DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

October 13, 2016

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-16-3227

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Department of Veterans Affairs (VA), Veterans Health Administration Central Office (VHACO), Washington, DC. The whistleblower alleges VHACO managers failed to take timely action to correct alleged violations of VA directives involving staff at the Veterans Crisis Line in Canandaigua, New York and that this conduct may constitute a violation of law, rule, or regulation; gross mismanagement; and a substantial and specific danger to public health and safety. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

VA found a violation of regulation; however we did not find gross mismanagement and abuse of authority, or a substantial and specific danger to public health and safety. We made several recommendations to the Canandaigua VA Medical Center and to the Office of Human Resources Management.

Thank you for the opportunity to respond.

Sincerely,

Robert D. Snyder
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-16-3277

Department of Veterans Affairs
Veterans Crisis Line
Washington, DC/Canandaigua, NY

Report Date: October 11, 2016

Executive Summary

The Office of the Secretary, Department of Veterans Affairs (OSVA), assembled a team to review allegations lodged with the Office of Special Counsel (OSC) concerning the Veterans Health Administration Central Office (VHACO). A person (hereafter, the whistleblower), who chose to remain confidential, alleged that VHACO engaged in conduct that may constitute a violation of law, rule, or regulation, and gross mismanagement, which may lead to a substantial and specific danger to public health and safety.

Specific Allegations of the Whistleblower

1. VHACO has allowed 35 Veterans Crisis Line (VCL) responders to remain in their positions, despite management's knowledge that these employees lacked the requisite education for their jobs; and

2. VA officials proposed transitioning these employees into positions that include clinical duties that appear to violate agency regulations regarding scope of duties.

After conducting a preliminary review of the allegations, and with knowledge of the readily-available documented information concerning VCL staffing, OSVA established a team of experts familiar with the facts to draft a report to present the facts.

OSVA co-developed this report with representatives from VA's Office of Human Resources and Administration (HR&A). The team consulted with the Office of the Medical Inspector (OMI) and the Office of General Counsel (OGC) to address OSC's concerns that VHACO may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. HR&A examined personnel issues to establish accountability, and the Office of Accountability Review (OAR) has reviewed the report and has or will address potential senior leadership accountability.

As a general practice, VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for Allegation 1

- VA substantiates that VCL responders were allowed to remain in their positions despite management's knowledge that these employees lacked the requisite

education for their jobs; however management was actively involved in taking steps to address the situation.

- Canandaigua VA Medical Center (VAMC) Human Resources (HR) and the Office of Human Resources Management (OHRM)/HR&A were taking action to regularize the Health System Specialist (HSS) position. These VCL employees lacked the requisite education for their jobs because they were either moved into HSS positions as part of the initial consolidation of social worker, psychologist, addiction therapist, and registered nurses positions or hired using position announcements which did not include the educational requirement.

- VA found that by leaving these VCL responders in their positions, for which they did not qualify, there was a violation of title 5, Code of Federal Regulations (CFR), part 338, Qualification Requirements (General). As soon as Canandaigua VAMC HR and OHRM became of aware of the misalignment of duties and qualifications, they took action to align employees to position descriptions for which they qualified or removed non-qualifying employees to non-clinical positions.

- Due to the extensive training that each VCL responder undergoes and the continued quality assurance monitoring, VA determined that there was no substantial or specific danger to public health and safety.

Recommendations to Canandaigua VAMC HR and OHRM

1. Canandaigua VAMC HR and OHRM continue to work with the Office of Personnel Management (OPM) to resolve outstanding staffing variations.

2. Ensure HR policy includes guidance to:

   a. Compare position descriptions with employee resumes when position realignments occur to ensure employees are qualified for the positions to which they are assigned; and

   b. Review all job announcements to ensure they include all necessary qualifications, such as education and/or experience.

Conclusions for Allegation 2

- VA substantiates that employees continued to perform clinical duties; however due to prior experience, extensive training, and continued quality assurance monitoring, there was no substantial or specific danger to public health and safety.

- To limit the degradation of services provided by VCL and avoid mass termination of employees, VA moved qualifying employees to the new Social Science Program Specialist (SSPS) position, which included the same core duties and considered prior experience as a qualification, unlike the HSS position.

- Canandaigua VAMC HR and OHRM submitted staffing variation packages to OPM to request service credit for the duties performed in order to qualify the employees for the newly-established SSPS position. Most of the staffing variation packages have been approved.

Recommendations to Canandaigua VAMC HR

3. Complete the review of the qualifications of all current HSS/SPSS incumbents and new HSS/SPSS hires since these positions were identified and verify that all incumbents have the required qualifications or approved staffing variation waiver from OPM.

4. Conduct review of current/future HSS and SPSS job opportunity announcements to ensure they were/are posted with the correct qualification standards.

Summary Statement

A team of experts familiar with the facts of this case developed this report. The team consulted with OMI and OGC to address OSC's concerns that VHACO may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. HR&A examined personnel issues to establish accountability, and OAR has reviewed the report and has or will address potential senior leadership accountability. *VA found a violation of regulation; however we did not find gross mismanagement and abuse of authority, or a substantial and specific danger to public health and safety.*

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I. Introduction

The Office of the Secretary, Department of Veterans Affairs (OSVA) assembled a team to review allegations lodged with the Office of Special Counsel (OSC) concerning the Veterans Health Administration Central Office (VHACO). A person (hereafter, the whistleblower), who chose to remain confidential, alleged that VHACO engaged in conduct that may constitute a violation of law, rule, or regulation, and gross mismanagement, which may lead to a substantial and specific danger to public health and safety.

The team consulted with representatives from VA's Office of Human Resources and Administration (HR&A), the Office of the Medical Inspector (OMI) and the Office of General Counsel (OGC). HR&A examined personnel issues to establish accountability, and the Office of Accountability Review (OAR) has reviewed the report and has or will address potential senior leadership accountability.

II. Veterans Crisis Line Profile

The Veterans Crisis Line, located in Canandaigua, New York, is staffed with a combination of phone responders and social service assistants to provide comprehensive service and support to Veterans. VCL provides around-the-clock assistance to Veterans in crisis. Callers dial 1-800-273-TALK (8255) and choose option 1 to reach a Crisis Line Responder. Since its inception in July 2007, the VCL has answered over 2.5 million calls and initiated the dispatch of emergency services to callers in imminent crisis 65,695 times. The Veterans Chat, an online, one-to-one "chat service" for Veterans who prefer reaching out for assistance using the internet, has answered 307,582 requests for chat services since its inception on July 4, 2009. Crisis line texting became available in November 2011 and since, responders have answered 60,242 requests for text services. The text number is 838255. Additionally, VCL Staff have forwarded over 408,000 referrals to local VA Suicide Prevention Coordinators on behalf of Veterans to ensure continuity of care with Veterans' local VA providers. The data provided are current through September 2016.

Responders attend VA New Employee Orientation that is required of all new Federal employees. The local VA facility tracks and assigns all mandatory, annual VA and VA Talent Management System trainings for all staff at the VCL. After the general VA training is complete, VCL specific training is coordinated by the VCL Training Team that is led by a Clinical Training Manager. Trainers are assisted by subject matter experts in suicide prevention, risk management, and the crisis call center industry practice. This training occurs in five phases: administrative call center training, VCL basic training, VCL operations training, VCL job skills-based training, and transition to independent work training. These training phases include approximately 20 modules, both in person and online, on a wide variety of topics and skills in crisis intervention, motivational interviewing, and suicide prevention. Included in these training modules is operational information for each of the contact channels: phone, chat, text, and other work, such as

processing email requests for outreach, reviewing VCL's Facebook page for suicidal content, and processing documentation from backup center calls. Classroom training is augmented by discussing live calls as well as by monitored role plays. During the transition to independent work, responders receive daily peer and supervisory feedback on calls for an average of 3 weeks until they and their supervisor determines they are ready to work independently. Supervisors then silently monitor new staff and if they pass the monitoring phase, they are cleared to work independently. Responders receive additional training, approximately once per quarter, from VCL trainers and peers, to enhance existing skills and learn new skills. Remediation training is provided, when necessary, and progress is tracked by an interdisciplinary team of supervisors, senior management, and psychologists.

III. Specific Allegations of the Whistleblower

1. VHACO has allowed 35 Veterans Crisis Line (VCL) responders to remain in their positions, despite management's knowledge that these employees lacked the requisite education for their jobs; and

2. VA officials proposed transitioning these employees into positions that include clinical duties that appear to violate agency regulations regarding scope of duties.

IV. Presentation of Facts

VCL is staffed with a variety of personnel. Originally, VCL was staffed by social workers, psychologists, addiction therapists, and registered nurses. In an effort to consolidate each of these positions under one position description, they were converted to the Health Science Specialist (HSS), GS-0601-9/11 position in October 2008. HSSs provide evidence-based paraprofessional skilled intervention services to assist with any crisis a caller or contact may be facing. The crisis responder works with contacts, who are experiencing an emotional crisis that may result in harm to themselves or others. As the VCL expanded, new employees were brought into the HSS positions using the original HSS position announcement.

In September 2014, the Canandaigua VA Medical Center (VAMC) Human Resources (HR) Office discovered that 32 HSSs did not meet the qualification requirements established by the Office of Personnel Management (OPM). In accordance with Office of Personnel Management (OPM), the qualifications for the GS-0601, General Health Science occupation, has a basic educational requirement of an undergraduate or graduate degree in a major study in an academic field related to the health sciences or allied sciences. This requirement was inadvertently not included on multiple job opportunity announcements posted in 2012-2014, which ultimately resulted (after an initial audit) in the employment of 32 employees who lacked the basic education requirement.

After the discovery via an internal audit, in September 2014, the Canandaigua HR Office notified VA's Office of the Assistant Secretary for Human Resources and

Administration, Office of Human Resources Management (OHRM), of the issue and began meeting with local management officials, union partners, Veterans Health Administration Central Office (VHACO) Workforce Management and Consulting Office (WMC), and Mental Health leaders to develop an action plan to resolve the matter. To limit the interruption to VCL service and to avoid mass terminations of VCL staff, leadership from WMC and the Executive Director of VHA's Office of Mental Health Operations recommended to the Deputy Secretary that the HSSs continue to perform their duties while HR actively worked to find a solution to correct the employees' appointments. The Deputy Secretary approved their recommendation. Due to the extensive training that each VCL responder undergoes and the continued quality assurance monitoring, VA determined that there was no substantial or specific danger to public health and safety by allowing these responders to continue to perform their duties.

The team working to resolve the matter decided to gain a waiver of qualifications and if disapproved, then regularize (i.e., effect a personnel action or actions to correct the erroneous appointments) the appointments of the impacted employees and request a proper staffing variation from OPM. A staffing variation, in accordance with Civil Service Rule V (section 5.1, 5 Code of Federal Regulations), allows the Director of OPM to authorize, whenever there are practical difficulties and unnecessary hardships in complying with the strict letter of the regulation, to grant a staffing variation from the strict letter of the regulation if such a variation is within the spirit of the regulations and the efficiency of the Government and the integrity of the competitive service are protected and promoted.

In September 2015, the Deputy Secretary met with VCL leadership and staff to express his commitment to resolving this matter. A memo was sent to the Director of OPM requesting a waiver of the educational qualifications for the 32 employees. While awaiting approval from OPM, the Canandaigua HR Office proceeded with correcting the 31 HSS erroneous appointments, and effective October 4, 2015, the appointments were regularized by reassigning the employees to a newly-established qualifying position, a Social Science Program Specialist (SSPS), GS-0101-GS-9/11. (NOTE: At the time the Canandaigua HR Office began the regularization process, one employee had resigned.) An SSPS is responsible for the same core duties as an HSS but with different qualification requirements. The new SSPS position description allows employees who possess an undergraduate and graduate degree, 4 years of experience directly related to crisis counseling, or a combination of education and experience, to be qualified for these clinical duties.

In VA, HR Offices are instructed to use VA Handbook 5005, Staffing, Part I, Appendices B, C, and D to correct erroneous appointments and internal movements. When an erroneous action is discovered, VA policy instructs HR Offices to immediately pursue actions to regularize or correct the appointment. VA considered numerous ways to attempt to correct the VCL appointments and treated them as erroneous hiring actions; therefore, not removing the employees before or while the regularization attempts are made. Furthermore, HR Offices are to follow the step-by-step guidance on correcting

the appointment and if successful, submit a staffing variation to OPM to request service credit and/or retention of employees.

In December 2015, the Canandaigua HR Office submitted staffing variation to OHRM to review and request a staffing variation from OPM. After OHRM's technical review of the submissions, it was determined that an on-site review was required to finalize the staffing variation waiver requests. During the week of February 8, 2016, a team of HR subject matter experts from OHRM and VHACO WMC went to the Canandaigua VAMC to provide technical guidance to the Canandaigua VAMC HR Office on how to appropriately prepare the staffing variation waiver requests.

Upon further review by OHRM, 3 of the 31 employees did not qualify for the SSPS position, which required the Canandaigua VAMC HR Office to find other placement opportunities within VCL to correct the appointments. These three employees no longer triaged incoming calls from Veterans. In addition, one waiver request package was pending final qualification determination to be based on certification of additional education and experience. (NOTE: The HR Office later determined that this employee qualified for the SSPS position). And finally, 2 of the 31 employees did not require waiver requests as they subsequently separated from Federal service.

During the period of June 9-14, 2016, OPM approved the remaining 25 staffing variation packages that were submitted to them on April 18, 2016. These 25 employees are eligible to serve in the SSPS position and continue to perform clinical duties. Four additional packages were subsequently sent to OPM on May 24, 2016. Three were approved on July 26, 2016, and one is still pending. One additional impacted employee has been identified, and that staffing variation waiver request package is pending submission to OHRM by the Canandaigua VAMC HR Office before forwarding to OPM for approval. On August 8, 2016, OPM responded to the Deputy Secretary's original waiver request, requesting the Department continue on the course of action already being worked with OPM (i.e., seek staffing variations vice qualification waivers).

VI. Conclusions and Recommendations

Allegation 1

VHACO has allowed 35 VCL responders to remain in their positions, despite management's knowledge that these employees lacked the requisite education for their jobs.

Conclusions for Allegation 1

- VA substantiates that VCL responders were allowed to remain in their positions despite management's knowledge that these employees lacked the requisite education for their jobs; however management was actively involved in taking steps to address the situation.

- Canandaigua VAMC HR and OHRM/HR&A were taking action to regularize the HSS position. These VCL employees lacked the requisite education for their jobs

because they were either moved into HSS positions, as part of the initial consolidation of social worker, psychologist, addiction therapist, and registered nurses positions, or hired using position announcements which did not include the educational requirement.

- VA found that by leaving these VCL responders in their positions, for which they did not qualify, there was a violation of title 5, Code of Federal Regulations (CFR), part 338, Qualification Requirements (General). As soon as Canandaigua VAMC HR and OHRM became of aware of the misalignment of duties and qualifications, they took action to align employees to position descriptions for which they qualified or removed non-qualifying employees to non-clinical positions.

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Recommendations to Canandaigua VAMC HR and OHRM

1. Canandaigua VAMC HR and OHRM continue to work with OPM to resolve outstanding staffing variations.

2. Ensure HR policy includes guidance to:

    a. Compare position descriptions with employee resumes when position realignments occur to ensure employees are qualified for the positions to which they are assigned; and

    b. Review all job announcements to ensure they include all necessary qualifications, such as education and/or experience.

Allegation 2

VA officials proposed transitioning these employees into positions that include clinical duties that appear to violate agency regulations regarding scope of duties.

Conclusions for Allegation 2

- VA substantiates this allegation that employees continued to perform clinical duties; however due to prior experience, extensive training, and the continued quality assurance monitoring, there was no substantial or specific danger to public health and safety.

- To limit the degradation of services provided by VCL and avoid mass termination of employees, VA moved qualifying employees to the new SSPS position, which included the same core duties and considered prior experience as a qualification, unlike the HSS position.

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Summary Statement

A team of experts familiar with the facts of this case developed this report. The team consulted with HR&A, OMI and OGC to address OSC's concerns that VHACO may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. HR&A examined personnel issues to establish accountability, and OAR has reviewed the report and has or will address potential senior leadership accountability. *VA found a violation of regulation; however we did not find gross mismanagement and abuse of authority, or a substantial and specific danger to public health and safety.*

Attachment A

Documents reviewed:

Civil Service Rule V (section 5.1, 5 CFR), allows the Director of Office of Personnel Management to authorize, whenever there are practical difficulties and unnecessary hardships in complying with the strict letter of the regulation, to grant a staffing variation from the strict letter of the regulation if such a variation is within the spirit of the regulations, and the efficiency of the Government and the integrity of the competitive service are protected and promoted.

In accordance with 5 CFR 338.301, agencies must ensure that employees who are given competitive service appointments meet the requirements included in the Office of Personnel Management's Operating Manual: Qualification Standards for General Schedule Positions. The Operating Manual is available to the public for review at agency personnel offices and Federal depository libraries, and for purchase from the Government Printing Office.