ron Johnson
328 Hart Senate Office Building
Washington, DC 20510

Ranking Member Tom Carper
513 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Johnson and Ranking Member Carper:

On behalf of the Government Accountability Project (GAP), this letter is to provide an unqualified recommendation to confirm a second term for Special Counsel Carolyn Lerner. While it would be unprecedented, the choice should be noncontroversial for a fundamental reason: the Office of Special Counsel's (OSC) record of public service under her leadership has been unprecedented.

When Ms. Lerner took office, the OSC's credibility was at its lowest point in 25 years. Under the prior Special Counsel, the Office had an almost nonexistent track record of results in terms of effectively defending the merit system. Part of the reason is that the OSC was embroiled in whistleblower reprisal litigation filed by its own staff. The Office rewrote unequivocal statutory provisions to reflect the prior Special Counsel's discriminatory bias against sexual freedom, leading to Congressional hearings. Systematic misconduct was so extreme that the Office was nationally humiliated by an FBI raid, with the Special Counsel later criminally convicted and briefly imprisoned. In short, the OSC had degenerated into a serious threat to the merit system, as well as a national embarrassment.

The challenge to restore legitimacy could not have been more extreme. Yet within five years, under Ms. Lerner's leadership the OSC has become the Executive branch's chief good government agency, having earned unsurpassed credibility both with employees and agencies alike. Ms. Lerner's team has aggressively and effectively used the Whistleblower Protection Enhancement Act new *amicus* authority to defend merit system principles. Under her leadership, among other accomplishments the OSC has achieved record results for handling retaliation complaints; achieving corrective action; ordering investigations of whistleblowing disclosures and monitoring subsequent corrective action; and training agencies in merit system principles. Under her leadership, the previously demoralized, disillusioned OSC staff now operates with justifiable pride in accomplishing its mission.

Considering the seemingly hopeless circumstances Ms. Lerner inherited, her record of effective leadership is extraordinary. It is exciting to consider what she could accomplish in another term that starts with the OSC operating from the high ground, instead of deep in a hole that the agency had dug through its own violations of the merit system. Hopefully through your leadership she will have that chance.

Sincerely,

Thomas Devine
Legal Director

U.S. Department of Justice

Office of the Inspector General

December 17, 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security and Governmental Affairs
United States Senate
344 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Tom Carper
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate
340 Dirksen Senate Office Building
Washington, DC 20510

Dear Mr. Chairman and Senator Carper:

I write in strong support of the nomination of Carolyn N. Lerner to serve another five-year term as the Special Counsel of the U.S. Office of Special Counsel. I have worked closely with Ms. Lerner on a wide variety of issues since I became Inspector General at the Department of Justice in April 2012, and I can think of no one more qualified to serve as the Special Counsel.

Whistleblowers play a critical role in making our government more effective and efficient and, during Ms. Lerner's tenure as Special Counsel, the Office of Special Counsel has played a vital role in protecting whistleblowers and in conducting outreach and education on whistleblower issues. Ms. Lerner also has worked hard to develop close and constructive relationships with the Inspector General community. One of my priorities as Inspector General has been to address issues related to whistleblowers, and Ms. Lerner and her office have been instrumental in assisting us with our efforts in this area. Her knowledge of and leadership on whistleblower matters has been extremely impressive, and she has assembled an outstanding staff at the Office of Special Counsel. I consult with Ms. Lerner regularly, and her advice and guidance has always proven to be invaluable. Additionally, since becoming Chair of the Council of Inspectors General on Integrity and Efficiency (CIGIE) in January 2015, I have had the opportunity to work with Ms. Lerner on whistleblower issues that affect the entire Inspector General community. We also have collaborated on many other issues that go well beyond those affecting

whistleblowers given her membership on both CIGIE and the CIGIE Integrity Committee. Through all of these interactions, I have seen first-hand the extraordinary integrity, dedication, and devotion that Ms. Lerner brings to her position as Special Counsel.

I have the utmost respect for Ms. Lerner and am confident that, if confirmed to another five-year term as Special Counsel, she will continue to build on the remarkable record of accomplishment that she has achieved since first becoming Special Counsel in 2011. Please do not hesitate to contact me at (202) 514-3435 if you have any questions.

Sincerely,

Michael E. Horowitz
Inspector General

U.S. House of Representatives
COMMITTEE ON VETERANS' AFFAIRS
ONE HUNDRED FOURTEENTH CONGRESS
335 CANNON HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
http://veterans.house.gov

December 7, 2015

The Honorable Ron Johnson
Chairman
Homeland Security & Governmental Affairs Committee
United States Senate
Washington, DC 20510

Dear Mr. Chairman,

I write to express my enthusiastic support for the confirmation of Ms. Carolyn Lerner for reappointment to lead the Office of Special Counsel (OSC).

Ever since the House Committee on Veterans' Affairs exposed the nationwide data manipulation and wait time scandal at the Veterans Health Administration in 2014, many conscientious employees from across VA stepped forward with reports of waste, fraud, and abuse. These whistleblowers have been at the heart of exposing misconduct and an endemic culture of corruption at VA. However, rather than thanking them for bringing longstanding problems to their attention and seeking real accountability, VA management has too often sought to suppress these whistleblowers through threats of job loss and other retaliation.

Fortunately, VA whistleblowers have had a champion in Special Counsel Lerner whose office is responsible for investigating prohibited personnel practices including retaliation against whistleblowers. Since 2014, OSC has been inundated with claims of retaliation from VA employees. OSC's numbers are at record-setting levels. Government-wide, OSC has received over 4000 prohibited personnel practice complaints this year and over 1400 of these complaints, approximately 35%, were filed by VA employees. In 2014, for the first time, VA surpassed the Department of Defense in the total number of cases filed, even though the DoD has twice the number of civilian employees as VA.

Due to the efforts of OSC, whistleblowers have received corrective actions such as reinstatement to their previous positions and the receipt of monetary damages for compensation. In addition, as a result of OSC criticism, VA has restructured its Office of Medical Inspector for better oversight and to be more responsive to threats to veteran health and safety. Most recently, Special Counsel Lerner wrote to the President noting that VA has failed to impose disciplinary action against managers who have retaliated against whistleblowers. Ms. Lerner stated, "The failure to take appropriate discipline, when presented with clear evidence of misconduct, can undermine accountability, impede progress, and discourage whistleblowers from coming forward."

Ms. Lerner has been an outstanding Special Counsel who marshalled her office's resources admirably to respond to the unexpected wave of VA complaints. She has worked tirelessly to promote accountability and restore confidence in VA. Therefore, I offer my wholehearted support for her confirmation for another term as Special Counsel.

Sincerely,

JEFF MILLER
Chairman

CJM/hr

January 11, 2016

Chairman Ron Johnson
328 Hart Senate Office Building
Washington, DC 20510

Ranking Member Tom Carper
513 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Johnson and Ranking Member Carper:

The undersigned members of the Make It Safe Coalition (MISC) and the broader good government community write to provide a strong recommendation to confirm a second term for Special Counsel Carolyn Lerner. MISC is a non-partisan national network of more than 75 groups whose members pursue a wide variety of missions that span defense, homeland security, doctors and patient advocates, natural disasters, scientific freedom, consumer hazards, and corruption in government contracting and procurement. We are united in the cause of protecting those in the public and private sector who honor their duties to serve and warn the public.

While a second term would be unprecedented, the choice should be noncontroversial for a fundamental reason: the Office of Special Counsel's (OSC) record of public service under her leadership has been unprecedented. When Ms. Lerner took office, the OSC's credibility was at its lowest point in 25 years. Under the prior Special Counsel, the Office had an almost nonexistent track record of results in terms of effectively defending the merit system. Part of the reason is that the OSC was embroiled in whistleblower reprisal litigation filed by its own staff. The Office rewrote unequivocal statutory provisions to reflect the prior Special Counsel's discriminatory bias against sexual freedom, leading to Congressional hearings. Systematic misconduct was so extreme that the Office was nationally humiliated by an FBI raid, with the Special Counsel later criminally convicted and briefly imprisoned. In short, the OSC had degenerated into a serious threat to the merit system, as well as a national embarrassment.

The challenge to restore legitimacy could not have been more extreme. Yet within five years, under Ms. Lerner's leadership the OSC has become the Executive branch's chief good government agency, having earned unsurpassed credibility both with employees and agencies alike. Ms. Lerner's team has aggressively and effectively used the Whistleblower Protection Enhancement Act new *amicus* authority to defend merit system principles. Under her leadership, among other accomplishments the OSC has achieved record results for handling retaliation complaints; achieving corrective action; ordering investigations of whistleblowing disclosures and monitoring subsequent corrective action; and training agencies in merit system principles. Under her leadership, the previously demoralized, disillusioned OSC staff now operates with justifiable pride in accomplishing its mission.

Considering the seemingly hopeless circumstances Ms. Lerner inherited, her record of effective leadership is extraordinary. It is exciting to consider what she could accomplish in another term that starts with the OSC operating from the high ground, instead of deep in a hole that the agency had dug through its own violations of the merit system. Hopefully through your leadership she will have that chance.

Sincerely,

Tom Devine, Legal Director, Government Accountability Project (GAP)

Danielle Brian, Executive Director, Project On Government Oversight (POGO)

Emily Gardner, Worker Health and Safety Advocate, Public Citizen

Jeff Ruch, Executive Director, Public Employees for Environmental Responsibility (PEER)

Marcel Reid, Co-Founder & National President, ACORN 8

Michael Ostrolenk, National Director, Liberty Coalition

Nathan R. Catura, National President, Federal Law Enforcement Officers Association (FLEOA)

Noah Bookbinder, Executive Director, Citizens for Responsibility and Ethics in Washington (CREW)

Pete Sepp, President, National Taxpayers Union (NTU)

POGO PROJECT ON GOVERNMENT OVERSIGHT
Exposing Corruption. Exploring Solutions.

December 4, 2015

Chairman Ron Johnson
328 Hart Senate Office Building
Washington, DC 20510

Ranking Member Tom Carper
513 Hart Senate Office Building
Washington, DC 20510

Dear Chairman Johnson and Ranking Member Carper:

We write to express our support for the President's nomination of Carolyn Lerner to serve a second term as head of the U.S. Office of Special Counsel (OSC).

Founded in 1981, the Project On Government Oversight (POGO) is a nonpartisan independent watchdog that champions good government reforms. POGO's investigations into corruption, misconduct, and conflicts of interest achieve a more effective, accountable, open, and ethical federal government. Thus, we are deeply concerned with the ability of OSC to fulfill its independent federal investigative and prosecutorial duties. We are pleased with how Lerner has led the agency in the last five years and with the commitment she has shown to protecting federal employees from prohibited personnel practices, especially whistleblowers.

Lerner took the helm of OSC when morale was low and the agency inspired very little confidence in those whom it was there to serve. But Lerner changed that when she stood up to call out agencies for mistreating whistleblowers and to fight for increased accountability.[1]

We urge you to confirm Lerner as head of the OSC for another five-year term so that she will be able to continue to lead this invaluable office in such an efficient and effective manner.

Sincerely,

Danielle Brian

Danielle Brian
Executive Director

cc: Members of the Committee on Homeland Security and Governmental Affairs

[1] Testimony of Carolyn Lerner, Special Counsel, Office of Special Counsel, before the House Committee on Veterans' Affairs regarding "VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability," July 8, 2014.

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

July 8, 2015

Ms. Linda Halliday
Deputy Inspector General
Office of the Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Ms. Halliday:

The Committee on Homeland Security and Governmental Affairs has been investigating the tragedies that occurred at the VA Medical Center in Tomah, Wisconsin (Tomah VAMC), including the health care inspection of the facility performed by the Department of Veterans Affairs Office of Inspector General (VA OIG). I was surprised to receive an unsolicited letter from Richard J. Griffin, former Deputy Inspector General of the VA OIG, dated June 4, 2015, and an accompanying "white paper" that purports to support the findings of the VA OIG's health care inspection.[1] The VA OIG prepared and transmitted the letter and white paper at that same time that it is withholding material in the face of a subpoena issued by the Committee on April 29, 2015.[2]

The VA OIG's entire course of conduct during its interactions with the Committee on this matter has been baffling. The OIG has gone to great lengths to hide its work from Congress and the American public. The most recent letter and white paper resort to *ad hominin* attacks, misleading statements, and victim-blaming to defend the work of the office. Rather than draft a lengthy defense of the inspection—which, at thirteen pages, is two pages longer than the inspection report itself—I would have preferred if Counselor to the Inspector General Maureen Regan and the rest of the VA OIG legal team had dedicated those efforts to properly informing the public and fully complying with the subpoena.

I am extremely disappointed by the posture of the VA OIG during the course of the Committee's oversight and investigation concerning the Tomah VAMC. As you know, one of VA OIG's chief duties is to keep Congress "*fully* and *currently informed* about problems and deficiencies relating to the administration of programs and operations and the necessity for and progress of corrective action."[3] The Committee's initial efforts to secure the VA OIG's cooperation, however, were unreciprocated. In the ensuing months, VA OIG staff questioned

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[1] Letter from Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec & Governmental Affairs (June 4, 2015).
[2] *See* Subpoena issued to Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., by S. Comm. on Homeland Sec. & Governmental Affairs (Apr. 29, 2015).
[3] 5 app. U.S.C. §(2)(a)(3) (emphasis added).

my motives in conducting this investigation,[4] and implied that my criticism of the VA OIG is unfounded because I am not a "medical expert."[5] This resistance to my investigation is inappropriate, unnecessary, and counterproductive to the goal of improving the VA.

Most perplexing, on June 4, 2015, the VA OIG issued an unsolicited thirteen-page white paper purporting to defend the work of the VA OIG[6]—at the same time that the VA OIG was consciously withholding documents subpoenaed by the Committee. A copy of this white paper was sent to 38 separate Senators and Congressmen[7]—some with no involvement whatsoever in the Committee's investigation, or any connection to the Tomah VAMC—apparently with the hope that the document would be provided to the media. It was not. Undeterred, the VA OIG issued a press release on June 18 highlighting the white paper and followed the release with at least five separate tweets promoting the document.[8] From these actions, I can only assume that the white paper had the primary goal of attracting media attention by defaming many of the victims and Tomah whistleblowers.

Beyond this unusual behavior, the substance of the white paper highlights an unfortunate posture with respect to the Committee's investigation of the Tomah VAMC. I wish to address some particular examples in the white paper in which the VA OIG makes unprompted *ad hominem* attacks against victims and whistleblowers at the Tomah VAMC and provides misleading and incorrect information about the Committee's investigation.

a. The VA OIG's *ad hominem* attacks in its white paper against victims and whistleblowers of the Tomah VAMC are unacceptable.

In attempting to defend its work, the VA OIG criticizes and demeans the very individuals its health care inspection failed to protect in the first place—the victims and whistleblowers of the Tomah VAMC. The paper impugns their motives, assassinates their character, and offers irrelevant information to discredit their accounts. These arguments are remarkable—and unfortunate—from an office whose duty it is to work with the Office of Special Counsel and other entities in *protecting* whistleblowers.[9] In light of the VA OIG's treatment of the victims and whistleblowers at the Tomah VAMC, it should not come as a surprise that VA whistleblowers and others would rather seek assistance from nonpartisan good-government

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[4] Telephone call between Comm. staff and Dep't of Vet. Affairs Off. of Inspector Gen. staff (Mar. 24, 2015).
[5] Donovan Slack, *Tomah probe finds no wrongdoing in death*, APPLETON POST CRESCENT, June 18, 2015 (quoting VA OIG spokeswoman Catherine Gromek).
[6] DEP'T OF VET. AFFAIRS OFF. OF INSPECTOR GEN., ANALYSIS OF THE EVIDENCE SUPPORTING THE FINDINGS OF THE VA OFFICE OF INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS ADMINISTRATIVE CLOSURE OF ITS INSPECTION OF COMPLAINTS REGARDING THE TOMAH, WISCONSIN, VA MEDICAL CENTER (June 4, 2015) [hereinafter "VA OIG white paper"].
[7] The white paper was copied to Senators McConnell, Reid, and Carper; Representatives Miller, Brown, Abraham, Duffy, Kind, Pocan, and Walz; and the entire memberships of the Senate Committee on Homeland Security and Governmental Affairs and the Senate Committee on Veterans' Affairs.
[8] Dep't of Vet. Affairs Off. of Inspector Gen., OIG Releases White Paper on Evidence Supporting Administrative Closure of 2014 Tomah, WI, VA Medical Center Inspection on Opioid Prescription Practices (June 18, 2015).
[9] *See generally* Whistleblower Protection Act, Pub. L. 101-12, 103 Stat. 16; P.L. 103-424, 108 Stat. 4361 (codified, as amended, in various sections of Title 5 U.S.C.).

groups—like the Project on Government Oversight—than the VA OIG.[10] I wish to address the particular treatment of Dr. Noelle Johnson, Dr. Christopher Kirkpatrick, the Simcakoski family, the Baer family, and Mr. Ryan Honl.

1. Dr. Noelle Johnson

Dr. Noelle Johnson, a former pharmacist at the Tomah VAMC, offered important testimony at the Committee's field hearing about her firsthand experiences working at the Tomah VAMC.[11] Dr. Johnson testified—under oath—that she raised concerns about opioid prescription practices and was terminated for her actions.[12] The white paper implies that Dr. Johnson had "no personal knowledge of the facts and circumstances as they existed during [the OIG's] inspection."[13] This argument is curious given that the VA OIG investigators interviewed Dr. Johnson during the inspection—meaning that they presumably thought that she had personal knowledge about the facility. It is difficult to understand how the VA OIG can discount her testimony to the Committee because she has "no personal knowledge" when VA OIG investigators took her testimony as part of the VA OIG inspection.

In fact, the VA OIG's administrative closure report appears to include information obtained from Dr. Johnson. The VA OIG report stated:

> We substantiated the allegation that at least five outpatient pharmacy staff left the facility in recent years. . . . One pharmacist, a new employee, was not retained by the facility at the conclusion of his/her initial employment period. This individual reported that on three occasions he/she had refused to fill prescriptions for controlled substances due to concerns about patient safety and/or drug diversion.[14]

This pharmacist—"a new employee"—appears to be Dr. Noelle Johnson. The fact that the administrative closure included information relating to Dr. Johnson strongly suggests that the inspection covered the timeframe during which Dr. Johnson was employed at the facility. If, as the VA OIG alleged in the white paper, Dr. Johnson had no personal knowledge of the facts and circumstances surrounding the Tomah VAMC, I am at a loss as to why the VA OIG would interview her, draw conclusions from her interview, and include that material in the final product.

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[10] *"Addressing Continued Whistleblower Retaliation": Hearing before the Subcomm. on Oversight & Investigations of the H. Comm. on Veterans' Affairs*, 114th Cong. (2015) (Statement for the Record by the Project on Government Oversight), http://www.pogo.org/our-work/testimony/2015/pogo-provides-statement-for-house-hearing-on-va-whistleblowers.html?referrer=https://www.google.com/.

[11] *See "Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications": J. Hearing before the S. Comm. on Homeland Security & Governmental Affairs & the H. Comm. on Veterans' Affairs*, 114th Cong. (2015) [hereinafter "Tomah field hearing"].

[12] *Id.*

[13] *See* VA OIG white paper, *supra* note 6, at 3.

[14] DEP'T OF VET. AFFAIRS OFF. OF INSPECTOR GEN., ALLEGED INAPPROPRIATE PRESCRIBING OF CONTROLLED SUBSTANCES AND ALLEGED ABUSE OF AUTHORITY, TOMAH VA MEDICAL CENTER 5 (Mar. 12, 2014) [hereinafter "VA OIG administrative closure"].

Moreover, the white paper attempted to discredit Dr. Johnson's whistleblower retaliation claim by negatively characterizing the circumstances of her termination from the Tomah VAMC. In the white paper, the VA OIG quotes from Dr. Johnson's first and second line supervisors to justify her removal from the Tomah VAMC, claiming that Dr. Johnson had "poor interpersonal skills," "repeated negative interactions," and an "unsatisfactory" performance.[15] The VA OIG also attempted to discredit Dr. Johnson by implying that her perception of the retaliation was tainted because she was "only a probationary employee" who "had just completed her training and this was her first position as a pharmacist."[16] The VA OIG, however, failed to document in the white paper the entire account of Dr. Johnson's termination from the Tomah VAMC.

The Committee has obtained the Merit Systems Protections Board (MSPB) case file for Dr. Johnson's claim against the VA for wrongful termination. The file contains twelve letters of support from Tomah VAMC employees who interacted with Dr. Johnson during her tenure at the Tomah VAMC.[17] It also provides evidence that Dr. Johnson's support service line manager rated her as a "fully successful" employee in metrics of clinical functions, program management, customer service & value-added service, communications, and core competencies.[18] In 2010, Ms. Johnson and the VA settled her claim before the MSPB, resulting in her full reinstatement as an employee of the VA.[19] In fact, Ms. Johnson is currently employed at another VA facility. In spite of this positive information about Dr. Johnson's service, the VA OIG only focused on the comments and reviews that paint Dr. Johnson in a negative light.

2. Dr. Christopher Kirkpatrick

In the white paper, the VA OIG also needlessly attacked Dr. Christopher Kirkpatrick, a former Tomah VAMC doctor who tragically committed suicide on the same day in 2009 that he was terminated from the facility. The VA OIG acknowledged that Dr. Kirkpatrick's death was the "only specific death brought to [the VA OIG's] attention during the inspection."[20] The VA OIG's administrative closure alluded to his death, noting that VA OIG investigators reviewed documents concerning the death.[21] The closure, however, made no findings about Dr. Kirkpatrick's death, and it was not until the white paper that the VA OIG discussed the death in any detail.[22]

In the white paper, the VA OIG "strongly" recommended that readers undertake a "thorough" review of the Juneau County Sheriff's report about Dr. Kirkpatrick's death.[23] The VA OIG specifically pointed out "the voluminous amounts and types of marijuana and what

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[15] *See* VA OIG white paper, *supra* note 6, at 9-10.
[16] *Id.* at 10.
[17] Noelle A. Johnson v. Dep't of Veterans Affairs, MSPB Docket No. CH-1221-10-0036-W-1, Exhibits T1-T12 [hereinafter "Noelle Johnson MSPB File"].
[18] Noelle Johnson MSPB File, Attachment N4
[19] *Id.*, Tab 16
[20] VA OIG white paper, *supra* note 6, at 8.
[21] VA OIG administrative closure, *supra* note 14, at 2
[22] *Id.*
[23] VA OIG white paper, *supra* note 6, at 8.

appears [*sic*] to be other illegal substances found in Dr. Kirkpatrick's residence."[24] The VA OIG concluded:

> The evidence indicates that Dr. Kirkpatrick was likely not only to have been using but also distributing the marijuana and other illegal substances. The Sheriff's report also lists large amounts of various prescription drugs found onsite, some of which were lying around loose with no indication whether they were prescribed for Dr. Kirkpatrick and, if so, when and by what provider.[25]

I do not understand why the VA OIG would cite this information in its white paper—information that is irrelevant and vastly out of context to the Dr. Kirkpatrick's criticism of the Tomah VAMC prescribing practices and his death—except in a desperate attempt to discredit Dr. Kirkpatrick by implying he was a drug dealer.

Curiously, although the VA OIG recommended a "thorough" review of the Sheriff's file, it omits other information in the file—information that has a direct relationship to the circumstances at the Tomah VAMC and the VA OIG's health care inspection. The file contains an April 2009 counseling memorandum that Dr. Kirkpatrick received from his immediate supervisor because Dr. Kirkpatrick "criticized" a physician's assistant and raised questions about medications that veterans were prescribed.[26] The allegations in the written counseling were made to Dr. Kirkpatrick's supervisor by Dr. Houlihan.[27] The file also contains Dr. Kirkpatrick's response to the counseling memorandum in which he explained that he questioned the physician's assistant on medications because he and several other staff members at the Tomah VAMC "notic[ed] changes in demeanor in our patients."[28] He added that he believed "it is important there be a dialogue between providers [regarding medication] so as to best serve our patients."

Also within the Juneau County Sheriff's file are union documents that describe concerns with opioid over-prescription at the Tomah VAMC. One document from the spring of 2009 specifically references Dr. Houlihan's nickname as the "Candy Man" and concerns that "[v]eterans served at this facility are prescribed large quantities of narcotics."[29] Communications between the union and Dr. Kirkpatrick indicate that he was perplexed by the allegations that it was "inappropriate somehow in discussing medications that patients [both Dr. Kirkpatrick and the physician's assistant] see are prescribed."[30] He added that the situation placed him in an "ethical dilemma" and the fact that his discipline came months after he questioned the prescription protocols of Dr. Houlihan was "open to interpretation."[31] Dr. Kirkpatrick concluded

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[24] *Id.* at 8-9.
[25] *Id.* at 9.
[26] Memorandum from Dr. Gary J. Loethen to Christopher M. Kirkpatrick, Apr. 30, 2009.
[27] *Id.*
[28] Letter from Christopher Kirkpatrick to Dr. Gary J. Loethen, May 13, 2009.
[29] Letter from Am. Fed'n of Gov't Emps Local 1882 AFL-CIO to Ben Balkum, Apr. 17, 2009.
[30] E-mail from Christopher Kirkpatrick to Am. Fed'n of Gov't Emps. Local 7 Leadership, Apr. 23, 2009.
[31] *Id.*

that, based on what fellow employees of the Tomah VAMC told him, he had "every reason to be afraid of Dr. Houlihan" and he asked the union for help.[32]

It is beyond belief that the VA OIG could perform a "thorough" review of the Sheriff's investigative file, seemingly ignore the evidence with any actual merit to the subject of its inspection, and instead focus solely on information to attempt to discredit a deceased witness. Both the administrative closure and the white paper acknowledged the fact that the VA OIG reviewed material relating to Dr. Kirkpatrick's death during the health care inspection at the Tomah VAMC. However, the only analysis of this information, which the VA OIG offers with scant evidence, appears to consist of blaming Dr. Kirkpatrick and implying that drug use contributed to his death. Nowhere does the VA OIG discuss the actual evidence in the Juneau County Sheriff's file relevant to the subject matter of its inspection of the Tomah VAMC.

3. The Simcakoski Family

The VA OIG's white paper also attempted to discount the testimony of the family of Jason Simcakoski, a Marine veteran who died of "mixed drug toxicity" at the Tomah VAMC.[33] In the white paper, the VA OIG states that "testimony of the family of Jason Simcakoski was limited to their knowledge of his care, not the care of veterans in general at the Tomah VA medical center."[34] I do not understand why the VA OIG would believe that information about Jason Simcakoski's treatment at the Tomah VAMC has no relevance to "the care of veterans in general." I can think of no better source of information on the treatment of veterans at the Tomah VAMC than the veterans themselves and their family members who have firsthand experience of treatment at the facility.

In addition, both Marvin Simcakoski and Heather Simcakoski testified that their observance of Jason's care occurred *during* the period of the VA OIG's health care inspection. Marvin Simcakoski, who played a large role in helping his son navigate the struggles of post-traumatic stress disorder and addiction, testified that he had "argued with Jason's doctors for the last four years about them overmedicating him."[35] He recounted an instance in which VA doctors "sent [Jason] a three-month supply of lorazepam and [Jason] took them all in four days and almost died."[36] Jason's widow, Heather Simcakoski, testified that in 2013—during the VA OIG's health care inspection—Jason communicated with the Federal Bureau of Investigation, the Tomah VAMC police, and the Tomah municipal police about veterans at the Tomah VAMC selling their prescription medications.[37] The white paper fails to note any of this information.

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[32] *Id.*
[33] *Tomah VAMC: Examining Quality, Access, and a Culture of Overreliance on High-Risk Medications": J. Hearing before the S. Comm. on Homeland Security & Governmental Affairs & the H. Comm. on Veterans' Affairs,* 114th Cong. (2015).
[34] VA OIG white paper, *supra* note 6, at 3.
[35] Tomah field hearing, *supra* note 11 (testimony of Marvin Simcakoski).
[36] *Id.*
[37] *Id.* (testimony of Heather Simcakoski).

It is beyond disappointing that the VA OIG has gone to such lengths in its attempt to discredit and downplay the firsthand experiences of the Simcakoski family. Jason's widow and father lived the nightmare of watching Jason battle the demons of addiction. It is insulting that the VA OIG would conclude that they have no "personal knowledge of the facts and circumstances" of the Tomah VAMC.

4. The Baer Family

The VA OIG in the white paper attempted to discount the critical testimony of Candace Delis, the daughter of Thomas Baer, by stating that "Mr. Baer had not been seen or treated at the Tomah VAMC for over 30 years."[38] I am unclear why the VA OIG believes that Mr. Baer's infrequent treatment at the Tomah VAMC disqualifies his family from testifying about his treatment at the facility on January 12, 2015. Ms. Delis accompanied Mr. Baer to the Tomah VAMC and was present during his treatment. The thirty-year gap between his visits to the facility is simply irrelevant. Even a patient on his or her first visit to the Tomah VAMC is an authority for evaluating the treatment he or she received; it does not take multiple or frequent visits to develop a basis for an opinion about the treatment and the VA facility.

5. Ryan Honl

In the white paper, the VA OIG further attempted to discredit former Tomah VAMC employee Ryan Honl by stating that he had no personal knowledge of narcotic over-prescription.[39] The VA OIG neglects to mention Honl's testimony about a culture of fear at the facility. Indeed, Honl testified that his initial complaints to the VA OIG were "centered on a hostile work environment that tolerated fraud and abuse."[40] He continued: "There is a culture in the VA where cronyism runs rampant leaving incompetence in charge at all levels that tolerates unethical practices."[41] Certainly, from Honl's tenure working at the Tomah VAMC, he has firsthand experience about the culture of fear and abuse of authority—an apparent focus of the VA OIG's inspection. To discount Honl's testimony on such narrow grounds indicates a tainted and slanted perspective within the VA OIG. Even the VA, after only a month of investigation, confirmed that a culture of fear existed within the Tomah VAMC.[42]

b. The VA OIG's white paper includes misleading statements about the Committee's involvement concerning the Tomah VAMC.

The VA OIG also resorted to attacking the Committee and me in particular. It asserts that "although Senator Johnson and his staff have publically criticized our findings, neither he nor any other Member of this Committee has requested to be personally briefed regarding the

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[38] VA OIG white paper, *supra* note 6, at 3.
[39] *Id.*
[40] Tomah field hearing, *supra* note 11 (testimony of Ryan Honl).
[41] *Id.*
[42] *See* Memorandum from Carolyn M. Clancy, Interim Under Secretary for Health, Dep't of Veterans Affairs (Mar. 10, 2015), *available at* http://www.va.gov/opa/docs/MEMO_Summary_of_Phase_One_Clinical_Review_Findings_Tomah_WI.pdf.

allegations, our inspection, our findings, and supporting evidence."[43] This statement is extraordinarily misleading in several regards.

First, in early February 2015, my staff requested and received a detailed briefing from Dr. John Daigh, Dr. Alan Mallinger, and Catherine Gromek about the VA OIG's inspection of the Tomah VAMC, its findings, and the supporting evidence.[44] In fact, it was during this meeting that the Committee first learned of the existence of supporting material gathered by VA OIG investigators in the course of conducting the inspection. My staff had another meeting with VA OIG staff, including Maureen Regan, on February 18, specifically to discuss the inspection and the supporting evidence.[45] It was at this meeting that VA OIG staff alluded to the Committee that the VA OIG would not voluntarily produce the supporting evidence.

Second, I met personally on March 2, 2015, with the former Deputy Inspector General Griffin.[46] I expected at this meeting to discuss the work of the VA OIG in its Tomah VAMC inspection. However when we met, he offered no information about the allegations at the Tomah VAMC, the inspection, findings, or the supporting evidence. Instead, Mr. Griffin used the meeting to question the Committee's reasons for examining the Tomah VAMC, to complain about my staff, and to attempt to persuade me to give up the inquiry. In short, I gave him an opportunity to personally brief me on the inspection, and he declined to do so.

Since then, the focus of the Committee's investigation has been precisely what the white paper accuses me of neglecting—a search for the evidence supporting the allegations, inspection, and findings. The VA OIG has refused to produce the evidence supporting the inspection. It is a curious position to take—to criticize me on the one hand for allegedly not examining the VA OIG inspection and the evidence supporting it, while on the other hand refusing to produce the very same supporting evidence requested and subpoenaed by the Committee.

Finally, in its white paper, the VA OIG implied I was personally aware of the allegations surrounding the Tomah VAMC as early as 2011.[47] In support of this accusation, the VA OIG cited to testimony and a letter from an unnamed individual,[48] but the VA OIG has no real evidence—other than rumor and innuendo—that my office received the complaint in 2011. As I have stated before, this assertion is untrue. When I did first learn of the tragedies at the Tomah VAMC in January 2015, I directed my staff to immediately begin an investigation. I can only assume that the motivation of the VA OIG in making this accusation against me is to deflect criticism from the OIG. Similar to how the VA OIG shamelessly attacked whistleblowers and family members of the victims of the Tomah VAMC, the VA OIG appears to be attacking me in an attempt to discredit my committee's investigation.

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[43] VA OIG white paper, *supra* note 6, at 1.
[44] Meeting between Comm. staff and Dep't of Vet. Affairs Off. of Inspector Gen. staff (Feb. 4, 2015).
[45] Meeting between Comm. staff and Dep't of Vet. Affairs Off. of Inspector Gen. staff (Feb. 18, 2015).
[46] Meeting between Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs, & Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen. (Mar. 2, 2015).
[47] VA OIG white paper, *supra* note 6, at 2.
[48] *Id.*

c. The VA OIG's white paper artificially narrows the scope of the Committee's investigation, thereby raising serious concerns about the VA OIG's inspection.

The white paper artificially and erroneously narrows the scope of the Committee's investigation to argue that the VA OIG has fully complied with the Committee's oversight. The VA OIG's entire white paper purports to be a "summary of the evidence as it relates to what Senator Johnson has articulated to be the scope of his investigation in this matter."[49] In reality, the white paper consists of a flimsy defense by cherry-picking statements that I have made about the Tomah VAMC. As I have explained to Mr. Griffin in writing several times previously, the Committee is conducting a broad investigation of circumstances relating to the Tomah VAMC, including allegations of veterans deaths, retaliation against whistleblowers, a culture of fear among employees, opioid over-prescription, abuse of authority, and the VA OIG's health care inspection.

However, even among the issues that the VA OIG defines as the scope of the Committee's investigation, there are several areas of concern that demand the Committee's oversight of the VA OIG and the Tomah VAMC.

1. Who Knew What and When

The VA OIG claims that the Committee's investigation is limited to "who knew what and when." I am certainly interested in better understanding how far back the problems extend at the Tomah VAMC and why no serious actions had been taken by officials—in the VA and the VA OIG—to address them. But from the VA OIG's white paper, I am concerned that the VA OIG does not share this goal. In particular, the white paper states that it was "not necessary" during the VA OIG's inspection to determine who knew what and when.[50] This statement suggests a fundamental weakness and a lack of rigor with the VA OIG's inspection.

The white paper acknowledged that the VA OIG received allegations of misconduct at the Tomah VAMC in March 2011.[51] The VA OIG received these allegations from a Marine Corps veteran who worked at the Tomah VAMC.[52] In three separate communications, the veteran relayed serious allegations including overdose deaths, drug diversion, and Dr. Houlihan's prescribing practices, specifically referencing the mixture of opioids, benzodiazepines and amphetamines.[53] The veteran included news articles that outlined veteran deaths and arrests for alleged drug diversion dating back to 2009.[54] Both the VA OIG's criminal and health care inspection divisions declined to review the case,[55] and the allegations were ultimately investigated by VA's regional Veterans Integrated Service Network 12 (VISN 12).[56]

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[49] *Id.* at 1.
[50] *Id.* at 2
[51] *Id.*
[52] Dep't of Vet. Affairs Off. of Inspector Gen. production of pursuant to S. Comm. on Homeland Security and Governmental Affairs subpoena (Apr. 29, 2015) at bates number 1511 [herein after "subpoenaed documents"].
[53] *See id.* at 1402, 1405-08, 1511.
[54] *Id.* at 1419-1433.
[55] *Id.* at 1377.
[56] *Id.* at 1438.

The VA OIG eventually conducted a review of the Tomah VAMC based on a Hotline complaint it received in August 2011. During this review of the facility, VA OIG inspectors examined events dating back to at least 2009. According to the administrative closure, the VA OIG reviewed the "OIG Master Case Index records of 19 cases at Tomah VAMC since 2009."[57]

Given that the VA OIG inspection of the Tomah VAMC examined events dating back to at least 2009, I am troubled by the statement that "because [the VA OIG] did not substantiate the Hotline allegations [from August 2011], it was not necessary for the inspectors to determine who knew what and when for the purpose of holding people accountable."[58] This conclusion begs the question—how do you substantiate allegations if you do not even attempt to construct a timeline of wrongdoing during an investigation? The examination of who knew what and when is a basic, crucial, part of any investigation. The Committee will continue this part of its investigation.

2. Allegations of drug diversion

The OIG's white paper states that "drug diversion was not identified as an issue being addressed in Senator Johnson's investigation."[59] To the contrary, my first letter to VA Secretary Robert McDonald, dated February 4, 2015, requested several categories of material about potential drug diversion at the Tomah VAMC.[60] In addition, the VA OIG provided an unsolicited response to another request I made to the VA about potential drug diversion.[61] In the white paper, however, the VA OIG stated that it investigated no cases of drug diversion involving the Tomah VAMC. This statement contradicts other documents obtained by the Committee.

According to documents obtained by the Committee, the DEA conducted a drug diversion investigation in concert with the VA OIG's health care inspection of the Tomah VAMC in 2011 and 2012.[62] These documents show that as of August 2011, DEA investigators had initiated an investigation based on anonymous complaints that Dr. Houlihan and another medical professional at the Tomah VAMC were "excessively prescribing opiate medications to patients with PTSD."[63] In April 2012, a VA OIG criminal investigator met with the DEA investigators, during which the DEA confirmed that "they had initiated a diversion investigation in regards to the Tomah VAMC and local area veterans in Tomah, and that they would cooperate

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[57] VA OIG administrative closure, *supra* note 14.
[58] VA OIG white paper, *supra* note 6, at 2
[59] *Id.* at 7.
[60] Letter from Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs, to Robert McDonald, Dep't of Vet. Affairs (Feb. 4, 2015).
[61] Letter from Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs (May 8, 2015).
[62] *See* U.S. Dep't of Veterans Affairs, Office of Inspector Gen., MCI No. 2011-04212-HI-0267, Administrative Closure: Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center (2014), *available at* https://www.documentcloud.org/documents/1384916-2014-va-oig-report.html.
[63] See *MCI Search Results MCI# 2011-04212-DC-0252*, subpoenaed documents, *supra* note 52, at 1392.

with the VA OIG investigation."[64] Later, in April 2012, a VA OIG investigator, along with DEA investigators and a Tomah police detective, interviewed a Tomah VAMC employee.[65] The employee told them that "Houlihan and [another medical professional] are the root of drug diversion/pill-selling by veterans at the Tomah VAMC and they have created a culture of fear within the Tomah VAMC, to which employees are afraid to step forward and/or speak their minds."[66] The employee also said that particular patients of Dr. Houlihan frequently requested early refills in conjunction with their high prescription rates of narcotics.[67]

I hope you are as concerned as I am by the VA OIG's statement in the white paper that it investigated no cases of drug diversion concerning the Tomah VAMC when these documents show that a VA OIG investigator actively worked with other law-enforcement officials to investigate potential drug diversion at the facility.

3. Culture of fear at the Tomah VAMC

The VA OIG office attempted in the white paper to characterize the Committee's investigation as limited to the examination of "culture of fear" at the Tomah VAMC, and it explained that the VA OIG health care inspection did not address the issue. The VA OIG also noted, however, that while "some individuals expressed that they had some level of fear, . . . it was based primarily on gossip, rumor, and hearsay, not personal experiences or fact."[68] This statement, too, contradicts other information known to the Committee.

The VA OIG in the white paper claims that it found no witnesses with "any direct negative personal experiences with Dr. Houlihan" relating to a culture of fear.[69] Yet, the VA OIG then cited firsthand evidence about "negative" personal experiences with Dr. Houlihan:

> During her interview, Ms. [Noelle] Johnson related interactions between her and Dr. Houlihan in which she stated that he yelled and used profanity toward her. No other witnesses related any similar conduct on the part of Dr. Houlihan. One witness indicated that Dr. Houlihan would raise his voice and yell, but did not tell us that Dr. Houlihan used profanity. Another witness interviewed in 2012 described one meeting in which Dr. Houlihan yelled but also stated that he had calmed down a lot.[70]

Thus, the testimony that the VA OIG cited to attack Ms. Johnson and undermine her credibility *directly supports her account*. I am perplexed by the VA OIG's use of these logical and

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[64] *Id.*
[65] See *MCI Search Results MCI# 2011-04212-DC-0252*, subpoenaed documents, *supra* note 52, at 1393; *See also* interview between Greg Porter, et al. and "Anonymous Tomah VAMC Employee, Apr. 25, 2012, subpoenaed documents, *supra* note 52, at 1475-76.
[66] Interview between Greg Porter, et al. and "Anonymous Tomah VAMC Employee, Apr. 25, 2012, subpoenaed documents at 1476.
[67] See *MCI Search Results MCI# 2011-04212-DC-0252*, subpoenaed documents, *supra* note 52, at 1393
[68] VA OIG white paper, *supra* note 6, at 10.
[69] *Id.* at 11.
[70] *Id.*

rhetorical summersaults. The white paper rejected this negative firsthand evidence by citing other evidence that Dr. Houlihan is "quite nice" and "not a rude person at all."[71] However, it failed to explain why it discredited the negative evidence suggesting a culture of fear—with at least three examples of yelling—in favor of contrary evidence. Notably, while the VA OIG's multi-year inspection did not "substantiate" a culture of fear, the VA's own month-long investigation substantiated the allegation in March 2015.[72] This discrepancy is of significant concern to me and necessitates continued oversight by the Committee.

4. The Committee's subpoena is not "significantly broader" than the records the Committee have been requesting for months.

Mr. Griffin's cover letter to me accompanying the white paper accused the Committee of "significantly" broadening the scope of its subpoena over previous requests.[73] However, my requests to the VA OIG have been consistent. In our interactions with the VA OIG, my staff and I have consistently asked for the entire VA OIG case file since February 4, 2015. The subpoena reflects the Committee's longstanding request for the VA OIG's entire case file relating to the Tomah VAMC health care inspection.

As the Committee has become aware of additional information pertaining to the Committee's investigation, I have requested that material as well. For that reason, when the Committee became aware of the existence of 140 previously-unreleased healthcare inspections, I asked the VA OIG to produce the reports to the Committee.[74] Those reports were not produced as requested— but instead were posted as redacted copies on the VA OIG website—and therefore I included an item in the subpoena requiring the VA OIG to produce all administratively closed reports.

The unprecedented attempts to artificially redefine the scope of the Committee's investigation are unnecessary and counterproductive. The congressional power of inquiry and the processes to enforce it is "an essential and appropriate auxiliary of the legislative function."[75] The Supreme Court has held that "[t]he scope of [Congress's] power of inquiry . . . is as penetrating and far-reaching as the potential power to enact and appropriate under the Constitution."[76] It is the prerogative of the Committee—and not the VA OIG—to define the scope its investigation into the circumstances surrounding the Tomah VAMC. While the VA OIG's three-year health care inspection is an important piece of the much-larger inquiry, it is by no means the entire scope of the Committee's review. However, based on the information

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[71] *Id.*
[72] *See* Memorandum from Carolyn M. Clancy, Interim Under Secretary for Health, Dep't of Veterans Affairs (Mar. 10, 2015), *available at* http://www.va.gov/opa/docs/MEMO_Summary_of_Phase_One_Clinical_Review_Findings_Tomah_WI.pdf.
[73] Letter from Richard J. Griffin, Dep't of Vet. Affairs Off. of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec. & Governmental Affairs (June 4, 2015).
[74] Letter from Ron Johnson, S. Comm. on Homeland Security & Governmental Affairs, to Richard J. Griffin, Dep't of Vet. Affairs Office of Inspector Gen. (Mar. 17, 2015)
[75] *McGrain v. Daugherty*, 273 U.S. 135, 174 (1927).
[76] *Eastland v. U.S. Servicemen's Fund*, 421 U.S. 491, 504, n. 15 (1975) (quoting *Barenblatt v. United States*, 360 U.S. 109, 111 (1959)).

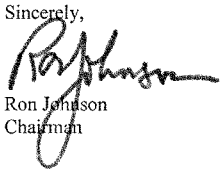
known at this time, the Committee has significant and growing concerns about the VA OIG's health care inspection of the Tomah VAMC.

d. Conclusion

The VA OIG's unsolicited white paper attacked the victims and whistleblowers of the Tomah VAMC, mischaracterized the Committee's investigation, and exhibited a serious disregard for Congressional oversight. The assertions in this white paper are inappropriate, counterproductive, and without merit. That this unusual document was created by an inspector general's office makes it all the more confounding. Even more troubling, the VA OIG prepared, transmitted, and publicized this white paper at the same time that it consciously had failed to comply fully with the Committee's subpoena.

As you assume your new duties leading the VA OIG, I hope that you will attempt to restore trust in the VA OIG. I urge you to reconsider the VA OIG's contemptuous posture with respect to the Committee's investigation, as shown in the VA OIG's white paper, and join me in working to bring transparency and accountability for our nation's veterans. Thank you for your attention to this important matter.

Sincerely,



Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510–6250

September 29, 2015

Ms. Linda Halliday
Deputy Inspector General
Office of the Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, DC 20420

Dear Deputy Inspector General Halliday:

Thank you for your testimony at the Committee's hearing on September 22, 2015, entitled, "Improving VA Accountability: First-Hand Accounts of Department of Veterans Affairs Whistleblowers."[1] During the hearing, I asked you about the process that led to the drafting of the "white paper" that your office sent to me on June 4, 2015 and subsequently released publically on June 18, 2015.[2] I am writing to request more information about the white paper.

As I wrote in my July 8 letter to you,[3] and reiterated at the hearing last week, the white paper's attacks on the courageous Tomah VAMC whistleblowers was callous and reprehensible. Among the most troubling aspects of the white paper is the VA OIG's insinuation that Dr. Christopher Kirkpatrick, the psychologist at the Tomah VAMC who committed suicide after he was fired from the facility for raising concerns about over-medication of veterans, was a drug dealer. Not only is this information irrelevant to Dr. Kirkpatrick's criticisms of the Tomah VAMC's prescribing practices and the VA OIG's review of the facility, but it also needlessly attacked a dead man who is in no position to defend himself. As the Kirkpatrick family continues to grieve the loss of their loved one and learn all the facts surrounding Dr. Kirkpatrick's termination and death, the need for transparency and accountability out of the VA OIG has never been more important.

In order to assist the Committee's ongoing investigation of the Tomah VAMC, as well as the Committee's work to develop enhanced whistleblower protections for federal employees, I request that you produce the following information in non-redacted form:

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[1] "Improving VA Accountability: First-Hand Accounts of Department of Veterans Affairs Whistleblowers," hearing of the S. Comm. on Homeland Sec & Governmental Affairs, Sept. 22, 2015.
[2] Letter from Richard Griffin, Dep't of Vet. Affairs, Off. of Inspector Gen., to Ron Johnson, S. Comm. on Homeland Sec & Governmental Affairs (June 4, 2015).
[3] Letter from Ron Johnson, S. Comm. on Homeland Sec & Governmental Affairs, to Linda Halliday, Dep't of Vet. Affairs, Off. of Inspector Gen. (July 8, 2015).

1. All documents and communications referring or relating to the drafting or publication of the VA OIG's Tomah VAMC white paper for the time period January 1, 2015 to the present. This request includes, but is not limited to:

    a. All drafts of the white paper;
    b. All emails between VA OIG employees referring or relating to the drafting or publication of the white paper; and
    c. All emails between VA OIG employees and employees of the VA referring or relating to the drafting or publication of the white paper.

Please provide this information as soon as possible but no later than 5:00 p.m. on October 6, 2015.

If you have any questions about this request, please contact Kyle Brosnan or Brian Downey of the Committee staff at (202) 224-4751. Thank you for your prompt attention to this matter.

Sincerely,

Ron Johnson
Chairman

cc: The Honorable Thomas R. Carper
Ranking Member

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

OCT - 6 2015

The Honorable Ron Johnson
Chairman
Committee on Homeland Security
and Governmental Affairs
U.S. Senate
Washington, DC 20510

Dear Mr. Chairman:

This is in response to your letter dated September 29, 2015, requesting additional information concerning the Office of Inspector General's (OIG) white paper dated June 4, 2015, with a cover letter signed by the former Deputy Inspector General explaining the purpose of the document and his decision to send it to you. As I stated at the Committee's hearing on September 22, 2015, I had no role in drafting this document or the decision to release it as I was not the Deputy Inspector General at the time. I would emphasize that all staff were operating under the direction of the former Deputy Inspector General, who is the responsible official who directed, signed, and issued the document.

Your letter requests copies of all documents and communications referring or relating to the drafting or publication of the VA OIG's Tomah VA Medical Center white paper for the time period of January 1, 2015, to the present including:

a. All drafts of the white paper;
b. All emails between VA OIG employees referring or relating to the drafting or publication of the white paper; and
c. All emails between VA OIG employees and employees of the VA referring to or relating to the drafting or publication of the white paper.

As you previously suggested, I consulted with Mr. Michael E. Horowitz, Chair, Council of the Inspectors General on Integrity and Efficiency, regarding the types of documents that can be released to the Committee. He generally advised to withhold draft documents and information concerning the drafting of documents because they are part of the deliberative process. When Mr. Horowitz and I jointly met with your Committee staff on August 13, 2015, he expressed these same concerns about draft documents and the deliberative process.

Releasing these deliberative process materials is of concern to me and the Inspector General community at large because maintaining the integrity of the deliberative process is essential to the independence of our offices and our ability to perform work

under the Inspector General Act. As evident in our Semiannual Reports to Congress, my staff makes difficult and complex independent assessments of issues impacting VA programs and operations. Ultimately, they must remain fair, balanced, and absolutely independent. There are no documents responsive to paragraph c because no one in VA was involved in drafting or publication of the white paper.

I can assure you that maintaining the independence and integrity of this office is of utmost importance to me. To that end, I have taken the following actions since assuming the position of Deputy Inspector General:

1) Met with veteran service organizations to determine how we can best address their concerns.
2) Required my senior staff to sign Independence and Impairment statements reinforcing our values of independence and objectivity.
3) Directed training for all OIG employees on whistleblower protections so that the OIG will meet Office of Special Counsel criteria for its 2302(c) Certification Program before the end of this calendar year.
4) Worked to find ways within the limits of the law to provide information requested by the Committee regarding our review of issues at the Tomah VA Medical Center.

In consideration of these actions and the need to preserve the independence and integrity of the deliberative process across the Inspector General community, I respectfully ask that you withdraw your request for the documents described in paragraphs a and b.

I am confident that, under your leadership, the Committee and the OIG can forge a new relationship, based on mutual respect, cooperation, and a shared mission of ensuring veterans receive the care they have earned through their service to our Nation. I appreciate your consideration of this request.

Sincerely,

Linda A. Halliday

LINDA A. HALLIDAY
Deputy Inspector General

Copy to: Senator Thomas J. Carper, Ranking Member, Committee on Homeland Security and Governmental Affairs

Mr. Michael E. Horowitz, Chair, Council of the Inspectors General on Integrity and Efficiency

WHITE PAPER

ANALYSIS OF THE EVIDENCE SUPPORTING THE FINDINGS OF THE VA OFFICE OF INSPECTOR GENERAL, OFFICE OF HEALTHCARE INSPECTIONS ADMINISTRATIVE CLOSURE OF ITS INSPECTION OF COMPLAINTS REGARDING THE TOMAH, WISCONSIN, VA MEDICAL CENTER

On April 29, 2015, Senator Ron Johnson, in his capacity as Chairman of the Senate Committee for Homeland Security and Governmental Affairs, issued a subpoena to the Department of Veterans Affairs Office of Inspector General (VA OIG) seeking documents relating to a healthcare inspection conducted in or around 2012 at the VA medical center in Tomah, Wisconsin. The inspection, which was administratively closed in March 2014, did not substantiate the majority of the allegations relating to prescribing practices and other related issues. The administrative closure received significant media attention beginning in early January 2015, due to new allegations received in or around September 2014 from a former Tomah VA medical center employee. The inspection was conducted by staff in the VA OIG's Office of Healthcare Inspections and included two physicians board certified in psychiatry, two physicians board certified in internal medicine, a physician board certified by the American Board of Physical Medicine and Rehabilitation, a pharmacist, and other health care personnel. In addition, a Special Agent in our Office of Investigations participated in the interviews and followed up on specific allegations with potential criminal implications. The psychiatrist who led the inspection, Dr. Alan Mallinger, had more than 30 years of experience in the clinical practice of psychiatry before joining the VA OIG Office of Healthcare Inspections. In 2013, he was inducted into the American College of Psychiatrists, which comprises more than 800 psychiatrists who have demonstrated excellence in the field of psychiatry, and achieved national recognition in clinical practice, research, academic leadership, or teaching. The inspection included recorded interviews, review of medical records and other related records, review of background materials, treatment guidelines, medical research, and analyses of data relating to early prescription refills and prescribing practices.

Although Senator Johnson and his staff have publicly criticized our findings, neither he nor any other Member of this Committee has requested to be personally briefed regarding the allegations, our inspection, our findings, and supporting evidence. In fact, Representative Ron Kind is the only Member of Congress who requested and received a personal briefing to discuss the evidence supporting our findings. In response to the subpoena, my staff produced 13,949 pages of documents to both the majority and minority staff. Below I am providing a summary of the evidence as it relates to what Senator Johnson has articulated to be the scope of his investigation in this matter. My staff will be happy to provide a briefing to any Member who wishes to further discuss these issues.

Who knew what and when

During the March 26, 2015, hearing held by the Senate Veterans' Affairs Committee, *Opioid Prescription Policy, Practice, and Procedures*, Senator Johnson stated that he was conducting an investigation to inquire how far back these problems went and who knew so that these "tragedies" do not happen again. He further stated that he wanted to know who knew what and when to hold people accountable. As I explained in my April 24, 2015, letter to Senator Johnson because we did not substantiate the Hotline allegations, it was not necessary for the inspectors to determine who knew what and when for the purpose of holding people accountable. I previously produced copies of records responsive to the scope of the investigation that Senator Johnson articulated at the hearing with my April 24, 2015, letter. Attached are copies of Senator Johnson's April 20, 2015, letter and my April 24, 2015, response. If any Member of the Committee would like a copy of the documents produced with my response, I will provide them directly to you or your staff.

As I noted in prior correspondence to Senator Johnson, the healthcare inspection was initiated based on an anonymous complaint received by the VA OIG Hotline in August 2011. The complaint we received indicated that the complainant had sent copies to "all of Wisconsin's senators and representatives in Congress." Records produced, pp. 5716-5720. The records produced in response to the subpoena also include statements by an individual who told us during a subsequent interview that she had sent the August 2011 letter. During the interview, the individual reaffirmed that the letter had been sent to all Wisconsin Senators and Representatives. Records produced, p. 5323. Wisconsin Representative Ron Kind forwarded a copy of the letter to the VA OIG Hotline in September 2011. Records produced, pp. 4159-4161. We did not receive this complaint from nor were there any inquiries about any issue regarding the Tomah VA medical center from any other Member of Congress prior to Senator Tammy Baldwin's request in June 2014 after she received a separate complaint. Despite the media attention given the administrative closure, which led to the subpoena, as noted above, Representative Kind is the only Member of Congress who requested and was personally briefed regarding the evidence supporting the conclusions in our administrative closure. My staff and I welcome the opportunity to provide the same detailed briefing to any Member of the Committee or Congress who has an interest in hearing the facts in this matter and answer any questions you may have. Interviews and other information gathered during the inspection related primarily to the 2011-2012 time period. Subsequent to our onsite inspection, which was concluded in late 2012, through the date the inspection was closed administratively in March 2014, we did not receive any similar complaints from Members of Congress, through our Hotline, or from any other source.

VA OIG records show that the first complaint we received regarding problems relating to prescribing practices at the Tomah VAMC was in March 2011. Records produced, pp.1377-1388. The March 2011 complaint was referred to the Veterans Health Administration (VHA) for review and response, and the response was reviewed by the VA OIG, Office of Healthcare

Inspections. The review conducted by VHA substantiated allegations relating to prescribing practices for two of the patients identified in the complaint. VHA provided an action plan that included a review by the Veterans Integrated Systems Network 12 (VISN 12) of refill/lab testing policies, evaluating practice trends, and working with the Chief of Staff at Tomah to evaluate pain approaches and effectiveness. Allegations of travel benefit fraud, poor communications with a patient, and diversion/sale of controlled substances were not substantiated. Records produced, pp. 1389-1391, 1438-1443 (VHA's response). When the VA OIG Hotline received a second complaint in August 2011, Records produced, p. 1388, the VA OIG Office of Healthcare Inspections began its in-depth inspection of the allegations as evidenced by the administrative closure report and the almost 14,000 pages of documents produced in response to the subpoena.

During the inspection and around the same time that we were conducting our onsite work in 2012, another team in the Office of Healthcare Inspections was conducting a cyclical Combined Assessment Program (CAP) review of the Tomah VA medical center. Part of each CAP review includes an Employee Assessment Review (EAR) survey. The employee responses to the 2012 EAR survey included complaints that opioids were being overprescribed. Records produced, pp. 4153-4155. This was the only time that the employee responses to the EAR survey included complaints about prescribing practices at Tomah. In comparison, responses to the EAR survey conducted between August 18 and September 8, 2014, did not include such complaints.

It took us considerable time to conduct the interviews, research the medical issues, review medical and other records, and conduct detailed analyses of large amounts of data to reach conclusions in the administrative closure. To date, no one has presented any evidence to show that our findings and conclusions relating to the prescribing practices and other conditions existing in 2011 and 2012 were in error. Witnesses who testified at the field hearing held by Senator Johnson on March 30, 2015, at the Tomah VA medical center did not include anyone with personal knowledge of the facts and circumstances as they existed during our inspection. One witness, Noelle Johnson, stated in her written statement for the March 30, 2015, field hearing that she had been terminated from her positon at the Tomah VA medical center in June 2009. The other witness, Ryan Honl, was employed at the facility from August 10 to October 2014, when he resigned. He also admitted in his written statement for the May 30, 2015, field hearing that he "wasn't a witness to the over prescription of narcotics. . ." and that his information came from other (unidentified) employees. Similarly, testimony from the family of Thomas Baer was limited to what occurred on January 12, 2015. Mr. Baer had not been seen or treated at the Tomah VA medical center for over 30 years. Similarly, testimony of the family of Jason Simcakowski was limited to their knowledge of his care, not the care of veterans in general at the Tomah VA medical center.

Extensive medical and pharmacy record reviews did not support allegations relating to early refills and opioids being prescribed to treat Post Traumatic Stress Disorder (PTSD)

As noted in our administrative closure, to address these issues we conducted extensive and in-depth reviews of patient records and other information. The review included general chart reviews of the patients who were specifically identified by multiple sources including various individuals who were interviewed during our inspection, patients who were included in a 2011 peer review of Dr. Houlihan's practice, a patient who was identified by an informant to Tomah municipal police as allegedly being involved in drug diversion, and selected individuals from a list of the 100 patients at the Tomah medical center who were receiving the highest doses of opioids. In addition, we performed structured chart reviews and compiled the results of 56 patients, which included all patients (32) in the care of Dr. Houlihan and a nurse practitioner who were among the 100 patients at Tomah having the highest doses of opioids. The 56 patients also included patients on a list provided by the Tomah municipal police department of individuals suspected of drug crimes, who were receiving prescriptions for controlled substances from any provider at Tomah (24 patients). Of the 24 patients, 15 were patients of Dr. Houlihan or the nurse practitioner. Records produced, pp. 4201-4465. We also compiled, reviewed, and analyzed extensive datasets derived from pharmacy records including records relating to early refills of controlled substances and antidepressants (for comparison) over the period of January 1, 2011, to September 12, 2012, (Records produced, pp. 1551-1942), and total morphine equivalents of opioids dispensed during fiscal year (FY) 2012 in all VISN 12 facilities by patient and provider. Records produced, pp. 1946-2057, 2879-4129. We also reviewed and analyzed datasets for early refills for all VISN 12 facilities. Records produced, pp. 2059-2878. The prescription records included more than 150,000 line entries.

As stated in the administrative closure report (p. 9), we did not substantiate the allegation that "opioids are contraindicated for PTSD, but this is part of [Dr. Houlihan's] treatment plan." Based on our review of patient records, we found that none of the patients were prescribed opioids to treat PTSD and a majority of the patients did not have a diagnosis of PTSD listed in the medical record. Records produced, pp. 4202-4282 & 4351-4465. If one accepted the statement that "opioids are contraindicated for PTSD" then patients receiving them even for a co-existing conditions such as pain would be a problem. In fact, however, opioids are not contraindicated in PTSD. *See e.g.*, pp. 13731-13772. Also as stated in the administrative closure report (p. 9), the medical record reviews indicated a history of a pain-related condition(s) and use of opioids for the treatment of pain.

The structured chart review showed that 48 of the 56 patients (86 percent) had entered into narcotics contracts and that 52 of the patients (93 percent) had submitted to urine drug screening (UDS). We noted in the administrative closure report (p. 6), that our medical record review identified four patients who had no UDS performed during the 3-year time interval, although they were treated chronically with opioids during this period. We also stated in the administrative closure that of the 52 patients we identified through the chart reviews who had

UDS performed at least one time between January 2009 and April 2012, we identified 5 patients who were being prescribed opioids at the time of the negative test, i.e., the test failed to confirm that they were actually taking their prescribed medication. *Id.*

With regard to early refills (greater than 7 days early), our extensive reviews of prescription records (cited above) showed that 29 of the 56 patients (56 percent) had early refill(s) of opiates and/or stimulants during a 1 year time interval beginning 366 days before the date that the chart was reviewed (between April 16 and June 14, 2012). For the 29 patients with early refills, the number of early refills per patient ranged from one to eight. Twelve patients had a single refill, and 17 obtained multiple (two or more) early refills during the year. Eight patients obtained early refills on four or more occasions during the year. Records produced, pp. 1151-2041, 5927, 13659-13670. From a clinical perspective, sudden cessation of opiate medication for patients chronically taking opiates is likely to precipitate a withdrawal syndrome involving physical and psychological sequellae. Therefore the undesirability of early refills and potential for drug misuse or diversion needs to be balanced against potential risks and harm associated with opiate withdrawal.

Our various analyses of prescription data from the Tomah and other VA medical centers and among various providers also failed to support many of the allegations. Examples of these analyses can be found at pp. 1551-4152, 12979-13551 of the records produced. We found the early refill rate for January 1, 2012 to September 12, 2012, at the Tomah VA medical center of 24 percent for scheduled drugs (controlled substances) and a 36 percent rate for antidepressants. Records produced p. 1552. We expanded the time frame to January 1, 2011 through September 12, 2012, and found that the rates were 26 percent for scheduled drugs and 38 percent for antidepressants. Records reviewed, p. 13547. The rates for both time periods were significantly less than alleged by some witnesses interviewed. We also note that the chart reviews (Records produced, pp. 4201-4265) showed policies and procedures in place to monitor early refills such as requiring a police report if the medication was reported stolen. *See also,* Records produced, p. 6147-6148.

With regard to the 3-day early refill policy, our review of the prescription data cited above found 179 instances in which patients having prescriptions for controlled substances from Dr. Houlihan requested refills at the pharmacy window more than 3 days early during the period from January 1, 2011 through September 12, 2012 (median days early = 7), and 246 such instances for the nurse practitioner (median days early = 6). Records produced, pp. 12408-12430. Overall, the pharmacy window had to deal with 1,051 out of policy early refills from all providers. Thus, during the approximately 89 weeks evaluated, the pharmacy window dealt with nearly five out-of-policy refills per week from Dr. Houlihan and the nurse practitioner alone, and nearly 12 per week overall. This confirmed the impressions of dispensing pharmacists we interviewed that dealing with early refill requests was a daily occurrence. However, it did not confirm their perceptions that all or most patients were getting early refills.

Our administrative closure report includes a Table (p. 8) which shows the results of our analysis of the prescription practices for the 10 highest individual VISN 12 clinician prescribers. The Table shows a wide range in morphine equivalents prescribed per patient among the 10 highest prescribers. Dr. Houlihan was fourth and the nurse practitioner a distant second to the highest prescriber who was not at the Tomah VA medical center (63,184 morphine equivalent per unique patients v. 29,264 for the nurse practitioner). These findings were derived from the spreadsheets produced at 1946-2057, 2879-4129. As noted in the administrative closure p. 9, overall we concluded that the opioid prescribing by specified practitioners at the Tomah VA facility seemed unusually high.

While most of the pharmacists were concerned about the high doses of opioids, there was testimony indicating that part of the problem was that the pharmacists had no experience working with the complex medical/psychiatric issues facing the veterans at the Tomah VA medical center. One experienced pharmacist told us that "some of the pharmacists . . . they come out of school, they're young guys, they're clinical pharmacists, they're just set back by the quantities and the high doses on – on some of this. You know, and basically they – they go seek another job and eventually find one and they're gone." Records produced, p. 5340. The same individual testified that some psychiatrists use a lot of narcotics and some do not use any. The individual noted that Dr. Houlihan uses a lot and for him it was proper treatment. He also noted that the nurse practitioner prescribes a lot of narcotics because of the patients she has. Records produced, p. 5343. As noted in our administrative closure report, the patients were being treated for very complex medical and psychiatric conditions.

In an interview with a psychiatrist at the Tomah VA medical center, we asked about a specific patient of Dr. Houlihan's who was identified by multiple pharmacists as being overprescribed opioids and of suspected drug diversion. The psychiatrist had provided care to this individual during a hospital admission. When asked about this patient, the psychiatrist told us that the patient was on "very high doses" of pain medications. He told us that he assessed the patient and the patient's ability to function on the high doses ("not impaired in any way"), and confirmed that the patient was taking the opioids as prescribed. Records produced, pp. 5383-5384. The psychiatrist also noted that Dr. Houlihan treated the "most difficult adults in the hospital." Records produced, p. 5385. This patient was the only patient identified by multiple current and former pharmacists as being suspected of drug diversion. An investigation into this allegation, which included witness interviews, undercover surveillance, and review of evidence obtained via subpoena, did not substantiate the suspicions. Records produced, p. 1393

Based on our analysis of the prescribing practices, the patient records, and other information available to us, our expert psychiatrists and other physicians concluded in our administrative closure pp. 6-7, that the "appropriateness of prescribing opioids to a particular patient or the appropriateness of a particular dose utilized is a complex matter that must take into account the patient's history, current medical and psychiatric status, social situation, and other factors." Our experts further concluded that clinical decision making underlying this process is based on the

practitioner's clinical judgment and other factors that vary from patient to patient." As is evident from the interviews produced, particularly the interviews with past and present pharmacy staff, no one, other than Dr. Houlihan, the nurse practitioner, and other prescribing physicians had the requisite knowledge of the particular patients and their specific conditions to make these decisions.

More than one pharmacist told us that one of the problems was the lack of knowledge that the pharmacists have with the overall picture regarding each patient. One pharmacist told us: "the physician or provider certainly has, you know, the overall big picture of the patient, you know. We are part of the therapy, of course, you know, but sometime I look (inaudible) because we are dispensers of medicine (inaudible) portion that would fill, of course, with, you know . . . we're dispensers." Records produced, p. 6032. This point was emphasized during the interview of a pharmacist, with many years of experience at the Tomah facility, who, when asked to comment on the doctors' prescription histories advised, "there are some that are of course prescribing more than others, and I don't know ...if that's their treatment field." When specifically asked about Dr. Houlihan's practice, the pharmacist stated, "Dr. Houlihan uses a lot, and I know he thinks ... this is proper treatment. You know, I'm not judging if it is or not." The pharmacist also commented on the effect differing practice areas might have on the amount of narcotics a specific provider might prescribe. To illustrate his point the pharmacist discussed the practice of a nurse practitioner stating, "Basically she deals with these types of guys and that's all she deals with. So I mean, she's not going to be dealing with blood pressure or high cholesterol ... so she's prescribing a lot, but she's going to have to, because that's the type of patient she has." Records produced 5342-5343.

The inspection did not support allegations of drug diversion

While drug diversion was not identified as an issue being addressed in Senator Johnson's investigation, I believe it is worth discussing in this letter because a number of current and former employees, including Noelle Johnson, raised it in their interviews with the Healthcare inspectors. Although the issue was raised, none of the witnesses identified a specific patient who was known to be diverting drugs. As with other statements, the concerns were based on speculation, gossip, and rumors. The documents I submitted with my April 24, 2015, letter, included reports of contact with various law enforcement entities, including the Tomah police, who did not substantiate the allegations. Records produced, pp. 1549, 5726-5729. In addition, the records produced include an email from the VA Police at the Tomah facility that also did not substantiate the concerns raised by the individuals we interviewed.

On May 8, 2015, I provided a response to a request from Senator Johnson for information relating to cases of drug diversion that we investigated in Wisconsin and VISN 12. In my response, I reported that from January 1, 2008, to the present that we conducted six investigations in VISN 12 of which four cases were in Wisconsin. However, none of the cases

involved the Tomah VA medical center. I also reported that the cases involved 11 individuals of which seven were prosecuted. All subjects in those cases were employees, not veterans.

The VA OIG administrative closure did not address any tragedies or veterans deaths

In a February 11, 2015, email, Mr. David Brewer stated that the Chairman of the Committee had "directed [them] to examine the circumstances surrounding the tragedies at the Tomah VAMC" and Senator Johnson referred to "tragedies" in his statement at the March 26, 2015, hearing. As I explained in my February 27, 2015, letter to Senator Johnson, I do not know what tragedies he was referring to because the inspection, which was primarily conducted in 2012, did not include any deaths, and none were identified in the August 2011 complaint. Accordingly, I advised that our files did not include any records on this issue. I also stated in my February 27, 2015, letter that when we recently became aware of two specific deaths (August 2014 and January 2015) that were alleged to be related to poor quality care, we opened an investigation and an inspection to address these complaints. These activities are ongoing. Attached is a copy of my February 27, 2015, letter.

In his April 20, 2015, letter, Senator Johnson redefined the scope of his investigation stating that the "Committee is investigating allegations of veterans' deaths at the Tomah VAMC, retaliation against whistleblowers, and a culture of fear among employees at the facility that date back almost a decade." I addressed these issues in-depth in my April 24, 2015, letter and provided responsive records. I advised that because our Healthcare inspection did not address allegations of veterans' deaths at the Tomah VAMC, the file does not include any records responsive to this aspect of Senator Johnson's investigation. I also advised that if there is a specific death that Senator Johnson believes may have been brought to our attention during the review, to let me know and we will re-check our files. Neither I nor anyone on my staff received a request for documents or other information relating to a specific veteran's death or other such tragedy. I note that there are no records in our file for the 2011-2012 inspection relating to the death of a specific veteran due to poor quality care. Had we received such allegations, we would have reviewed the circumstances surrounding the death, including the care provided at the Tomah VA medical center.

The only specific death brought to our attention during the inspection was that of a psychologist, Christopher Kirkpatrick, who committed suicide after being terminated from his temporary position at the Tomah medical center on July 14, 2009. We did not find any evidence that Dr. Houlihan was in any way responsible for Dr. Kirkpatrick's death, although the Vice President of the local chapter of the American Federation of Government Employees (AFGE) expressed this opinion in documents she provided to the Juneau County Sheriff's Department who was responsible for investigating the suicide. I strongly recommend a thorough review of the in-depth Sheriff's report, a publicly available document, that is included in the documents produced, Records produced, pp. 5795-5851, with specific attention to the pages detailing the voluminous amounts and types of marijuana and what appears to be other illegal substances

found in Dr. Kirkpatrick's residence as well as other items, including a scale and used devices containing marijuana residue. The evidence indicates that Dr. Kirkpatrick was likely not only to have been using but also distributing the marijuana and other illegal substances. The Sheriff's report also lists large amounts of various prescription drugs found onsite, some of which were lying around loose with no indication whether they were prescribed for Dr. Kirkpatrick and, if so, when and by what provider.

Mr. Honl alleged in his written statement for the March 30, 2015, field hearing that "Dr. Kirkpatrick, who raised concerns about Dr. Houlihan's prescribing practices, was terminated, and went home and committed suicide." As previously noted, Mr. Honl was not employed by the VA in July 2009 when the event occurred and by his own admission has no personal knowledge of the death or the circumstances surrounding it. There is no evidence to support Mr. Honl's statement. Even the complaint from the Vice-President of the local AFGE, which is included in the Sheriff's report, does not allege that Dr. Kirkpatrick raised concerns about Dr. Houlihan's prescribing practices.

Retaliation for Whistleblowing

With respect to the issue of retaliation for whistleblowing, our inspection did not address this issue. Other than former Tomah VAMC pharmacist, Noelle Johnson, who testified at the field hearing held by Senator Johnson on March 30, 2015, in Tomah, Wisconsin, no one told us that they were retaliated against for whistleblowing nor did anyone identify a specific individual who was retaliated against for whistleblowing. Ms. Johnson has alleged both in her interview with VA OIG staff and in her testimony on March 30, 2015, that her termination from her position as a pharmacist at the Tomah VA medical center in June 2009 during her probationary period was in retaliation for whistleblowing because she would not fill a prescription. The evidence that we reviewed during the inspection does not support her assertion. We suggest that Committee Members review the document in the records produced, titled Agency's Pre-Hearing Submission, which relates to Ms. Johnson's appeal of her removal that she filed with the Merit Systems Protection Board (MSPB) (Submission). Records produced, pp. 4883-4899. This document addressed her her alleged whistleblowing including the fact that she went to the Office of Special Counsel which determined that she did not make a protected disclosure. More importantly, the document details the circumstances surrounding and reasons for her termination and refutes her assertion that she was fired for refusing to fill a prescription. This information is important because the transcripts of the interviews with numerous current and former pharmacy employees reflect a fear of Dr. Houlihan because of what they had heard about Ms. Johnson's termination, not their personal knowledge of the facts.

The Submission states that Ms. Johnson's first line supervisor recommended her termination because she had poor interpersonal skills and was caustic with clinicians. Her second line supervisor was expected to testify that Ms. Johnson had repeated negative interactions with clinicians and that he met with her concerning these issues. After the second level supervisor left

for a military deployment, the individual who was acting in that position was expected to testify at the hearing that she rated Ms. Johnson's performance as unsatisfactory in June 2009 based on complaints by the first level supervisor, provider complaints, and Ms. Johnson's unwillingness to be a team player. This rating resulted in Ms. Johnson's removal. Dr. Houlihan was identified in the Submission as a witness but his proposed testimony was limited to his interactions with Ms. Johnson, not the decision to remove her. Records produced, pp. 4883-4898.

I also refer you to the transcript of our interview with Ms. Johnson's first level supervisor who told us that Ms. Johnson was having a hard time and "she brought a lot of negativity back into the department and there were some people who didn't agree with her at first and so that created friction." Records produced, p. 6009. He further stated that one of the problems they had with Ms. Johnson was that "it was her way or the highway, but she didn't have that kind of authority, but if you didn't agree with her you were obviously less intelligent than her. . . . That's why she became difficult to work with in committees because if you disagreed with her you obviously were not as intelligent as her and that kind of rolled into the pharmacy too where people were siding with her or siding against her, and that was kind of driving it down a different path." *Id.*

Contrary to statements by Ms. Johnson and the perceptions of several witnesses interviewed during our review, some of whom were not even employed at the Tomah VA medical center when Ms. Johnson's employment was terminated, the records available to us during our review do not support the conclusions that Dr. Houlihan fired Ms. Johnson, that she was fired in retaliation for whistleblowing or that she was fired for refusing to fill a prescription. It must be noted that at the time, Ms. Johnson was not only a probationary employee, she also had just completed her training and this was her first position as a pharmacist.

Culture of Fear

The third issue identified as being within the scope of Senator Johnson's investigation is the "culture of fear that dates back for almost a decade." Our Healthcare inspection did not address this specific issue. While it is true that some individuals expressed that they had some level of fear, the transcripts of the interviews show that it was based primarily on gossip, rumor, and hearsay, not personal experiences or fact. As discussed above, a number of witnesses cited the removal of Ms. Johnson as the basis for their fear of Dr. Houlihan, which they believed was based on her refusal to fill a prescription. For example:

- One pharmacy employee told us "there was kind of urban legends of other pharmacists leaving because their voices weren't being heard." Records produced, p. 5095.
- Another, who had worked at a community based outpatient clinic affiliated with the Tomah VA medical center, was critical of Dr. Houlihan because she heard that he blamed her for the death of a patient who committed suicide in 2010 after she refused to provide an early refill for a patient who subsequently committed suicide. However, she did not discuss the matter with Dr. Houlihan and told us that she "tried to stay as far

away from him because of what Noelle Johnson went through with him, the pharmacist that he fired over her refusing to fill narcotic prescriptions." Records produced, pp. 5047-5048. When pressed for more information, the individual admitted that she didn't "know the details" and suggested that we speak with Noelle Johnson. Records produced, p. 5054. Although the pharmacist said that she was aware that Dr. Houlihan was upset with the decision she made and told us (in 2012) that "he was out to get her" for the 2010 incident, she admitted that no action was taken against her. Records produced, p. 5051.

- Another pharmacy employee told us that he did not question things because he was "scared to question it." Records produced, p. 5483. When asked why he was afraid, the individual told us: "Well, right before I came here as a student, a pharmacist was let go and basically, you know, I wasn't here for it, but everybody has told me that she was let go because she questioned a prescription from Dr. Houlihan and he basically found a way to release her." *Id.*
- Another pharmacist told us: "If I piss off the wrong people I'm gone and there's been stories that a pharmacist here a few years ago that was not playing ball was gone." Records produced, 6036.

The fact is that although some witnesses expressed concern over what they feared Dr. Houlihan would do if they questioned him or another provider, it is clear from the interviews that staff did raise questions and that no one was subjected to any disciplinary or performance based action for doing so. In summary, the current or former employees who expressed fear of Dr. Houlihan all worked in the pharmacy, did not have any direct negative personal experiences with Dr. Houlihan, and had no personal knowledge regarding Ms. Johnson's removal. Accordingly, their fears were not based on personal experience or personal knowledge of the facts and were unsupported by fact. As we stated in the administrative closure report p. 5, "In the context of having obtained multiple contradictory facts and statements during the course of this inspection, often based on second or third hand accounts, we did not substantiate allegations of abuse of authority, intimidation and retaliations when staff questioned controlled substance prescription practices."

During her interview, Ms. Johnson related interactions between her and Dr. Houlihan in which she stated that he yelled and used profanity towards her. No other witness related any similar conduct on the part of Dr. Houlihan. One witness indicated that Dr. Houlihan would raise his voice and yell, but did not tell us that Dr. Houlihan used profanity. Records produced, pp. 5995, 5998. Another witness interviewed in 2012 described one meeting in which Dr. Houlihan yelled but also stated that he had calmed down a lot. Records produced, p. 6052. In contrast, other witnesses, including personnel in pharmacy, told us that they had positive interactions with Dr. Houlihan. One pharmacist denied any inappropriate behavior by Dr. Houlihan and told us that he had to call him a couple of times with concerns and that he "is quite nice in the way he gets his point across and all that" and "he is not a rude person at all." Records produced, p. 5499. A

pharmacist who was in a supervisory position and working with Dr. Houlihan daily at the time of our site visit described his working with Dr. Houlihan as "fine" and stated that "It's no challenge at all." Records produced, p. 6143. A physician related to us that when he got to the Tomah VA medical center, he noticed a "handful of staff talked about Dr. Houlihan in a way that sounded at the time a little unbalanced and paranoid...It sounded as if he were doing all kinds of things and it was never very specific." Records produced, p. 5352. The physician discussed concerns raised by the manager of the residential programs who talked about Dr. Houlihan as if "there wasn't any faith in him" and that the individual had said "you can't trust him. Be careful around him." However, the physician added that the individual making these statements was "never specific." *Id.* This physician told us that in his experience, Dr. Houlihan knows the patients and "has been quite reasonable as far as the concerns have been," *Id.* He volunteered that "We have no belief that he deliberately gives veterans something or did anything criminal. He has been very receptive to people and to veterans." *Id. See also,* pp. 6068- 6069, 6130, 6132, 6148, 6150, 6165-6166. Another psychiatrist told us that he does not prescribe opioids because he was not trained to do that and that he has not felt any pressure from his supervisors to prescribe opioids. Records produced, p. 5382. When asked about his interactions with Dr. Houlihan, the psychiatrist stated that Dr. Houlihan was a resource for him and that he found him very approachable. He stated that Dr. Houlihan hired him, that that he did not "have a problem picking up the phone and talking to him . . .," and that he "encouraged [his] colleagues to do the same. Don't be afraid." Records produced, 5382-5383.

The August 2011 anonymous complaint cited an incident in which Dr. Houlihan interfered with the arrest of one of his patients by the police on the Tomah campus. As noted above, during an interview with VA OIG Office of Healthcare Inspections and Criminal Investigations personnel, the individual acknowledged sending the letter. When asked to provide more detail, including the identity of the police officer, she was unable to do so. When initially asked, the individual said "That's what this guy told me," but did not identify the "guy." When pressed for more information, the individual stated, "If I got my story right, you know. I'm just trying to go from memory" . . . "But I'm pretty sure that's what he said." Records produced, p. 5326. *See also,* pp. 5321, 5325. Despite multiple attempts to identify the police officer or obtain other information from the Tomah police and the VA police onsite at the facility, we were unable to substantiate that the incident alleged in the August 2011 complaint actually occurred. A witness knowledgeable regarding law enforcement activities at the Tomah VA medical center denied any interference by Dr. Houlihan with law enforcement activities or the reporting of concerns to the VA OIG. He also denied that Dr. Houlihan crossed any boundaries with regard to law enforcement. Records produced, pp. 6130-6132.

We recognized during the inspection that there was friction between the pharmacy and the providers, not just Dr. Houlihan, particularly with regard to early refills and what some perceived as over prescribing of opioids. We noted in our administrative closure report p. 10, that we had a concern about the "dysfunction of multidisciplinary collaboration in patient care that we

observed, particularly between pharmacy staff and Dr. Z [Houlihan]. *Perceptions* of abuse of authority, intimidation and retaliation are problematic in themselves because they diminish or even preclude the willingness to communicate concerns about potential safety issues or aberrant patient behaviors. . .The pharmacy staff uniformly indicated that they were reluctant to question any prescription ordered by Dr. [Houlihan] or any aberrant behavior by his patients (for example, frequent requests for early refills because they feared reprisal, even though most of them could not give a first-hand account of negative actions towards them by Dr.[Houlihan]. For his part, Dr. [Houlihan] complained that the pharmacists, (except for one) were unwilling to approach him with problems or concerns and were uninterested in learning more about his treatment approach and rationale." (Emphasis added). To address this issue, we suggested to the facility Director and VISN management the "facility Director should implement a vehicle by which clinicians and staff can openly and constructively communicate concerns and rationale when disagreements arise concerning dispensing of opioid prescriptions."

Summary

We prepared this document to supplement the 13,949 pages of material that we provided in compliance with the Committee's subpoena. We would be happy to provide a briefing to any Committee Member on our work during 2011-2012, which is highlighted in this analysis.

We are working diligently to complete our work concerning the circumstances involving the deaths of Thomas Baer and Jason Simcakowski. Upon completion, we will be available to provide a briefing of our conclusions to the Committee.

United States Government Accountability Office

GAO

Report to Congressional Committees

January 2016

DOD AND VA HEALTH CARE

Actions Needed to Help Ensure Appropriate Medication Continuation and Prescribing Practices

GAO-16-158

GAO Highlights

Highlights of GAO-16-161, a report to congressional committees

Why GAO Did This Study

Medication continuation, when clinically appropriate, is critical for transitioning servicemembers with PTSD or TBI who have been prescribed psychiatric, pain, or sleep medications. Adverse health effects may occur if these medications are inappropriately discontinued.

The National Defense Authorization Act for Fiscal Year 2015 included a provision for GAO to assess transitions of care, particularly medication continuation for servicemembers with PTSD or TBI transitioning to VHA. GAO examined (1) the extent to which DOD and VHA developed and monitored recommended medication practices for PTSD and TBI, (2) the extent to which psychiatric, pain, and sleep medications on DOD's formulary are on VA's formulary, and how differences might affect medication continuation, and (3) key efforts VHA has to help ensure medication continuation, and the extent it is monitoring these efforts. GAO reviewed documents and analyzed DOD and VHA data from fiscal years 2014 through 2015, and interviewed DOD and VHA officials from headquarters and the Army and DOD facilities selected for variation in size and location. GAO focused on the Army as the largest number of its servicemembers served in recent conflicts.

What GAO Recommends

GAO recommends that the Army monitor prescribing practices of medications discouraged under the PTSD guideline and that VHA clarify its medication continuation policy. DOD and VHA concurred with the recommendations.

View GAO-16-161. For more information, contact Debra Draper at (202) 512-7114 or draperd@gao.gov.

January 2016

DOD AND VA HEALTH CARE

Actions Needed to Help Ensure Appropriate Medication Continuation and Prescribing Practices

What GAO Found

The Department of Defense (DOD) and the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) have collaborated to develop clinical practice guidelines for post-traumatic stress disorder (PTSD) and mild traumatic brain injury (TBI). The mild TBI guideline does not include recommendations based on scientific evidence regarding the use of medications to treat symptoms because of a lack of available research; however, the PTSD guideline discourages the use of benzodiazepines (a sedative) and states that the use of antipsychotics to treat PTSD lacks support, based on available research. VHA monitors the prescribing of benzodiazepines and antipsychotics to treat PTSD nationally and by VA medical centers (VAMC) and requires VAMCs to implement improvement plans if their prescribing is significantly higher than the average of all VAMCs. GAO found that DOD relies on each military service to review the medication prescribing practices of its providers and that the Army does not monitor the prescribing of medications to treat PTSD on an ongoing basis. Without such monitoring, the Army may be unable to identify and address practices that are inconsistent with the guideline. Federal internal control standards require agencies to have control activities to establish performance measures, implement ongoing monitoring to assess performance, and ensure that the findings of reviews are promptly resolved.

As of August 2015, VA's formulary included 57 percent of the psychiatric, pain, and sleep medications on DOD's formulary. These medications are prescribed to treat symptoms common among servicemembers and veterans with PTSD or mild TBI, and most of the DOD prescriptions in fiscal year 2014 for these medications (88 percent) were on both formularies. In addition, DOD and VHA officials GAO interviewed agreed that the differences did not affect the continuation of medications for servicemembers transitioning from DOD to VHA.

VHA has two key efforts to help ensure continuation of medications for transitioning servicemembers, including those with PTSD or mild TBI, but a lack of clarity of one effort may limit its effectiveness. VHA's nonformulary request process is one key effort that helps ensure newly transitioned veterans avoid medication discontinuations due to differences between the DOD and VA formularies. VHA monitors nonformulary requests. VHA data show that 81 percent of requests submitted from fiscal years 2012 through 2014 were approved, and 98 percent of requests were adjudicated within VHA's required time frame of 96 hours. The other key effort is VHA's 2015 policy instructing its providers not to discontinue mental health medications initiated by DOD providers due to formulary differences. However, VHA providers GAO interviewed had varying interpretations of which medications are covered by this policy, and VHA officials acknowledged that the definition of a mental health medication could be subjective. Federal internal control standards state that agencies should establish control activities, such as developing clear policies. Because VHA's policy lacks clarity, VHA providers may be inappropriately discontinuing mental health medications due to formulary differences, which could increase the risk of adverse health effects for transitioning servicemembers.

Contents

Abbreviations

DOD	Department of Defense
MTF	military treatment facility
PTSD	post-traumatic stress disorder
TBI	traumatic brain injury
VA	Department of Veterans Affairs
VAMC	VA medical center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

January 5, 2016

Congressional Committees

Post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) are two of the most prevalent injuries occurring as a result of military operations in Afghanistan and Iraq. Servicemembers diagnosed with PTSD or TBI, which is classified as mild, moderate, or severe, are treated with various therapies to manage their symptoms. These therapies may include psychiatric, pain, and sleep medications to manage symptoms such as irritability, insomnia, and headaches. If these medications are abruptly changed or discontinued, adverse health effects may occur. For example, a servicemember with PTSD whose symptoms of outbursts and self-destructive behavior have been stabilized with a psychiatric medication may experience a return of symptoms or withdrawal effects if the medications are suddenly stopped. A servicemember could also experience the onset of new side effects when initiating a new medication.

Effective medication management, which includes ensuring that medication regimens are continued when clinically appropriate, is critical for servicemembers with PTSD or TBI who transition their health care from the Department of Defense (DOD) to other health care systems, including the one operated by the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA). In particular, some stakeholders have raised concerns that VHA providers may change or discontinue servicemembers' medications upon transition to VHA because the VA formulary includes fewer medications than the DOD formulary. Further, some stakeholders have recommended that DOD and VA have a single formulary to better ensure medication continuation for transitioning servicemembers.

The Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 included a provision for us to assess the transition of care, particularly with respect to medications, for

servicemembers with PTSD or TBI as they transition from DOD to VHA.[1] This report examines

1. the extent to which DOD and VHA have developed and monitored recommended medication practices for PTSD and TBI;
2. the extent to which psychiatric, pain, and sleep medications on DOD's formulary are also on VA's formulary, and how, if at all, any differences have affected the continuation of medications for servicemembers transitioning from DOD to VHA; and
3. key efforts, if any, VHA has in place to help ensure the continuation of medications for servicemembers transitioning from DOD to VHA, and the extent to which VHA is monitoring these efforts.

To determine the extent to which DOD and VHA have developed and monitored recommended medication practices for PTSD and TBI, we reviewed documents and interviewed officials from DOD, the Department of the Army, and VHA. We focused our review of DOD's monitoring efforts on the Army because, compared to the other military services, it has the largest number of servicemembers who served in military operations in Iraq and Afghanistan, placing them at increased risk for having PTSD or TBI. We further focused our review on mild TBI because these patients are typically treated on an outpatient basis while patients with more severe TBI are treated in inpatient settings and medication discontinuation in outpatient settings may be especially challenging. We reviewed documents, such as the VA/DOD clinical practice guidelines for management of PTSD and mild TBI, and department policies and program documents related to medication treatments and monitoring efforts, including reports summarizing the prescribing of medications to treat servicemembers and veterans with PTSD. We interviewed officials from DOD, Army, and VHA headquarters to obtain information about recommended medication practices for patients with PTSD or mild TBI and monitoring efforts to help ensure that providers are following these practices. Specifically, for DOD, we interviewed officials from the Office of the Assistant Secretary of Defense for Health Affairs (Health Services Policy and Oversight), the Defense and Veterans Brain Injury Center within the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, and the Defense Health Agency Pharmacy Operations Division. For the Army, we interviewed officials from the Office

[1]Pub. L. No. 113-291, § 731, 128 Stat. 3292, 3422 (Dec. 19, 2014).

of the Surgeon General Behavioral Health Service Line and Traumatic Brain Injury Program, Medical Command Evidence-Based Practice Office, and the Pharmacovigilance Center. For VHA, we interviewed officials from the National Center for PTSD; Office of Mental Health Operations; Office of Quality, Safety, and Value Evidence-Based Clinical Practice Guidelines Program; Pharmacy Benefits Management Services; Pain Management Program; and Polytrauma System of Care at the Richmond, Virginia VA Medical Center (VAMC). We interviewed pharmacists, psychiatrists, and other providers who treat patients with PTSD or mild TBI about the recommended medication practices and related monitoring at three VAMCs located in Washington, D.C.; Boise, Idaho; and Tuscaloosa, Alabama; and two Army military treatment facilities (MTF) located in Fort Hood, Texas and Fort Carson, Colorado.[2] We selected the VAMCs and Army MTFs for variation in size and geographic location. As part of our review, we examined the extent to which the Army's and VHA's efforts were consistent with the standards for internal control in the federal government—specifically those related to control activities and monitoring.[3]

To determine the extent to which the psychiatric, pain, and sleep medications on DOD's formulary are also on VA's formulary and how, if at all, any differences have affected the continuation of medications for servicemembers transitioning from DOD to VHA, we conducted a comparison of the two formularies and interviewed DOD and VHA officials and stakeholders for their perspectives on any differences. We selected these three categories of medications because they are used to treat symptoms that are common among patients with PTSD or mild TBI. DOD's Pharmacy Operations Division identified the psychiatric, pain, and

[2]We interviewed pharmacists about recommended medication practices and related monitoring because pharmacists are responsible for reviewing prescriptions for clinical appropriateness and may also be responsible for reviewing the utilization of certain medications.

[3]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

sleep medications on DOD's formulary as of August 2015.[4] We compared the active pharmaceutical ingredients on this list with those on the VA formulary as of August 2015, as provided by VHA.[5] Because we focused on transitions of care from DOD to VHA, we did not determine which medications on VA's formulary were not on DOD's formulary. To provide further context to our formulary comparison, we analyzed DOD's utilization of the medications on its formulary. We obtained data from DOD on the number of prescriptions filled by DOD for active duty servicemembers in fiscal year 2014, the most recent year of complete data available, for each of the psychiatric, pain, and sleep medications on its formulary. We spoke with knowledgeable DOD officials about the formulary and prescription data, including their methodology for identifying pain, psychiatric, and sleep medications, and as a result, DOD made several modifications to its final list of medications. We also spoke with DOD and VHA officials about our methodology for comparing the formularies. On the basis of these discussions, we determined the data to be sufficiently reliable for the objectives of our report.

We also interviewed DOD and VHA officials about the reasons for, and potential implications of, identified formulary differences. In addition, we reviewed analyses conducted by VHA and other organizations on the possible implications of formulary differences, including the extent to which differences may have affected medication continuation.[6] We also obtained the perspectives of providers and pharmacists from our selected VAMCs and Army MTFs, as well as case managers who help manage

[4]These medications included nonopioid pain management agents, narcotic analgesics, nonsteroidal anti-inflammatory agents, antianxiety agents, antidepressants, attention-deficit hyperactivity disorder agents, and sedative hypnotics, among others, that are commonly used to treat pain, psychiatric, and sleep disorders. DOD's Pharmacy Operations Division excluded psychiatric, pain, and sleep medications that were available over-the-counter, were bulk medications used by pharmacists for compounding, or were provided through certain routes of administration, such as intravenous pain medications.

[5]According to DOD and VHA officials, different formulations (such as dosage form) and different routes of administration do not always correspond to clinically significant differences. However, in some cases, different formulations may be prescribed for different clinical indications and may have significant implications for patients. We determined that medications on the DOD and VA formularies were not the same in cases where the VA formulary was limited to formulations with a different clinical indication.

[6]For example, we reviewed VHA's 2015 study of servicemembers transitioning from DOD to VHA with psychiatric, pain, or sleep medications. We also reviewed multiple estimates of the costs associated with developing a common DOD and VA formulary.

and transition the health care of servicemembers and veterans with complex needs. In addition, we interviewed seven stakeholder groups—American Legion, Iraq and Afghanistan Veterans of America, Military Officers Association of America, three Vet Centers (associated with the three VAMCs included in our review), and the Military Compensation and Retirement Modernization Commission.[7]

To identify the key efforts, if any, VHA has in place to help ensure the continuation of medications for servicemembers transitioning from DOD to VHA and to determine the extent to which VHA is monitoring these efforts, we interviewed VHA officials and reviewed related VHA documentation and data. Specifically, to determine how VHA providers prescribe medications that are not on VA's formulary to servicemembers transitioning from DOD, we reviewed VHA policy documents and interviewed VHA officials, providers and pharmacists from our three selected VAMCs, and the Veterans Integrated Service Networks (VISN) for the VAMCs in our review.[8] We obtained data, from fiscal years 2012 through 2014, from VHA on medications that were not on VA's formulary that VHA providers requested, and we analyzed the data to determine the percentage of such requests that were approved and the extent to which these requests were adjudicated in a timely manner.[9] We also obtained data on VHA's prescription rates for fiscal year 2014 for the top five psychiatric, pain, and sleep medications prescribed by DOD that were not on VA's formulary to determine the extent to which VHA prescribes

[7]Vet Centers provide confidential counseling and referral services to veterans and their families through a nationwide system of community-based centers that VA established separately from other facilities.

The Military Compensation and Retirement Modernization Commission, established by the National Defense Authorization Act for Fiscal Year 2013, as amended, was charged with conducting a review of the retirement and military compensation systems—including military health benefits—and making recommendations to modernize these systems. In January 2015, the commission issued a report to the President and Congress that included a recommendation that DOD and VA establish a single formulary for pain and psychiatric medications and any other types of medications identified as critical for transitioning servicemembers. See Military Compensation and Retirement Modernization Commission, *Final Report of the Military Compensation and Retirement Modernization Commission* (Arlington, VA: Jan. 29, 2015).

[8]Each VISN is responsible for managing and overseeing VAMCs within a defined geographic area. At the time of our review, there were 21 VISNs.

[9]Our review included all medications not on VA's formulary that were requested by VHA providers and was not limited to psychiatric, pain, and sleep medications.

medications that are not on the formulary. Based on our discussions with VHA, VISN, and VAMC officials about how prescription data and requests for medications not on the VA formulary are collected, analyzed, and reported, we determined the data to be sufficiently reliable for the objectives of our report. In addition, we interviewed VHA officials to identify policies related to continuation of medications for transitioning servicemembers and reviewed those policies, including the extent to which VHA monitors their effectiveness. As part of our review, we examined the extent to which VHA's policies and monitoring efforts were consistent with the standards for internal control in the federal government—specifically those related to control activities and monitoring.[10]

We conducted this performance audit from May 2015 to December 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

DOD and VHA Health Care

DOD and VHA provide health care, including medications for psychiatric, pain, and sleep conditions, to servicemembers and veterans through their respective health care systems. DOD provides health care to active duty servicemembers; Reserve and National Guard members on active duty; and other beneficiaries, such as family members and retired servicemembers, through TRICARE, its health care program.[11] TRICARE beneficiaries can obtain comprehensive health care services—including outpatient and inpatient care, mental health care, and prescriptions for medications—through a direct-care system of MTFs operated by the

[10]GAO/AIMD-00-21.3.1.

[11]Reserve and National Guard members on active duty for more than 30 consecutive days are covered by TRICARE. They also may be eligible for TRICARE coverage prior to active duty, and, after active duty, they may be eligible to purchase TRICARE coverage when they return to inactive status.

Departments of the Army, Navy, and Air Force, or through a purchased-care system of civilian health care providers.[12] Prescription medications can be obtained through MTF pharmacies, retail pharmacies, and the TRICARE mail-order pharmacy. DOD is required by law to make all clinically appropriate medications available to servicemembers, and, with the exception of certain classes of medications, such as weight-loss medications, DOD makes all Food and Drug Administration-approved prescription medications available.[13] DOD's formulary process is administered by DOD's Pharmacy and Therapeutics Committee, and the formulary includes a list of medications that all MTFs must provide and medications that an MTF may elect to provide on the basis of the types of specialized services that the MTF offers (such as cancer medications).[14] DOD classifies certain medications as "nonformulary" on the basis of its evaluation of their cost and clinical effectiveness, and DOD's nonformulary classification applies to all MTFs and DOD's purchased-care system. Nonformulary medications are available to beneficiaries at a higher cost, unless the provider can establish medical necessity.

Veterans who served in active military duty, and were discharged or released under conditions other than dishonorable are generally eligible for VHA health care.[15] In general, veterans must enroll in VHA health care to receive VHA's medical benefits—a set of services that includes a full range of hospital and outpatient services, mental health care, and

[12]DOD's direct-care system of MTFs included 55 hospitals and 373 ambulatory care clinics in 2014.

[13]See 10 U.S.C. § 1074g(a)(3); 32 C.F.R. §§ 199.4(g), 199.21(h)(3)(iii).

[14]DOD's Pharmacy and Therapeutics Committee is responsible for evaluating the clinical and cost effectiveness of medications for inclusion on DOD's formulary and its membership includes representatives from the military services.

[15]Any veteran who has served in a combat theater after November 11, 1998, and who was discharged or released from active military duty on or after January 28, 2003, has up to 5 years from the date of the veteran's most recent discharge or release from active duty service to enroll in VHA and receive health care services. See 38 U.S.C. § 1710(e)(1)(D),(e)(3). For those veterans who do not enroll during their enhanced eligibility period, eligibility for enrollment and subsequent care is based on other factors such as compensable service-connected disability, VA pension status, catastrophic disability determination, or financial circumstances. Reserve and National Guard members also may be eligible for VHA health care if they were called to active duty by federal order and completed the full period for which they were called, or when they demobilize from combat operations, even if they have not separated from military service.

prescription medications.[16] VHA provides health care services at various types of facilities, including VAMCs and community-based outpatient clinics.[17] Veterans may obtain prescription and over-the-counter medications through VAMC or community-based outpatient clinic pharmacies, VHA's mail-order pharmacy, or through certain non-VHA pharmacies. VA's formulary provides access to medications for eligible beneficiaries. VHA manages VA's formulary and makes decisions about whether to add medications to the formulary on the basis of clinical and cost effectiveness and, like DOD, provides access to nonformulary medications when providers establish medical necessity. Because VHA only fills prescriptions written by VHA providers or providers VHA has authorized its patients to see, VHA generally has direct control over the medications that are prescribed to its patient populations.

PTSD and Mild TBI

PTSD is a trauma and stressor-related disorder that can occur after a person is exposed to a traumatic or stressful event such as a death or serious injury; its onset may be delayed. As defined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders, to be diagnosed with PTSD, patients must have experienced four types of symptoms that continue for more than 1 month after the event:

- **persistently re-experiencing the event** such as through flashbacks and traumatic nightmares;
- **persistently avoiding trauma-related stimuli** such as places or situations that are reminders of the event;
- **negative changes in cognitions and mood** that began or worsened after the event, such as persistent negative beliefs about oneself or the world; and
- **changes in arousal and reactivity** that may include aggressive or self-destructive behavior and insomnia.[18]

[16]VA's enrollment system includes eight categories for enrollment, with priority generally based on service-connected disability, low income, and other recognized statuses, such as former prisoner of war. See 38 U.S.C. § 1705; 38 C.F.R. § 17.36.

[17]According to VHA, as of June 30, 2015, there were 167 VAMCs.

[18]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, 5th ed., (DSM-5)* (Arlington, VA: 2013).

The symptoms cause significant distress or impairment—for example, in the patient's social relationships and work life—and the duration of symptoms varies, according to the *Diagnostic and Statistical Manual of Mental Disorders*. That is, some patients with PTSD have symptoms for less than 3 months while others may experience symptoms for longer than a year and sometimes for many years. In addition to providing medication therapy, DOD and VHA provide psychotherapy, which has been shown to be effective in the treatment of PTSD in clinical research studies, as well as other types of therapies.[19]

Mild TBI (also known as a concussion) is caused by a blow or jolt to the head that temporarily disrupts the normal function of the brain. The diagnosis is based on several factors including that the patient has an alternation of consciousness that may last from a moment up to 24 hours or has a loss of memory for the events immediately before or after the injury that lasts for a day or less.[20] There are many causes of this condition—such as blasts and car accidents—and, while not all patients with mild TBI have symptoms, those that do typically experience symptoms immediately following the event. Headache is the most common symptom, and other common symptoms include dizziness, fatigue, irritability, and insomnia. A very small proportion of patients with mild TBI have symptoms that persist beyond 6 months, although symptoms may last longer after repeated mild TBIs.[21] In addition to providing medication therapy for certain symptoms, DOD and VHA provide other services for the treatment of mild TBI symptoms which may include physical and occupational therapy and neuropsychological care. Servicemembers that are diagnosed with mild TBI as a result of combat also have a higher risk of experiencing PTSD. Additionally, servicemembers with either PTSD or mild TBI often experience other co-

[19]Effective psychotherapy for PTSD includes cognitive elements (e.g., identifying and modifying trauma-related beliefs) and/or exposure elements (e.g., the repetitive review of traumatic memories and trauma-related situations) or stress inoculation training (e.g., breathing retraining and muscle relaxation). Other types of therapies include complementary or alternative therapies such as relaxation therapy.

[20]Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Management of Concussion/mild Traumatic Brain Injury* (Washington, D.C.: April 2009).

[21]Ibid.

occurring conditions, such as chronic pain, which may be related to their combat-related injuries.[22]

Medication Management and Continuation during Transitions of Care

As we previously have reported, the length of time that servicemembers take to transition their health care from DOD to VHA or another health care system varies.[23] Some servicemembers may not transition their care to VHA at all and instead seek care from other health care systems and providers. Of those transitioning to VHA, some servicemembers separate from the military and have their first appointment at VHA the following week. Others may take more time to transition to VHA, waiting months or years before scheduling their first appointment.[24]

Effective transitions of care, including for servicemembers transitioning from DOD to VHA, should include education and counseling about medication adherence, medication lists at discharge, and a plan for how to get medications during transitions, according to the National Transitions of Care Coalition—a nonprofit organization that produces tools and resources to assist with such transitions. As we previously have reported, DOD and VHA have established several programs to assist servicemembers, such as those with PTSD or mild TBI, with care transitions, including help with medication management.[25] For example, Army nurse case managers have procedures both to assess if servicemembers receiving care at MTFs have sufficient supplies of medications until their initial VAMC appointment and to share servicemembers' medication lists with VA liaisons.[26] VA liaisons, who are nurses or social workers stationed at MTFs, in turn, have procedures to ensure that VHA providers receive servicemembers' medication lists and

[22]Ibid.

[23]GAO, *DOD and VA Health Care: Medication Needs during Transitions May Not Be Managed for All Servicemembers*, GAO-13-26 (Washington, D.C.: Nov. 2, 2012).

[24]We have reported on concerns regarding VHA's ability to ensure and accurately monitor access to timely medical appointments. See for example, GAO, *VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, GAO-13-130 (Washington, D.C.: Dec. 21, 2012).

[25]For more information on DOD and VHA programs that provide assistance with care transitions and medication management, see GAO-13-26.

[26]Army nurse case managers provide services to servicemembers with case management needs, which may include servicemembers with PTSD or mild TBI.

that transitioning servicemembers have adequate supplies of medications until their initial appointments.[27] Another example is DOD's inTransition Program. The inTransition Program is a confidential personal coaching program that helps servicemembers with mental health conditions as they move between health care systems or providers. The inTransition Program coaches are social workers who encourage transitioning servicemembers with mental health needs to continue their medications.[28] The continuation of medication therapy, that is, prescribing the same medications when a servicemember separates from DOD and transitions to other health care systems including VHA, is another important element of effective care transitions. Continuing clinically appropriate medications during this transition is especially important for servicemembers and veterans with mental health or pain conditions, such as PTSD, whose symptoms may have been stabilized as a result of medications that DOD providers have prescribed. The treatment of symptoms with medications can enable patients with mental health conditions to return to near-normal functioning and can enhance the effectiveness of psychotherapy.

DOD and VHA Have Developed Medication Treatment Recommendations for PTSD and Mild TBI and VHA Monitors the Prescribing of Certain Medications for PTSD

[27]As of April 2015, 43 VA liaisons were stationed at 21 Army and other MTFs.

[28]Beginning in April 2015, servicemembers who received mental health services are automatically enrolled in the inTransition Program unless they choose to opt out. Prior to April 2015, servicemembers were referred to the program by DOD providers.

DOD and VHA Have Collaborated to Develop Clinical Practice Guidelines for Medication Treatment for PTSD and Mild TBI

DOD and VHA have jointly developed clinical practice guidelines related to PTSD and mild TBI, which include recommendations for the treatment of symptoms among servicemembers and veterans with these conditions.[29] Each guideline includes a discussion of, and recommendations on, management of care for servicemembers and veterans with these conditions, such as screening and diagnosis, types of treatment interventions, and assessing treatment responses. The PTSD clinical practice guideline includes evidence-based recommendations to assist DOD and VHA clinicians in their decision making about which medications to prescribe to treat the symptoms of PTSD.[30] The mild TBI clinical practice guideline also includes recommendations related to medications for treating the symptoms of the condition; these recommendations are based on expert opinions, rather than evidence-based research, because of the lack of published studies on mild TBI medication treatments.[31] The guidelines state that the recommendations should not prevent providers from using their own clinical expertise in the care of an individual patient and should never replace sound clinical judgment. In addition to providing guidance for clinical decision making, the guidelines are intended to help improve the quality and continuum of care and the health outcomes for servicemembers and veterans with PTSD and mild TBI.

The PTSD guideline recommends that patients with PTSD be offered certain types of antidepressants and discourages the use of benzodiazepines, a type of sedative.[32] According to the guideline, the use

[29]Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress* (Washington, D.C.: October 2010) and Department of Veterans Affairs and Department of Defense, *Clinical Practice Guideline for mild Traumatic Brain Injury*.

[30]The guideline is based on a review of research outcomes available at the time of publication. The evidence-based recommendations provide information regarding treatments that have been consistently shown in controlled research to be effective or ineffective for treating PTSD. The guideline also includes evidence-based recommendations for nonmedication treatments.

[31]The expert opinions were obtained from DOD and VHA clinical experts who updated the guideline. They represented various clinical specialties such as neurology, internal medicine, and psychiatry. The mild TBI guideline describes several challenges regarding the development of strong evidence-based studies on which to build recommendations for treating patients with mild TBI, including that the symptoms are common to other conditions and occur frequently in the larger population.

[32]DOD and VHA officials said that they plan to issue an updated version of the PTSD guideline by the end of 2016 or beginning of 2017.

of selective serotonin reuptake inhibitors or serotonin norepinephrine reuptake inhibitors (types of antidepressants) are strongly recommended because there is good evidence that they are effective in reducing the core symptoms of PTSD and are generally well tolerated by servicemembers and veterans with PTSD.[33] In contrast, the guideline states that the use of benzodiazepines should be discouraged because of their lack of effectiveness in treating PTSD and because the risks may outweigh potential benefits.[34] The guideline also states that there is evidence to suggest that benzodiazepines may worsen recovery and, once they are initiated, they can be very difficult to discontinue due to significant withdrawal symptoms.

Additionally, the guideline states that the use of antipsychotics (atypical and conventional) to treat PTSD is not supported because the existing evidence is insufficient to warrant their use.[35] The guideline specifically recommends against the use of one atypical antipsychotic (risperidone) to supplement the use of antidepressants in treating PTSD, based on evidence from a VA study.[36] This study showed that risperidone did not reduce the symptoms of PTSD and its use did not justify the risk for adverse events.[37]

The mild TBI guideline provides general guidance on medications for treating the condition's symptoms and on those medications that warrant

[33]The PTSD guideline assigns a grade to each recommendation reflecting the strength of evidence. For example, the recommendation for the selective serotonin reuptake inhibitors or serotonin norepinephrine reuptake inhibitors is assigned an "A" because good evidence was found that use improves health outcomes and benefits substantially outweigh harm. Certain other antidepressants (e.g., tricyclic antidepressants) are assigned a "B" because there is at least fair evidence that they are effective.

[34]Benzodiazepines also induce sleep and, as a result, may be prescribed to treat insomnia.

[35]Atypical antipsychotics, also called second-generation antipsychotics, refer to those that were more recently developed than conventional antipsychotics.

[36]J.H. Krystal, R.A. Rosenheck, J.A. Cramer, J.C. Vessicchio, K.M. Jones, J.E. Vertrees, R.A. Horney, G.D. Huang, and C. Stock, "Adjunctive Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service-Related PTSD: A Randomized Trial," *Journal of the American Medical Association*, vol.306, no.5 (2011).

[37]The PTSD guideline includes several other recommendations. For example, the guideline states that there is either insufficient evidence for, or the existing evidence does not support, the use of certain anticonvulsants.

particular caution, including antipsychotics and benzodiazepines.[38] According to the guideline, there is insufficient evidence for recommending the use of one medication over another to treat the symptoms of mild TBI. As a result, the guideline provides general recommendations about medications, such as ibuprofen or naproxen—nonsteroidal anti-inflammatory medications—that may be used to treat common symptoms, such as tension headaches that occur periodically. Because some patients with mild TBI may experience seizures and confusion, the guideline cautions against the use of medications that can increase a patient's susceptibility to seizures, including antipsychotics, and medications that can cause confusion, such as benzodiazepines. Further, the use of medications to treat the condition itself (brain injury) is not recommended since the Food and Drug Administration had not approved any medications for this purpose as of April 2009, as stated in the guideline.[39]

The PTSD and mild TBI guidelines also include clinical guidance for treating insomnia and pain in servicemembers and veterans with these conditions. The guidelines emphasize that, when possible, initial treatment for insomnia should begin with nonmedication options, and recommend treatments, such as good sleep hygiene practices and cognitive behavioral therapy. Should medications also be needed, the guidelines state that insomnia may be treated with the use of certain sleep medications that are not benzodiazepines, such as zolpidem.[40] For pain, the guidelines recommend individualized treatment plans tailored to the types of pain the patient is experiencing. If medications are included in the treatment plans, the guidelines recommend, for example, that non-steroidal anti-inflammatory medications be used to treat pain resulting from injuries to the bones and muscles. The PTSD guideline further recommends that providers prescribe low doses of opioids or other centrally acting pain medications (which reduce the transmission of pain

[38]DOD and VHA officials said that they plan to issue an updated version of the mild TBI guideline by the end of 2015 or beginning of 2016.

[39]DOD and VHA officials confirmed that, as of November 2015, the Food and Drug Administration has not approved a medication to treat mild TBI since the current guideline was issued.

[40]The PTSD guideline also includes recommendations for the use of the antidepressant trazodone to help manage insomnia and the blood pressure medication prazosin for the treatment of nightmares.

through the brain), if required, and only in the short term, because they can cause confusion, and then transition their patients to the use of non-steroidal anti-inflammatory medications.[41]

VHA Monitors the Prescribing of Medications to Treat PTSD, but DOD and the Army Do Not; None Monitor Mild TBI Medications Given Lack of Specific Medication Recommendations in Mild TBI Clinical Guideline

VHA monitors the prescribing of medications that are included in the PTSD guideline, but DOD and the Army do not monitor such prescribing among servicemembers. As part of its Psychotropic Drug Safety Initiative, which began in 2013, VHA tracks the prescribing of benzodiazepines, antipsychotics, and other psychiatric medications to treat veterans with PTSD.[42] VHA tracks the prescribing of these medications quarterly at the VAMC, VISN, and national levels. Specifically, VHA tracks the percentage of veterans with PTSD who have been prescribed: (1) a benzodiazepine, (2) an antipsychotic (atypical and conventional) without a separate diagnosis of severe mental illness, and (3) medications from certain classes of psychiatric medications for 60 days or more.[43]

As part of the Psychotropic Drug Safety Initiative, VHA requires each VAMC to develop and implement a plan to improve on any measure for which the individual VAMC was performing significantly below the average of all VAMCs. This requirement encompasses measures focused on reducing prescriptions for benzodiazepines, antipsychotics, and other classes of psychiatric medications to treat veterans with PTSD. If a VAMC does not have any measures that meet the criteria, VHA still requires the

[41]In 2010, DOD and VHA jointly developed a clinical practice guideline for the use of opioids to treat chronic pain conditions. It includes recommendations for determining the appropriateness of opioid therapy, starting and adjusting dosages, assessing patient adherence and response to the therapy, and discontinuing the therapy. See Department of Veterans Affairs and Department of Defense, *VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain* (Washington, D.C.: May 2010). DOD and VHA officials said that they plan to issue an updated version of the opioid therapy guideline by the end of 2016 or beginning of 2017.

[42]The overall goal of the initiative is to improve the safety and efficacy of care for veterans by ensuring the use of evidence-based medication treatments for veterans with mental health conditions.

[43]The classes of psychiatric medications are antidepressants, antipsychotics, benzodiazepines, mood stabilizers, and antianxiety medications. VHA tracks the percentage of veterans prescribed medications from three or more of these five classes at the same time. VHA also tracks the prescribing of psychiatric medications in other populations as part of the Psychotropic Drug Safety Initiative. For example, VHA tracks the percentage of elderly veterans prescribed a benzodiazepine. In total, VHA is tracking 34 measures through the initiative.

VAMC to implement a plan to reduce prescriptions for psychiatric medications based on at least one measure, such as the percentage of veterans with PTSD who have been prescribed a benzodiazepine. In 2015, 22 VAMCs had developed plans to decrease the percentage of veterans with PTSD who are prescribed benzodiazepines and 26 had developed plans to decrease the percentage of veterans with PTSD who are prescribed antipsychotics (without a diagnosis of severe mental illness). Specifically, one VAMC created a clinical reminder in its electronic medical record that is activated when a veteran with PTSD (without a diagnosis of severe mental illness) is prescribed an atypical antipsychotic. To order the prescription, the VHA provider must justify why the medication is needed. This VAMC decreased the percentage of veterans with PTSD who had been prescribed antipsychotics by almost half, from 21.8 percent in 2013 to 11.5 percent in 2015. In addition to continually monitoring these measures, VHA officials told us that they review VAMCs' improvement plans twice a year and provide VAMCs feedback. As part of the initiative, VHA provides patient-level data to VAMCs—such as information about each patient with PTSD who is prescribed a benzodiazepine along with the name of the provider who prescribed the medication—so that VAMCs can prioritize patients where prescribing practices can be improved. In 2013, VHA also began tracking annually the percentage of veterans with PTSD who are prescribed antidepressants and other medications including prazosin—a medication recommended for PTSD patients who experience nightmares—nationally and by VISN, and the results are shared with VISN pharmacy executives, who are responsible for tracking pharmacy and patient outcome data.

In addition, VHA has begun a program, known as Academic Detailing, to make resources available to providers to assist them in incorporating evidence-based recommendations in the treatment of veterans with mental health conditions, including PTSD. In 2014, VHA developed a guide for clinicians on treating PTSD patients that summarizes key recommendations for medication treatment included in the PTSD guideline and provides other information, such as guidance on how to discontinue benzodiazepines by tapering their dosage over time.[44] As part of the program, pharmacists meet one-on-one with providers that have a high proportion of patients who had been prescribed certain medications

[44]Department of Veterans Affairs, *A VA Clinician's Guide to Managing Posttraumatic Stress Disorder: Improving Quality of Life Through the Use of Evidence-Based Medicine* (Washington, D.C.: June 2014).

(e.g., benzodiazepines, opioids) for whom there are significant safety concerns, including risk for abuse, to identify and address any treatment gaps, according to a VHA official. Each VISN is responsible for implementing an Academic Detailing program and was required to have a program in place by September 30, 2015. VHA officials told us that as of October 2015, 6 of the 21 VISNs had fully implemented such a program.

In contrast to VHA, neither DOD nor the Army monitors the prescribing of medications to treat servicemembers with PTSD in accordance with the guideline recommendations, on an ongoing basis. DOD officials told us that DOD relies on each military service to review the medication prescribing practices of its providers and helps facilitate medication reviews by generating reports for all MTFs that include a list of patients who are prescribed multiple psychiatric and pain medications.[45] DOD officials also told us that they track the prescriptions of certain medications included in the PTSD guideline, such as antipsychotics, by individual military service but do not track prescriptions according to PTSD diagnosis on an ongoing basis. We found that the Army also does not monitor the prescribing of medications that are included in the guideline recommendations on an ongoing basis. Instead, Army officials told us they have emphasized the importance of the PTSD recommendations in their recently issued policies and provider training. Specifically, the Army issued a PTSD policy in 2012, reissued it in 2014, and provided related training on the medication recommendations in the guideline. The policy and training stated that prescribing benzodiazepines to patients with PTSD should be avoided and that prescribing atypical antipsychotics to patients with PTSD warrants caution, given concerns with potential adverse health effects.[46]

The Army issued a policy in 2012 that required MTFs to review their prescribing practices for atypical antipsychotics, but the policy did not apply to benzodiazepines, and it expired in 2014. Army officials stated that they issued the policy on atypical antipsychotics given concerns that these medications could be prescribed without sufficient clinical rationale

[45]According to DOD officials, DOD updates these reports monthly, and the reports include a list of servicemembers who have been prescribed four or more psychiatric and pain medications from seven categories, including antipsychotics.

[46]The policy states that if these medications are prescribed to servicemembers with PTSD, Army providers should document their clinical rationale for prescribing and obtain informed consent from patients.

by providers in the treatment of PTSD but said that they do not plan to re-issue it. Providers and pharmacists we interviewed from one Army MTF told us that they are continuing to conduct these reviews because they identified a higher-than-expected prescribing rate and believe improvements can be made with additional efforts, such as further education of providers. In contrast, providers and pharmacists we interviewed from another Army MTF said that they were no longer conducting the reviews because the policy expired. Army officials told us that they are focusing their monitoring efforts on the extent to which the clinical outcomes among servicemembers with PTSD improve over time. These officials added that they do not have the same level of concern about atypical antipsychotic prescribing for patients with PTSD as they did 5 years ago because they believe recent efforts to raise awareness about prescribing antipsychotics for PTSD have been effective.[47] After we asked Army officials about the effects of the policy, they responded by conducting an analysis, which showed that the proportion of servicemembers with PTSD (without a separate diagnosis of severe mental illness) prescribed atypical and other antipsychotics decreased by almost half, from 19 percent in fiscal year 2010 to 10 percent in fiscal year 2014. Army officials stated that they could repeat their analysis, if needed, but did not identify any specific plans to do so. They added that they could similarly track the percentage of servicemembers with PTSD prescribed a benzodiazepine using the same data source.

Although a decrease in the proportion of servicemembers prescribed atypical antipsychotics is important, the Army's lack of ongoing monitoring of the prescribing of these medications may increase the risk that the PTSD guideline recommendations are not effectively followed. Federal internal control standards require federal agencies to have control activities in place to establish and review performance measures over time and then implement ongoing monitoring to assess the quality of performance and ensure that the findings of reviews are promptly resolved.[48] Without ongoing monitoring of Army providers' prescribing of antipsychotics and benzodiazepines to servicemembers with PTSD, the

[47]As part of this effort, officials told us that the Army plans to track PTSD outcomes throughout its behavioral health clinics using a new electronic system, beginning in fiscal year 2016.

[48]GAO/AIMD-00-21.3.1.

Army may be unable to identify and address prescribing practices that are inconsistent with the guideline and do not have a clinical justification.

Neither VHA nor DOD and the Army monitor the prescribing of medications to treat mild TBI because the mild TBI guideline does not include specific medication recommendations. According to a VHA official, VHA does not conduct such monitoring because mild TBI is associated with a wide range of symptoms, and, thus, treatment regimens need to be individualized based on each patient's symptoms. In addition, this official added that, in contrast to the PTSD guideline, the mild TBI guideline does not recommend the use of a particular medication over another and there are no strict contraindications for certain medications. DOD officials told us that the individual military services have processes in place to review the prescribing practices of its providers. Army officials stated that the Army has procedures in place that may include the review of medication prescribing decisions, including for mild TBI, such as peer reviews that are part of the Army's privileging process.[49] Army officials explained that each department within an Army MTF is responsible for developing standards for their specialty and monitoring, for example, whether providers follow related evidence-based medical practices, which may include prescribing medications.[50] Army officials also stated that they are currently focusing their TBI monitoring efforts on tracking the clinical outcomes of TBI patients and have begun to pilot this effort in the TBI clinics at seven Army MTFs.

[49]Privileging is the process that defines the scope and limits of practice for a physician and is based on several factors, including a physician's clinical competence and recommendations from peers.

[50]Several VHA providers also told us that peer reviews, part of VHA's privileging process, may include the review of medication prescribing decisions, including for mild TBI.

VA's Formulary Included More than Half of the Psychiatric, Pain, and Sleep Medications on DOD's Formulary; Officials Agree That Differences Do Not Affect Medication Continuation

Our review found that VA's formulary included more than half of the psychiatric, pain, and sleep medications on DOD's formulary. These medications are prescribed to treat symptoms that are common among servicemembers and veterans with PTSD or mild TBI.[51] DOD and VHA officials we spoke with agreed that the formulary differences did not affect the continuation of medications for servicemembers transitioning from DOD to VHA. (See app. I for a complete list of the psychiatric, pain, and sleep medications on the DOD and VA formularies, as well as information on DOD prescriptions for these medications.) We also found that the vast majority of these medications that were actually prescribed by DOD in fiscal year 2014 were on both formularies.[52] (See table 1.) Additionally, we found the most agreement between the formularies for psychiatric medications, with the medications on VA's formulary representing 98 percent of the prescriptions that had been filled by DOD in fiscal year 2014.

Table 1: Summary Comparison of the Psychiatric, Pain, and Sleep Medications on the Department of Defense (DOD) and Department of Veterans Affairs (VA) Formularies

Medication type	Percentage of medications on both the DOD and VA formularies as of August 2015	Percentage of prescriptions filled by DOD for active duty servicemembers in fiscal year 2014 for medications on both the DOD and VA formularies as of August 2015[a]
Psychiatric	67%	98%
Pain	49	90
Sleep	22	75
Total	**57**	**88**

Source: GAO analysis of DOD and Veterans Health Administration data. | GAO-16-158

[a]This represents the most current data available for prescriptions filled by DOD for active duty servicemembers at the time of our review.

VHA officials told us that clinical considerations and cost are factors in determining whether to include a medication on the formulary.

[51]We compared the medications on the DOD and VA formularies as of August 2015.

[52]These medications include those that were prescribed by DOD and filled by active duty servicemembers. Fiscal year 2014 was the most recent fiscal year of data available at the time of our review.

Specifically, they said they first consider which medications are the safest and most effective for treating each condition, and then they select the most cost-effective options. As a result of this process, the VA formulary includes fewer medications than DOD's. For example, VHA officials told us that VA's formulary did not include the pain medication piroxicam because the formulary already included safer alternatives. VHA officials also said the VA formulary only included two sleep medications because of concerns about the appropriateness of some sleep medications for the treatment of insomnia. Further, VHA officials and providers noted that sleep problems are often a symptom of other conditions, including those related to mental health, and, therefore, treating the underlying condition may also treat the insomnia. Rather than including more of these medications on the VA formulary, VHA has developed evidence-based clinical recommendations for treating insomnia, which includes off-label use of other types of medications, such as antidepressants; over-the-counter medications, such as antihistamines; and nonmedication treatments.[53]

DOD and VHA officials told us they do not believe that the differences between the formularies affected the extent to which VHA providers continued medications prescribed by DOD providers, when clinically appropriate. In support of this position, officials noted the results of VHA's 2015 study on this issue.[54] Specifically, VHA conducted this study to assess the extent to which differences in the DOD and VA formularies affected medication continuation and found that VHA providers infrequently changed or discontinued medications for nonclinical reasons, including formulary differences.[55] As part of the 2015 study, VHA

[53]For example, VHA recommends that the medication diphenhydramine (an antihistamine) be prescribed to treat insomnia. Diphenhydramine is an over-the-counter medication that is included on VA's formulary. Department of Veterans Affairs, *Chronic Insomnia: VA Clinician's Guide to Managing Insomnia* (Washington, D.C.: Aug. 2014). Off-label use includes the use of a medication for a condition for which the medication was not approved by the Food and Drug Administration. Although a medication may not be Food and Drug Administration-approved for a certain condition, prescribing a drug off-label may be clinically appropriate.

[54]Department of Veterans Affairs, *Pilot Evaluation of Medication Continuation for Veterans Transitioning from the Department of Defense Health Care System to the Department of Veterans Affairs Health Care System* (Washington, D.C.: Feb. 2015).

[55]Nonclinical reasons also included changes for which the reason was not documented by the provider. VHA did not provide data on the number of changes in the nonclinical category that were due to missing documentation.

pharmacists reviewed DOD and VHA data on a sample of 729 servicemembers who transitioned from DOD to VHA in 2013 with a psychiatric, pain, or sleep medication to determine whether their medications were changed by VHA providers upon transition. For the 167 servicemembers whose medications were changed or discontinued, VHA pharmacists reviewed the individual medical records to determine the reasons why. VHA determined that 24 servicemembers (3 percent of the 729 servicemembers reviewed) had psychiatric, pain, or sleep medications that were changed or discontinued for nonclinical reasons, which could include formulary differences, upon transitioning to VHA.

Consistent with the findings of the 2015 VHA study, providers, pharmacists, and case managers we interviewed at three VAMCs and two Army MTFs, as well as military and veterans' stakeholder groups, were generally unaware of specific instances of medications being changed or discontinued for nonclinical reasons, including formulary differences. Although VHA providers and pharmacists said that this type of change could occur, they most commonly said that medications are changed for clinical reasons, such as side effects, the medication not working, interactions with other medications, and general disagreement with the prior treatment approach. Additionally, several VHA providers we interviewed said most of the psychiatric, pain, and sleep medications they would want to prescribe are already on the VA formulary, and we found that the majority of the medications providers said were not on the formulary have recently been added. For example, duloxetine, an antidepressant added to VA's formulary in 2015, was a commonly mentioned nonformulary medication during our interviews with providers.

Given the differences in the formularies, some stakeholders have suggested that DOD and VA establish a single formulary. The advantages and disadvantages of doing so would depend, in part, on the resulting formulary—that is, whether VA adopts all of the medications on DOD's formulary or, instead, VA and DOD agree to a new list of

medications.[56] When we discussed the concept of a single formulary with officials, VHA officials expressed concern that adopting DOD's formulary could diminish elements of their formulary process that they believe are important from a clinical and cost perspective. Specifically, VHA officials told us that adopting DOD's formulary would result in including medications that VHA has determined to be less safe than other alternatives. For example, the DOD formulary includes a recently Food and Drug Administration-approved extended release opioid medication associated with a greater risk of overdose, if used incorrectly, due to the larger amount of the active ingredient present in the medication, compared to some other pain medications (such as immediate release opioids). VHA officials told us they decided not to include this medication on the formulary, given its ongoing efforts to improve the safety of opioid prescribing.[57] In addition, the Congressional Budget Office estimated that VA's costs would increase if it were to adopt the psychiatric, pain, and sleep medications on the DOD formulary.[58] VHA officials explained that they are able to control pharmacy costs by requiring providers to prescribe the most cost-effective medications, unless there is a clinical reason to prescribe something else. Clinical reasons could include medication continuation or concerns about particular side effects for certain patients.

A single formulary could also be achieved by DOD and VA collaboratively selecting which medications to include. This approach could result in cost savings for DOD if the new formulary excluded higher cost medications. Although VHA officials told us they would be supportive of this approach, DOD officials said they are not because they view it as a reduction of the

[56]After we provided a draft of our report to the agencies for comment, a bill was signed into law that requires the Secretary of DOD and the Secretary of VA to establish a joint uniform formulary that will include psychiatric, pain, and sleep disorder medications and medications for other conditions critical for the transition of a servicemember from treatment furnished by DOD to treatment furnished by VA. The law also requires that the Secretaries, no later than July 1, 2016, issue a report to certain congressional committees on the joint uniform formulary, including a list of the medications selected for inclusion on the formulary. See National Defense Authorization Act for Fiscal Year 2016, Pub. L. No. 114-92, § 715, 129 Stat. 726 (Nov. 25, 2015).

[57]Under VHA's Opioid Safety Initiative, which began in 2012, VAMCs with high rates of opioid prescribing are required to implement plans to assess the appropriateness and decrease the prescribing rates when clinically possible.

[58]Congressional Budget Office, *Cost Estimate: H.R. 1735 National Defense Authorization Act for Fiscal Year 2016* (Washington, D.C.: May 11, 2015).

benefit that they currently provide, and believe it is important to have a more comprehensive formulary to better accommodate prescriptions written by civilian health care providers. In addition, DOD officials told us that current law requires them to include all clinically appropriate Food and Drug Administration-approved medications. DOD officials told us that including more medications on the formulary is beneficial because individual patients respond differently to different medications.

VHA Has Two Key Efforts to Help Ensure Continuation of Medications, but Lack of Clarity of One Effort May Limit Its Effectiveness

VHA's Nonformulary Request Process Helps Ensure Continuation of Medications and Most Requests Are Adjudicated within 96 Hours and Approved

VHA's nonformulary request process is one key effort that helps newly transitioned veterans, including those with PTSD or mild TBI, avoid medication discontinuations that could occur as the result of differences in the DOD and VA formularies, according to providers we interviewed and VHA documents we reviewed. Data provided by VHA show that the most commonly DOD-prescribed psychiatric, pain, and sleep medications not on the VA formulary are prescribed by VHA providers through this process.[59] According to VHA policy, providers may request a medication not on the VA formulary by submitting a nonformulary request, which is reviewed by a pharmacist. The pharmacist, in turn, either approves or denies the request based on whether the provider has demonstrated that there is a clinical necessity for the medication. To be approved, requests

[59]For example, VHA providers wrote over 24,000 prescriptions for the sleep medication eszopiclone in fiscal year 2014. Eszopiclone was one of the most commonly prescribed sleep medications by DOD providers in fiscal year 2014 and, as of August 2015, is not on the VA formulary.

for nonformulary medications must meet one of several clinical criteria.[60] For example, a request will be approved if the provider has documented that the veteran has had an allergic reaction to a formulary medication. The pharmacist who reviews the request must approve or deny it within 96 hours, and a provider may appeal a request that a pharmacist initially denied.

VHA monitors the rates in which VAMCs approve nonformulary requests and the extent to which they adjudicate the requests within the required timeframe of 96 hours. VAMCs report data quarterly to VHA on the number of nonformulary requests that their pharmacists approved and denied, the number of denied requests that providers subsequently appealed, and the number of appealed requests that were overturned. VHA does not collect data on the reasons why pharmacists deny nonformulary requests. VHA officials told us they do not collect such data because the only reason for a denial is that the provider did not establish clinical justification for the medication.

VAMCs also report to VHA the number of nonformulary requests that pharmacists adjudicated outside of VHA's required 96-hour timeline. For nonformulary requests that take longer than 96 hours to adjudicate, VAMCs are required to report the reasons for the delayed adjudication. For example, some of the reasons that VAMCs have reported include that a request was referred to a specialist (e.g., a physician or another pharmacist) for additional review and that the required documentation to determine the appropriateness of the request (e.g., lab value) was unavailable at the time of the request.[61] VHA officials combine data from VAMCs within each of the VISNs to report nonformulary request data quarterly to VISN pharmacists. VHA officials told us they examine the

[60]Department of Veterans Affairs, Veterans Health Administration, *VHA Formulary Management Process,* VHA Handbook 1108.08 (Washington, D.C.: Feb. 26, 2009). VHA issued a policy in January 2015 that established an exception for approving certain nonformulary requests for newly transitioned veterans. Specifically, if a provider documents that a nonformulary request is for a DOD-prescribed mental health medication for a newly transitioned veteran, then additional clinical documentation is not required for approval.

[61]In 2015, VHA officials narrowed the standard reasons for delayed adjudication that they track and discontinued tracking reasons provided as free-text, because they were unable to consistently categorize the provided reasons. These officials told us they believe that these revisions will be more useful for determining strategies to help reduce identified delays in adjudication.

data, among other things, to identify outliers across VISNs related to the number of nonformulary requests that take longer than 96 hours to adjudicate, and they discuss these results during quarterly meetings with VISN pharmacists who are responsible for overseeing the request process with their respective VAMCs. For example, in 2013, VHA officials identified a VISN with a relatively high number of nonformulary requests with delayed adjudication and discussed this outlier at a meeting with VISN pharmacists. This discussion led the VISN to implement several changes that ultimately resulted in a lower number of requests with delayed adjudication. Specifically, the VISN created an automated nonformulary request form that tracks how long each request takes from submission to adjudication. This change allows a provider that submits a nonformulary request, as well as the pharmacists that review the request, to be aware of requests that approach the required 96-hour timeframe for adjudication.

VHA's nonformulary request data show that pharmacists approved the majority of the nonformulary requests that providers submitted from fiscal years 2012 through 2014. Specifically, they approved 81 percent of the 2.1 million total nonformulary requests, or about 1.7 million, during this time period. (See table 2.) Of the 19 percent of requests that were denied (about 399,000), providers appealed 1 percent of these (about 4,600), and most were overturned (61 percent). Providers we interviewed from all three VAMCs told us that pharmacists approved the majority of nonformulary requests they submitted.

Table 2: Adjudication Results of VA Medical Center (VAMC) Nonformulary Medication Requests, Fiscal Years 2012 through 2014

Nonformulary medication request result	Total	2012	2013	2014
Number of nonformulary requests	2,113,973	771,319	664,152	678,502
Number and percent of nonformulary requests that VAMCs approved	1,715,394	630,789	535,160	549,445
	81.1%	81.8%	80.6%	81.0%
Number and percent of nonformulary requests that VAMCs adjudicated within 96 hours	2,069,280	751,424	651,461	666,395
	97.9%	97.4%	98.1%	98.2%
Number and percent of denied nonformulary requests that providers appealed	4,602	1,814	1,323	1,465
	1.2%	1.3%	1.0%	1.1%
Number and percent of appeals in which VAMCs overturned denied formulary requests	2,814	1,131	760	923
	61.1%	62.3%	57.4%	63.0%
Number and percent of appeals that VAMCs adjudicated within 96 hours	4,192	1,651	1,226	1,315
	91.1%	91.0%	92.7%	89.8%

Source: GAO analysis of Veterans Health Administration data. | GAO-16-158

Further, the vast majority of nonformulary requests that providers submitted from fiscal years 2012 through 2014 were adjudicated within 96 hours. Of the approximately 2.1 million nonformulary requests that providers submitted to pharmacists during this time, 98 percent were adjudicated within 96 hours. Providers we interviewed from the three VAMCs in our review told us that pharmacists adjudicated the majority of their nonformulary requests within the required timeframe, and several providers said they frequently received decisions on their requests within 1 or 2 hours of submitting them and sometimes sooner if they spoke directly with a pharmacist about the request. The VHA data also showed that the vast majority of requests that providers appealed were adjudicated within the required timeline of 96 hours (91 percent) from fiscal years 2012 through 2014. Of the nonformulary requests that took longer than 96 hours to adjudicate, three pain medications and one psychiatric medication were among the most frequently requested medications by providers.[62] However, the extent to which requests for these four medications were ultimately approved or denied is unknown because VHA officials do not separately track the results of nonformulary requests for specific medications, including those taking longer than 96 hours to adjudicate.

[62]The three pain medications were lidocaine patches, a gel formulation of the medication diclofenac, and pregabalin (which is currently only available as the brand name Lyrica, and is not on the DOD formulary) and the one psychiatric medication was duloxetine. VHA added duloxetine to the VA formulary in March 2015. Of the nonformulary requests that took longer than 96 hours to adjudicate, sleep medications were not among the top medications requested.

VHA Issued a Policy to Help Ensure Continuation of Certain Medications for Transitioning Servicemembers, but It Lacks Clarity

VHA issued a policy in January 2015 that instructs providers not to discontinue mental health medications initiated by DOD providers due to differences in the DOD and VA formularies; another key effort to help ensure medication continuation.[63] VHA officials said that the reason for issuing this policy was to provide added assurance that patients with mental health conditions—who are among the most vulnerable—would not have their mental health medications changed or discontinued for nonclinical reasons upon transitioning from DOD to VHA. However, the policy lacks clarity regarding which types of medications should be considered mental health medications and, therefore, are not to be discontinued. Specifically, the policy is unclear on whether providers should continue (when clinically appropriate) all of the medications prescribed by DOD providers for patients with mental health conditions or only the psychiatric medications (such as antidepressants) that were prescribed specifically to treat their mental health condition.

As pain and sleep medications treat symptoms that are commonly experienced by patients with mental health conditions, such as PTSD, VHA providers and pharmacists we interviewed had varying interpretations of whether these medications would be considered mental health medications under the new policy. For example, VHA providers had different interpretations about whether they should continue eszopiclone, a medication for the treatment of insomnia which is on DOD's formulary, but not VA's. Some VHA providers said they would have to switch medications for patients who transition from DOD on this medication to one on the VA formulary, unless there is a clinical reason not to do so. Other VHA providers said that the policy could cover other types of medications prescribed to patients with mental health conditions, such as sleep medications. In addition, in our review of VHA's 2015 study of transitioning servicemembers, we found that among the 24 servicemembers whose medications were changed or discontinued for nonclinical reasons, more than half of them (13 of 24) had a pain or sleep medication changed.

[63]The DOD providers that the policy refers to are those authorized by DOD, including MTF providers and civilian providers who have contracts with DOD to provide care to servicemembers through TRICARE. According to the policy, medications should also not be changed or discontinued for other nonclinical reasons, such as the cost of the medication. See Department of Veterans Affairs, Veterans Health Administration, *Continuation of Mental Health Medications Initiated by Department of Defense Authorized Providers*, VHA Directive 2014-02 (Washington D.C.: Jan. 20, 2015).

VHA officials acknowledged that the definition of a mental health medication could be subjective and that they intended the policy to be broad and to apply to any medication that is prescribed to treat a mental health condition. Therefore, they stated that pain and sleep medications should be considered mental health medications under the policy. However, they also noted that some pain and sleep medications are not intended for long term use, so providers may choose to discontinue prescribing them for clinical reasons.

Given that VHA's policy lacks clarity regarding which types of medications should be considered mental health medications, VHA providers may be inappropriately changing or discontinuing mental health medications due to formulary differences. Such changes could lead to adverse health effects, such as exacerbation of symptoms or new side effects. This lack of clarity in VHA's policy is inconsistent with federal internal control standards, which state that agencies should establish control activities, such as developing clear policies, in order to accomplish the agency's objectives.

VHA officials told us that they are planning to conduct another study of transitioning servicemembers to determine if the new policy is having the intended effect. Specifically, VHA officials told us that they plan to review the prescriptions of about 5,000 servicemembers who transitioned from DOD to determine whether their medications were continued at VHA when clinically appropriate.[64] VHA officials told us that they have been working with DOD officials to obtain the data needed to conduct this study.

Conclusions

Servicemembers and veterans diagnosed with PTSD or mild TBI may experience significant difficulties and impairments in their social relationships and work life. VHA and DOD have jointly developed a clinical practice guideline for PTSD patients that includes evidence-based recommendations to aid clinicians in their decision making about which medications to prescribe to treat the symptoms of PTSD. However, the

[64]VHA officials added that they would also like to review, on a more consistent basis, whether providers are continuing medications when clinically appropriate, by using real-time data from DOD on transitioning servicemembers' prescriptions. VHA officials told us that they have begun discussions with DOD officials about the feasibility of obtaining such data.

Army does not have a mechanism in place to monitor on an ongoing basis whether MTFs are prescribing medications that are consistent with these recommendations.

Ensuring that medication regimens are continued when clinically appropriate is critical for servicemembers transitioning their health care from DOD to VHA, including those with PTSD and mild TBI. We did not find evidence that the differences in the DOD and VA formularies for these medications result in the inappropriate discontinuation of medications. Although VA's formulary includes just over half of the medications on the DOD formulary, those on both formularies represent the most commonly DOD-prescribed psychiatric, pain, and sleep medications. However, we found that VHA's new policy to ensure the continuation of mental health medications lacks clarity on the types of medications considered mental health medications, and, as a result, VHA providers may be inappropriately changing or discontinuing mental health medications due to formulary differences, potentially increasing the risk of adverse health effects for transitioning servicemembers.

Recommendations for Executive Action

We recommend that the Secretary of Defense direct the Secretary of the Army to implement processes to review and monitor Army MTF prescribing practices for medications discouraged under the PTSD guideline and address identified deviations.

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to clarify which types of medications are covered by VHA's January 2015 policy on medication continuation.

Agency Comments

DOD provided written comments on a draft of this report, which we have reprinted in appendix II. In its comments, DOD agreed with our conclusions and generally concurred with our recommendation. DOD stated that any policy that it may issue related to the monitoring of prescribing practices would be directed toward all of the military services. DOD also provided technical comments, which we have incorporated in the report as appropriate.

VA also provided written comments on a draft of this report, which we have reprinted in appendix III. In its comments, VA agreed with our conclusions and concurred with our recommendation. VA stated that it will issue written guidance to its providers clarifying which types of medications are covered by its 2015 policy on medication continuation,

with an estimated completion date of March 2016. VA also provided technical comments, which we have incorporated in the report as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Defense, the Secretary of Veterans Affairs, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Debra A. Draper
Director, Health Care

List of Committees

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House of Representatives

Appendix I: Formulary Comparison

We found that the Department of Veterans Affairs (VA) formulary included 57 percent of the psychiatric, pain, and sleep medications on the Department of Defense (DOD) formulary, as of August 2015, and these medications represented the most frequently prescribed psychiatric, pain, and sleep medications on the DOD formulary in fiscal year 2014. (See table 3.)

Table 3: Comparison of the Psychiatric, Pain, and Sleep Medications on the Department of Defense (DOD) and Department of Veterans Affairs (VA) Formularies

Medication on DOD's formulary as of August 2015[a]	Medication on VA's formulary as of August 2015	Percentage of prescriptions, by medication type, filled by DOD for active duty servicemembers, fiscal year 2014[b]
Psychiatric	√	
Trazodone[c]	√	8.5
Amphetamine dextroamphetamine[c]	√	8.2
Bupropion[c]	√	7.1
Sertraline[c]	√	6.9
Diazepam[c]	√	6.8
Fluoxetine	√	6.5
Venlafaxine	√	6.4
Citalopram	√	6.0
Clonazepam	√	4.6
Topiramate	√	4.2
Amitriptyline	√	3.8
Escitalopram	√	3.5
Methylphenidate	√	2.6
Quetiapine	√	2.5
Alprazolam	√	2.1
Duloxetine	√	2.1
Mirtazapine	√	1.9
Lorazepam	√	1.9
Paroxetine	√	1.9
Buspirone	√	1.7
Aripiprazole	√	1.5
Nortriptyline	√	1.3
Valproate[d]	√	1.2
Modafinil		1.1
Lamotrigine	√	1.0
Atomoxetine		0.7

Medication on DOD's formulary as of August 2015[a]	Medication on VA's formulary as of August 2015	Percentage of prescriptions, by medication type, filled by DOD for active duty servicemembers, fiscal year 2014[b]
Risperidone	√	0.6
Levetiracetam	√	0.6
Doxepin	√	0.5
Lithium	√	0.3
Lisdexamfetamine		0.3
Oxcarbazepine	√	0.3
Dextroamphetamine	√	0.2
Olanzapine	√	0.2
Zonisamide	√	0.2
Ziprasidone	√	0.1
Carbamazepine	√	0.1
Armodafinil		0.1
Fluvoxamine		0.1
Imipramine	√	0.1
Haloperidol	√	< 0.1
Guanfacine		< 0.1
Chlorpromazine	√	< 0.1
Desipramine	√	< 0.1
Chlordiazepoxide	√	< 0.1
Clomipramine	√	< 0.1
Clozapine	√	< 0.1
Nefazodone		< 0.1
Clorazepate		< 0.1
Oxazepam		< 0.1
Protriptyline		< 0.1
Paliperidone[e]		< 0.1
Dexmethylphenidate		< 0.1
Perphenazine amitriptyline[f]	√	< 0.1
Olanzapine fluoxetine[e,f]		< 0.1
Fluphenazine	√	< 0.1
Perphenazine	√	< 0.1
Pimozide	√	< 0.1
Thiothixene	√	< 0.1
Phenelzine	√	< 0.1
Amitriptyline chlordiazepoxide[f]	√	< 0.1
Clonidine	√	< 0.1

Medication on DOD's formulary as of August 2015[a]	Medication on VA's formulary as of August 2015	Percentage of prescriptions, by medication type, filled by DOD for active duty servicemembers, fiscal year 2014[b]
Loxapine	√	< 0.1
Tranylcypromine	√	< 0.1
Trifluoperazine	√	< 0.1
Methamphetamine		< 0.1
Thioridazine		< 0.1
Isocarboxazid		< 0.1
Desvenlaxafine		< 0.1
Amoxapine		0.0
Ethosuximide		0.0
Ethotoin		0.0
Felbamate	√	0.0
Maprotiline		0.0
Meprobamate		0.0
Methsuximide		0.0
Rufinamide		0.0
Trimipramine		0.0
Vigabatrin		0.0
Subtotal psychiatric (79)		**100%**
Subtotal (percent) on both formularies	**53 (67%)**	
Pain		
Ibuprofen[c]	√	19.7
Naproxen[c]	√	17.1
Hydrocodone acetaminophen[c]	√	16.2
Oxycodone acetaminophen[c]	√	13.2
Tramadol[c]	√	9.0
Celecoxib		4.7
Gabapentin	√	3.8
Lidocaine[c]		3.5
Meloxicam	√	2.3
Oxycodone	√	2.1
Acetaminophen codeine	√	2.0
Butalbital acetaminophen caffeine	√	1.4
Diclofenac	√	1.2
Indomethacin	√	0.9
Piroxicam		0.5
Hydromorphone	√	0.4

Medication on DOD's formulary as of August 2015[a]	Medication on VA's formulary as of August 2015	Percentage of prescriptions, by medication type, filled by DOD for active duty servicemembers, fiscal year 2014[b]
Morphine	√	0.3
Ketorolac[c]		0.3
Etodola[c]	√	0.2
Tramadol acetaminophen[f]	√	0.1
Fentanyl	√	0.1
Buprenorphine[e]		0.1
Nabumetone		0.1
Hydrocodone ibuprofen		0.1
Oxymorphone		0.1
Meperidine[e]		0.1
Methadone	√	0.1
Codeine	√	0.1
Tapentadol		< 0.1
Oxaprozin		< 0.1
Diclofenac misoprostopol[f]	√	< 0.1
Butalbital aspirin caffeine	√	< 0.1
Ketoprofen		< 0.1
Sulindac	√	< 0.1
Naproxen esomeprazole		< 0.1
Butorphanol[e]		< 0.1
Codeine butalbital acetaminophen caffeine[f]	√	< 0.1
Diflunisal		< 0.1
Salsalate	√	< 0.1
Tolmetin		< 0.1
Flurbiprofen[e]		< 0.1
Pentazocine naloxone		< 0.1
Butalbital acetaminophen		< 0.1
Codeine butalbital aspirin caffeine[f]	√	< 0.1
Hydrocodone		< 0.1
Fenoprofen		< 0.1
Oxycodone aspirin[f]	√	< 0.1
Meclofenamate		< 0.1
Levorphanol		< 0.1
Ibuprofen oxycodone[f]	√	< 0.1
Choline magnesium salicylate		0.0
Codeine carisoprodol aspirin		0.0

Medication on DOD's formulary as of August 2015[a]	Medication on VA's formulary as of August 2015	Percentage of prescriptions, by medication type, filled by DOD for active duty servicemembers, fiscal year 2014[b]
Dihydrocodeine acetaminophen caffeine		0.0
Dihydrocodeine aspirin caffeine		0.0
Morphine naltrexone[g]		0.0
Subtotal pain (55)		**100%**
Subtotal (percent) on both formularies	**27 (49%)**	
Sleep	√	
Zolpidem[c]		67.8
Eszopiclone	√	19.5
Temazepam[c]		7.3
Triazolam		2.7
Zaleplon		2.6
Doxepin[e]		0.1
Flurazepam		0.1
Estazolam		< 0.1
Suvorexant[g,h]		0
Subtotal sleep (9)		**100%**
Subtotal (percent) on both formularies	**2 (22%)**	
Total (143)		
Total (percent) on both formularies	**82 (57%)[i]**	

Source: GAO analysis of DOD and Veterans Health Administration (VHA) data. I GAO-16-158

[a]DOD identified the psychiatric, pain, and sleep medications for this comparison. DOD did not include psychiatric, pain, or sleep medications on the DOD formulary that were available over-the-counter, were bulk medications used by pharmacists for compounding, or were provided through certain routes of administration, such as intravenous pain medications, typically administered in an inpatient setting. We conducted this analysis by active ingredient and did not account for differences in drug formulation, such as the dosage form (e.g., liquid or tablet), route of administration (e.g., oral or nasal), modified release formulation (e.g., extended or immediate release), salt form (e.g., hydrochloride or sulfate), or strength of the medication.

[b]This represents the most current data available for prescriptions filled by DOD for active duty servicemembers at the time of our review.

[c]We compared the specific formulations of medications available on the DOD and VA formularies for these 12 medications. We found that DOD's formulary included formulations not available on VA's formulary for 5 medications: diazepam, naproxen, oxycodone acetaminophen, tramadol, and zolpidem. DOD and VHA officials agreed that these differences were not generally clinically significant and would only have implications for specific patients.

[d]Valproate includes valproic acid and divalproex because these medications all have the same active ingredient.

[e]In instances where the formulations available on the VA formulary were for a different clinical indication or would typically be administered in an inpatient setting, we have not marked the medication as being on the VA formulary.

[i]VA generally does not include combination medications on its formulary. However, VHA officials told us that providers can prescribe several medications together, which can be equivalent to the combination medication. In cases where the VA formulary includes the individual medications that

make up a particular combination medication, we have marked it as being on the VA formulary. VHA officials noted that providers might be more likely to prescribe certain nonformulary combination medications using VHA's nonformulary request process rather than prescribe the individual ingredients.

[9]In fiscal year 2014 DOD did not fill any prescriptions for active duty servicemembers for morphine naltrexone and suvorexant because these medications were not available on the market at that time. DOD officials confirmed that the other 14 medications on the DOD formulary with zero prescriptions were on the market in fiscal year 2014.

[h]As of October 2015, DOD had removed suvorexant from its formulary.

[i]VA's formulary included 64 percent of the medications on DOD's formulary if the 16 medications for which DOD did not fill any prescriptions for active duty servicemembers in fiscal year 2014 are excluded from the calculation.

For a sample of psychiatric, pain, and sleep medications included on both the DOD and VA formularies and that were frequently prescribed by DOD providers in fiscal year 2014, we also compared the specific formulations that were available on each formulary. We conducted this supplemental analysis because DOD and Veterans Health Administration (VHA) officials told us that prescribing different formulations of the same medication may have clinical significance for certain medications or certain patients. Specifically, we reviewed differences in the medication formulations according to their available dosage form (e.g., liquid or tablet), modified release formulation (e.g., extended or immediate release), salt form (e.g., hydrochloride or sulfate), strength, and also their route of administration (e.g., oral or nasal).[1] We selected the five psychiatric and five pain medications most frequently prescribed and filled by DOD for active duty servicemembers in fiscal year 2014 that were on both DOD and VA formularies. For sleep, the VA formulary only included two medications, so we reviewed the formulations for both.

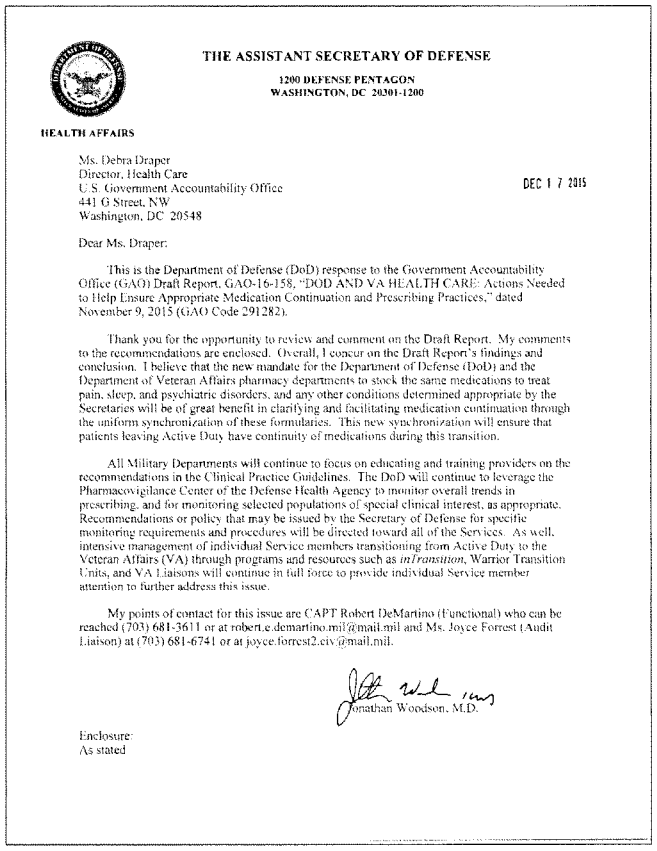
We found that the VA formulary included all of the formulations that were on the DOD formulary for 7 of these 12 medications. The formulation differences for the remaining 5 psychiatric, pain, and sleep medications resulted from differences in dosage form and modified release formulation. That is, 2 of the 5 medications were available on the DOD formulary but not the VA formulary in the liquid form, and the remaining 3 medications were available on the DOD formulary but not on the VA formulary in the extended release form.[2] For example, the DOD and VA

[1]Extended release medications are formulated to release the active ingredient slowly over time. For example, extended release medications may be taken every 12 or 24 hours, as opposed to more frequently.

[2]In addition, for one of the pain medications, the VA formulary also did not include a form with a coating that helps with digesting the medication.

formularies both include immediate release formulations of the sleep medication zolpidem, but the DOD formulary also includes the extended release version. We obtained the perspectives of DOD and VHA officials regarding the clinical significance of the formulation differences that we observed, and they agreed that these differences were not generally clinically significant and would only have implications for specific patients, such as certain patients who cannot swallow pills and who would benefit from the liquid forms. In addition, DOD and VHA officials both said that the primary difference between immediate release and extended release medications would be the frequency with which the patient needs to take the medication, but there could be differences in their effectiveness for certain patients. VHA officials noted that the formulations of medications that are not included on the VA formulary are often those for which there is a limited need in their patient population, but, in situations where these specific formulations are clinically indicated, they would utilize the nonformulary request process to prescribe that medication. DOD officials agreed that some of the formulations not available on VA's formulary are often not clinically indicated.

Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

Ms. Debra Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

DEC 17 2015

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-16-158, "DOD AND VA HEALTH CARE: Actions Needed to Help Ensure Appropriate Medication Continuation and Prescribing Practices," dated November 9, 2015 (GAO Code 291282).

Thank you for the opportunity to review and comment on the Draft Report. My comments to the recommendations are enclosed. Overall, I concur on the Draft Report's findings and conclusion. I believe that the new mandate for the Department of Defense (DoD) and the Department of Veteran Affairs pharmacy departments to stock the same medications to treat pain, sleep, and psychiatric disorders, and any other conditions determined appropriate by the Secretaries will be of great benefit in clarifying and facilitating medication continuation through the uniform synchronization of these formularies. This new synchronization will ensure that patients leaving Active Duty have continuity of medications during this transition.

All Military Departments will continue to focus on educating and training providers on the recommendations in the Clinical Practice Guidelines. The DoD will continue to leverage the Pharmacovigilance Center of the Defense Health Agency to monitor overall trends in prescribing, and for monitoring selected populations of special clinical interest, as appropriate. Recommendations or policy that may be issued by the Secretary of Defense for specific monitoring requirements and procedures will be directed toward all of the Services. As well, intensive management of individual Service members transitioning from Active Duty to the Veteran Affairs (VA) through programs and resources such as *inTransition*, Warrior Transition Units, and VA Liaisons will continue in full force to provide individual Service member attention to further address this issue.

My points of contact for this issue are CAPT Robert DeMartino (Functional) who can be reached (703) 681-3611 or at robert.e.demartino.mil@mail.mil and Ms. Joyce Forrest (Audit Liaison) at (703) 681-6741 or at joyce.forrest2.civ@mail.mil.

Jonathan Woodson, M.D.

Enclosure:
As stated

GAO DRAFT REPORT DATED NOVEMBER 9, 2015
GAO-16-158 (GAO CODE 291282)

"ACTIONS NEEDED TO HELP ENSURE APPROPRIATE MEDICATION CONTINUATION AND PRESCRIBING PRACTICES"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS

RECOMMENDATION 1: The Government Accountability Office (GAO) recommends that the Secretary of Defense direct the Secretary of the Army to implement processes to review and monitor Army Military Treatment Facility prescribing practices for medications discouraged under the post-traumatic stress disorder guideline and address identified deviations.

COMMENTS: There are many factors that need to be considered in a policy decision of this nature, and the Veterans Affairs (VA) policy approach outlined in the GAO report may not be optimal for the Army population needs. Furthermore, there are no universal definitions for what would constitute overly high or inappropriate prescribing practices in any specific health care setting. Instead, there is strong evidence that the Army's overall long-running strategies for improving behavioral health care have already worked and are working to reduce antipsychotic prescribing. The Army's data showed that the decline in antipsychotic use started before Army's 2012 policy memo, and arguably, what the Army established goes well beyond what is routinely considered standard of practice in other health care settings. Therefore, it is unlikely that the Army policy, in formal effect from 2012 to 2014, alone explains the large observed decline in antipsychotic medication use.

All Military Departments will continue to focus on educating and training providers on the recommendations in the Clinical Practice Guidelines. Furthermore, the Department of Defense (DoD) will continue to leverage the Defense Health Agencies, such as the Pharmacovigilance Center, to monitor overall trends in prescribing, as well as for monitoring selected populations of special clinical interest, as appropriate. Additionally, any recommendation or policy that may be issued from the Secretary of Defense for specific monitoring procedures should be directed toward all of the Services, and, only after appropriate review of the scientific evidence by all Services to support such a recommendation.

DoD RESPONSE: The DoD concurs, with comments as provided, above.

RECOMMENDATION 2: The GAO recommends that the Secretary of VA direct the Under Secretary for Health to clarify which types of medications are covered by the Veterans Health Administration's January 2015 policy on medication continuation.

COMMENTS: The GAO should note that, beginning June 1, under the National Defense Authorization Act for Fiscal Year 2016, SEC. 715. JOINT UNIFORM FORMULARY FOR TRANSITION OF CARE, both DoD and VA department pharmacies will be mandated to stock the same medications to treat pain, sleep, and psychiatric disorders and any other conditions determined appropriate by the Secretaries. The new synchronization will ensure that patients leaving Active Duty have continuity of medications during this transition.

DoD RESPONSE: The DoD concurs, with comment, as stated, above.

Appendix III: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

December 7, 2015

Ms. Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Draper:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, "DOD AND VA HEALTH CARE: Actions Needed to Help Ensure Appropriate Medication Continuation and Prescribing Practices" (GAO-16-158). VA agrees with GAO's conclusions.

The enclosure specifically addresses GAO's recommendations and provides an action plan for each, and provides technical comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Robert L. Nabors II
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
"DOD AND VA HEALTH CARE: Actions Needed to Help Ensure Appropriate Medication Continuation and Prescribing Practices"
(GAO-16-158)

Recommendation 2: We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to clarify which types of medications are covered by VHA's January 2015 policy on medication continuation.

VA Comment: Concur. The Veterans Health Administration (VHA) will provide clarification to VA clinicians about which types of medications are covered by VHA's January 2015 policy on medication continuation. This will be accomplished by communicating the clarification on national conference calls and by issuing written guidance from the Office of the Deputy Under Secretary for Health for Operations and Management. Target Completion Date: March 2016

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact	Debra A. Draper, (202) 512-7114 or draperd@gao.gov
Staff Acknowledgments	In addition to the contact named above, Janina Austin, Assistant Director; Jennie F. Apter; Pamela Dooley; Joshua D. Ferencik; Jacquelyn Hamilton; Toni Harrison; Katie McConnell; and Daniel Ries made key contributions to this report.