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US Office of Special Counsel
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7/3/2014

Enclosed please find my comments as the whistleblower in response to the agency's "supplemental report" regarding the Office of the Special Counsel (OSC) investigation case # DI-13-3661. I was the victim of a massive deliberate privacy breach orchestrated and directed by the facility director Mr. Phil Moschitta at the Veterans Affairs Medical Center located in Northport New York. I have some serious misgivings regarding the Veterans Affairs (herein referred to as the agency) Office of the Medical Inspector (OMI) team "investigation" and their "supplemental report." It offers no additional remedy as a victim of widespread systematic abuse against me as an employee and a 100% disabled veteran just as the original offered no remedy to me as the victim and to prevent further additional victimization of myself, other veterans, employees and veteran employees. The director and his league of henchmen continue their targeted and directed campaign of systematic terror against any employees that dare speak out to expose serious veteran abusive practices at the VA. The director et al have weaponized this VA vulnerability by using employees' Protected Health Information against whistleblowers in a retaliatory manner as extensively reported by most media outlets. It is deficient, delinquent and does NOT rise to the level of any sort of a serious investigation consistent with the widely reported white washing scam that has fueled public debate regarding the credibility and accuracy of the agency's OMI "investigations." It is inaccurate and incomplete; it's obvious that they did not interview all of the individuals on the access logs involved in the privacy breaches when comparing the list of employees that were interviewed v. the employees listed on the access logs that I've provided termed the Sensitive Patient Access Reports (SPAR) listing all of the individuals that illegally accessed my medical records - when this list is compared to the individuals listed by the agency's OMI team that were actually interviewed it is very clear that they only partially investigated some of the folks; it is highly disturbing that they would conduct only a partial investigation in light of the massive scale of the privacy breaches. I demand that the OMI team return to complete the investigation to include ALL of the individuals and to further investigate the privacy breaches delving deeper into this abysmal criminal activity v. their superficial review. I demand that all interviewees be sworn under oath either by a Kilbane or Garrity warning compelling them to tell the truth for fear of perjury. I demand that all interviews be recorded with all of the transcripts included as part of the agency's "investigative report" for independent verification and cross exam. I disagree with their sugar coated conclusions since it seems to promulgate and perpetuate the agency lies tantamount to a white washed cover up since it is the proverbial fox guarding the hen house. It is no doubt that a power washer connected to a turbo jet sprayer and white paint is part of the agency's investigation tool kit to cover up all of their criminal activities. The agency's OMI conclusions were based on vague, speculative, dismissive accepted agency responses (lies) at face value v. further independent validation. It was superficial and milk toast at best. For instance, many of the cases of improper accesses were chalked up to "mistaken entries", however, the agency failed to take a deeper look to verify if there actually could've been another veteran named Fasano scheduled at the exact same time and date that the "mistaken entry" occurred. I am the only Joseph Anthony Fasano 100% disabled

veteran employed by the entire VA placing me at a distinct disadvantage compared to my civilian counterparts since all of my Protected Health Information (PHI), Sensitive Individual Information (SPI) and Personal Individual Information (PII) is contained within the many data bases (hard copy and electronic) contained within the VA's System of Records readily available at the fingertips of any VA employee. The OMI seemed to dismiss all illegal accesses to my medical records for the purposes of "health care operations", however, they fail to detail which "health care operations" precisely were involved in their convenient contrived excuses since the illegal accessing wasn't related to treatment or payment related purposes. It is highly disturbing that a VA cop (Gino Nardelli) is allowed to waltz through my medical records since *your* local cop or sheriff just can't waltz into your private doctor's office and peruse through your medical records at a whim without a subpoena, court order, summons or signed release; neither can your supervisor, coworkers, subordinates, etc. It was also painfully obvious that the agency responses were coached. For instance, Nyny Romero and Maribel Haddock of the Northport Compensation and Pension (C + P) office used the lame excuse that they accessed my chart due to a Regional Office request regarding a C + P exam (the agency fails to provide a copy of this "request"), however, this is not true since by law I cannot have a C + P exam at the VA Northport since I am also employed at Northport representing a conflict of interest begging the question of what deeper ulterior nefarious motives were at stake with the subsequent illegal disenrollment of me as a veteran; all of my disability claims have already been adjudicated by the Veteran's Benefit Administration (VBA) with assigned disability ratings, etc. The OMI team also failed to further investigate the illegal access by Barbara Inskip RN Performance Improvement department of my medical records. Her excuse for illegally accessing my chart implicates my ex sister in law Catherine Fasano RN, however, the OMI team never interviewed Ms. Fasano since Ms. Fasano committed a crime in convincing Ms. Inskip to commit a privacy violation. In short these are but a few examples of an investigation and report riddled with agency bias. The agency's corrective action(s) are a weak inadequate anemic panacea that will not work to stave off the ongoing massive privacy breaches of myself and other VA employees as evidenced by the increased uptick of privacy breach complaints lodged by VA Northport employees with the OSC Disclosure Unit.

The agency's OMI supplemental report does NOT rise to the level of a serious and proper investigation since none of the interviews were recorded for independent review/ analysis/ cross examination. Simply put you cannot polish a turd! None of the interviewees were sworn in under oath so there was no compelling need to tell the truth. The report was based on a shoddy, sloppy, superficial and biased "investigation" that was too severely limited in scope to be of any substantive value. None of the culprits involved in the illegal privacy breaches were punished, disciplined or reported to their respective State Licensing Boards (SLBs). At best they received reprimands which are only filed at the local level and then automatically expunged after 3 months. The agency's OMI team should be forced to re-investigate this thoroughly, completely and properly. Every interviewee should be sworn in under oath compelling them to testify truthfully for fear of perjury. Every interview should be recorded so that the transcripts can be made part of the public record for independent review, analysis and cross examination. The agency's OMI supplemental report jumps to erroneous conclusions based on superficial face value biased.

I was the victim of Identity Theft recently as evidenced by this copied and pasted e-mail I received from USAA Credit Card company:

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New USAA Credit Card

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 **USAA SECURITY ZONE**
Joseph
Fasano
USAA # ending in: 8201

Dear Joseph Fasano,

We were notified by a payment processor that your USAA credit card information, such as your name, account number and expiration date may have been compromised. Unauthorized access to non-USAA systems may have occurred through a merchant where you shopped or dined, or by other fraudulent activity. Specific details about the compromise were not reported to USAA.

To reduce the risk of unauthorized transactions, **we're replacing your credit card ending in 2456. We'll send you a new card with a new account number and expiration date**, and you should receive it within 10 business days. Along with the card, we'll provide information about the steps you should take to activate your card and change your automatic payments.

What to do with your current credit card

Your current card will only remain active for 20 days after the postmarked date on the envelope containing your new card so it's important that you activate your new card immediately. After you have activated your new credit card, please destroy your current card and convenience checks. USAA will automatically cancel your existing card when you activate the new one. Refer to our [Frequently Asked Questions](#) for more information and important steps you should take regarding this matter.

We are committed to the security of your account and personal information. We apologize for the inconvenience. If you would like to speak to us about this matter, please call us at 1-800-945-3703.

Thank you,
USAA Savings Bank

I demand the immediate termination of Mr. Michael Sabo (VISN 3 director) for his complicit role in this criminal activity along with the immediate termination and criminal indictment of all of the guilty culprits with referral for prosecution to the Department of Justice (DOJ) and further investigation by the Federal Bureau of Investigations (FBI) including but not limited to VA Northport NY senior management that initiated, promulgated and instigated this targeted, adverse and retaliatory action against me including Mr. Phil Moschitta (Northport director), Ms. Maria Favale (Northport associate director), Dr. Michael Marino (Service Chief Psychology and chair Workplace Violence Committee), Mr. Nick Squicciarini (VA Northport police chief) and Mr. Steven Wintch (Northport privacy officer) who refused to investigate these matters despite years of requests to do so. I demand the immediate termination of Mr. Paul Haberman RN and Ms. Barbara Albanese RN who along with Mr. Wintch were part of an adverse illegal employee action against me based in large part on my service connected

disabilities that were illegally used against me to illegally restrict my access to health care and benefits as an employee and as a 100% disabled veteran. Mr. Haberman (AIB chair), Ms. Albanese and Mr. Wintch used this information against me in two days of grueling interrogations in a humiliating, provocative and disrespectful manner despite repeated pleas for them to stop which only seemed to fuel their perversion to instigate my PTSD. Your office has been provided copies of the transcripts of the AIB with my notes as proof of this yet these criminals were NEVER interviewed by the OMI team and NEVER disciplined by the agency. In fact all of the guilty culprits received promotions for their complicit criminal activities against me: Mr. Wintch was promoted by 2 grades from a GS-11 to a GS-13 series. Mr. Nardelli was promoted to Captain. Ms. Fasano RN was promoted to a position in the Performance Improvement department. Mr. Haberman RN was given a compressed work schedule (the only nurse manager to have this luxury). Mr. Thomas Sledge was promoted to the Business Office in a position under Mr. Wintch.

All veterans and VA employees should be able to independently and directly access their own access logs (SPAR) without having to go through the Privacy Officer since Mr. Wintch has proven to be an ineffective, lying, criminal dirt bag in his incompetence to do his job in attempts to cover up for the agency's wrong doings. All federal employees are able to access their Leave and Earnings Statements (LES) pay stubs this way as well as their own electronic personnel records, so why can't we have the same level of discreet access to our own SPAR? All veterans and VA employees should be able to directly access their medical records without having to go through the Release of Information (ROI) office; I'm able to do this with my private physician so why can't I do this with the VA? The VA police SHOULD NOT be allowed any type or level of access to veteran and/ or employee medical records without a court order, subpoena, release form, etc. The blanket application of TPO (treatment, payment or health care operations) has been too liberally applied. The local police, sheriff and state troopers can't just waltz into your private doctor's office and peruse your medical records so why are VA cops allowed to do so?

Mr. Wintch NEVER filed a Privacy and Security Event Tracking System for each and every instance of illegal access into my VA medical records. This MUST be done within 1 hour of discovery each and every time a privacy breach is suspected and/or occurs. This constant illegal prying into veteran medical records interferes and obstructs with a veteran employees' right to access medical care at the VA since we are fearful that the agency will use that illegally obtained PHI against us as repeatedly happened to me. The fact patterns are very clearly – my VA medical records were NEVER accessed prior to my employ with the agency, however, the illegal accessing clearly spiked with each and every adverse action the agency has taken against me as a veteran employee. The temporal proximity of the illegal accessing to the illegal adverse agency retaliatory actions against me are beyond a mere coincidence.

According to Mr. Moschitta's (VA Northport director) in sworn EEO testimony as part of an EEO Record of Investigation (EEO) he took full responsibility for these illegal adverse actions against me. He further stated that he based his decisions on the guidance and advice of the Disturbed Behavior Committee (DBC) chairs after a clinical exam/ evaluation, however, I was NEVER evaluated or examined or assessed. I was instantly restricted from accessing the healthcare and benefits that I am entitled to by law as a 100% permanently and totally disabled veteran based on the fraudulent reporting of the DBC chair Michael Marino and Nick Squicciarini (VA Northport police chief) in the absence of any wrong doing and without an investigation and without any charges specifying the alleged wrong doing. Michael Marino illegally practiced way outside/beyond his scope of practice when he illegally advised Mr.

Moschitta to illegally restrict my access to healthcare based strictly on the pretext of my PHI and disabilities that was illegally obtained from my medical records jeopardizing my life, health, safety and well-being. Michael Marino does NOT have the qualifications or clinical credentials or clinical practice privileges to take such vicious actions against any employee or veteran. The former VA secretary Mr. Shinseki had a closed door policy which is still followed to this day by VA senior management. VA employees are expressly forbidden from contacting the secretary's office with any concerns; rather than being praised for reporting issues employees that dare expose anything to the secretary's office are reprimanded by their supervisors since the VA actually has a policy enacted by the former VA Human Resources chief John Sepulveda that forbids VA employees from contacting the secretary's office. Mr. Shinseki further empowered supervisors to engage in whistleblower retaliation by enacting "7422" essentially enabling VA senior management to reprise against any title 38 employees by bypassing all bargaining unit rights with the ruthless and often times illegal application of "7422." This greatly discourages any VA employee from reporting issues.

My Veterans Administration medical records were illegally accessed multiple times by many VA employees including non-clinical staff such as administration, senior management, Business Office, etc. in violation of the Privacy Act of 1974, violation of the HIPAA act of 1996, violation of VHA handbook series pertaining to privacy mainly 1605, 1605.1, 1605.2, 1605.03, 6500 and 6500.2 **and the Federal Standards for Privacy of Individually Identifiable Health Information and/or the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Parts 160 and 164, Subparts A, C & E, the Privacy and Security Rules and the Breach Notification Rule Subpart D - Notification in Case of Breach of Unsecured Protected Health Information) (45 CFR SS 164.400 - 164-414).** I became very concerned regarding my VA medical records in light of the ongoing massive privacy breaches at the VA Northport NY facility. I requested copies of the access logs a.k.a. Sensitive Patient Access Report (SPAR) via the Privacy Office. This is a by-name listing of every single individual that accessed my VA medical records including the date and time of the entries. The illegal access to my medical records in many instances was NOT for treatment, payment or healthcare operations (TPO). Furthermore I never sought healthcare on the dates/times of many of the entries in the SPAR so the illegal access was NOT necessarily related to their position descriptions (PD), functional statements (FS), job title, etc. This is a continued violation of law, rule and regulation as detailed above. As a VA employee I am painfully aware of the agency's repeated failures to secure my privacy since I am at a distinct disadvantage as a veteran-employee vs. my private sector counterparts since the VA as my employer also happens to be the maintainer of my medical records with their massive Systems of Records (SOR). The VA SOR contains very detailed biometric data, Protected Health Information (PHI), Sensitive Protected Information (SPI) and Personally Identifiable Information (PII) that can be easily accessed by any VA employee and used in nefarious ways against me as an employee, a veteran, a private citizen, ID theft, etc. In the wake of the extensive government spying with the NSA scandals and the current VA scandals that are daily reported in the media I am hopeful that the OSC will refer this complaint for further investigation for criminal prosecution by the Department of Justice and FBI.

The OSC has openly admitted in a letter from Ms. Cynthia Lerner to the White House that the agency's OMI teams cannot be trusted to conduct any sort of credible investigations:

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

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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.”

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□ 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 unsupported 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.

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□ 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.

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□ 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.

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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

VA Medical Inspector Retires After Scathing Report
WASHINGTON — Jul 2, 2014, 6:34 PM ET
By MATTHEW DALY Associated Press

AP

The chief medical inspector for the Department of Veterans Affairs has retired, following a report that his office downplayed whistleblower complaints outlining serious problems at VA facilities across the country, acting VA Secretary Sloan Gibson said Wednesday.

Dr. John R. Pierce had served as medical inspector since 2004 and was deputy medical inspector for two years before that.

Pierce's office came under scrutiny last week, after the independent Office of Special Counsel issued a scathing report that identified "a troubling pattern of deficient patient care" at VA facilities around the country. The problems were pointed out by whistleblowers but downplayed by the medical inspector and other top officials, the report said.

Gibson met with Special Counsel Carolyn Lerner Tuesday and reaffirmed his commitment to prevent retaliation against employees who identify or report problems.

In a June 23 letter to President Barack Obama, Lerner cited canceled appointments with no follow up, drinking water that had been contaminated with the bacteria that causes Legionnaires' disease and improper handling of surgical equipment and supplies. One veteran was admitted to a long-term mental health facility but didn't get a comprehensive psychiatric evaluation for eight years, Lerner said.

Gibson said last week he was deeply disappointed by the allegations and vowed a quick response. A departmental review of the special counsel's report is due by July 7.

Pierce is one of a half-dozen high-ranking officials who have resigned or retired from the VA following a national outcry over reports of patient deaths, widespread treatment delays and falsified records at VA facilities nationwide. The outcry led to VA Secretary Eric Shinseki's resignation in late May. Since then, several other officials have resigned, including the agency's top health official and the man who replaced him as acting undersecretary for health. A third man who had been nominated by Obama for the top health job withdrew.

The agency's general counsel and assistant secretary for congressional and legislative affairs also have left in recent weeks.

On Monday, Obama nominated former Procter & Gamble CEO Robert McDonald to be VA secretary, saying his experience managing one of the world's most recognizable companies would help McDonald "deliver better results" at the VA.

Gibson said Wednesday that Leigh Bradley will join VA temporarily as his special counsel. Bradley is a former VA general counsel and currently serves as director of the Defense Department's Standards of Conduct Office, where she is responsible for the Pentagon's ethics program.

50 VA hospital workers claim retaliation for blowing whistle on the horrors they saw -

Washington Times

When Valerie Riviello, a nurse at a Veterans Affairs facility in New York, saw the clinic restrain a sexual assault survivor to a bed for seven consecutive hours, she released the woman. The next day, Ms. Riviello said, she was removed from her post as senior nurse manager and given a full-time desk job that prohibited her from contact with patients. She eventually was reprimanded and is facing a 30-day unpaid suspension for releasing the woman.

Now, Ms. Riviello is one of more than 50 whistleblowers who say the Veterans Affairs Department retaliated against them for trying to do their jobs. The complaints got backing last week from the Office of Special Counsel, which issued a stern warning for the VA to shape up. Ms. Riviello said her reprimand for the November incident has cowed other nurses at the Albany Stratton VA Medical Center in New York.

When the facility put the same female patient under restraints for 49 continuous hours in February, as a convenience to doctors who wanted to enjoy their holiday weekend, none of the nurses wanted to speak up, Ms. Riviello said.

“The nurses are afraid to complain or report anything,” she said. “They have 100 things they’ve noticed, but they’ve seen what is happening to me so they’re afraid to report anything.”

Ms. Riviello said the workplace is hostile and she thinks she is being bullied.

A Stratton VA official said the hospital takes the accusations “very seriously” and encourages all employees to report their concerns.

“VA employees have a number of venues available to them to raise issues and concerns,” said Peter Potter, director of public affairs for the facility. “The Albany Stratton VA Medical Center values all internal and external reviews as opportunities to affirm the quality of our medical care and practices and to identify opportunities for improvement.”

Ms. Riviello, a 28-year veteran of the VA health care system, disagreed. She said her unblemished record has been tarnished by the reprimand.

“I feel like I’ve been humiliated and it’s tarnished,” she said. “Sitting at a desk eight hours a day doing a project that is something to keep me away from the clinical arena, it’s too much.”

The VA has come under scrutiny after reports surfaced that the Phoenix facility was cooking its scheduling books and that some veterans had died while awaiting care. Whistleblowers at other facilities then came forward with similar reports of secret wait lists and poor scheduling, some of which have been substantiated by an internal audit.

Several subsequent reports have said the VA failed to heed the warnings of whistleblowers, who sounded alarms about waiting lists and about substandard care.

“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 nonresponsiveness,” according to the letter from the special counsel's office. “Too frequently, the VA has failed to use information from whistle blowers to identify and address systemic concerns that impact patient care.”

In Ms. Riviello’s case, the patient had been in restraints for seven hours when the nurse said she was no longer a threat and could have been released after two hours.

“When the patient was complaining of pain and boils, we couldn’t not take her out anymore. I called my supervisor and said we needed to take her out and give her basic care,” she said.

“When they found out she had been released, they wanted to put her back in restraints, but the nurses said no.”

The February incident was similar — except no nurses stepped forward to help the woman, Ms. Riviello said, which left her in restraints throughout the holiday weekend.

Because the patient was so unpredictable, if she had to be placed in restraints again to prevent harm to herself or others, a doctor would have had to come in and evaluate her within an hour according to VA policy, Ms. Riviello said. Since doctors didn’t want to possibly be disturbed in the middle of the night during a holiday weekend, she said, they just kept the patient in restraints for an extended time.

“To put someone in restraints and to keep them in restraints for any length of time or predetermined length of time is inhumane and it is against policy,” she said. “The leadership has changed over the last three years and has taken veteran-centered care and made it more physician-driven and for the physicians’ convenience.”

The special counsel's office declined to comment on its ongoing investigation into the VA treatment of whistleblowers.

Cheri Cannon, a partner at Tully Rinckey PLLC who is representing Ms. Riviello, said it may take awhile for the special counsel's office to finish investigating Ms. Riviello's case because it has at least 50 others.

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Read more: <http://www.washingtontimes.com/news/2014/jun/29/50-va-hospital-workers-claim-retaliation-for-blowi/#ixzz36dnvvKXx>

'Corrosive culture' at VA has led to significant failures in health care, White House review finds

Published June 27, 2014

[FoxNews.com](http://www.foxnews.com)

The troubled Veterans Affairs health care system is plagued by a "corrosive culture" of mismanagement and distrust that has had significant negative impacts on medical treatment for veterans, according to a White House review.

A summary of the review, which was done by deputy White House chief of staff Rob Nabors and released Friday, says the environment within the Veterans Health Administration hurt morale and affected the timeliness of health care, and the division of the department must be restructured.

The review came in the wake of reports of lengthy wait times for appointments and treatment delays in VA facilities nationwide.

The review offers a series of recommendations, including a need for more doctors, nurses and trained administrative staff. Those recommendations are likely to face skepticism among some congressional Republicans who have blamed the VA's problems on mismanagement, not lack of resources.

The White House released the summary after Obama returned from a two-day trip to Minneapolis and promptly ducked into an Oval Office to get an update on the administration's response to the VA troubles from Acting VA Secretary Sloan Gibson and Nabors.

"We know that unacceptable, systemic problems and cultural issues within our health system prevent veterans from receiving timely care," Gibson said in a statement following the meeting. "We can and must solve these problems as we work to earn back the trust of veterans."

Among Nabors' findings:

-- The VA acts with little transparency or accountability and many recommendations to improve care are slowly implemented or ignored. Concerns raised by the public, monitors or even VA

leadership are viewed by those responsible for VA's health care delivery as "exaggerated, unimportant, or 'will pass.'"

-- The VA's lack of resources is widespread in the health care field as a whole and in the federal government. But the VA has been unable to connect its budget needs to specific outcomes.

--The VA needs to better prepare for changes in the demographic profile of veterans, including more female veterans, a surge in mental health needs and a growing number of older veterans.

Since reports surfaced of treatment delays and of patients dying while on waiting lists, the VA has been the subject of internal, independent and congressional investigations. The VA has confirmed that dozens of veterans died while awaiting appointments at VA facilities in the Phoenix area, although officials say it's unclear whether the delays were the cause of the deaths.

One VA audit found that 10 percent of veterans seeking medical care at VA hospitals and clinics have to wait at least 30 days for an appointment. More than 56,000 veterans have had to wait at least three months for initial appointments, the report said, and an additional 46,000 veterans who asked for appointments over the past decade never got them.

This week, the independent Office of Special Counsel concluded there was "a troubling pattern of deficient patient care" at the Veterans Affairs that VA officials downplayed. Among the findings were canceled appointments with no follow up, contaminated drinking water and improper handling of surgical equipment.

The Associated Press contributed to this report

VA nurse alleges agency turned on her after she reported abuses

By Robert Gearty

Published June 25, 2014

FoxNews.com

A Veterans Affairs nurse who spent 28 years at the embattled agency's facility in Albany, N.Y., says when she came forward to report abuse including stolen drugs and mistreatment of patients, her supervisors turned on her instead of trying to fix things.

Nursing manager Val Riviello, 55, was considered an outstanding employee at the Albany Stratton VA Medical Center until last November, when she reported that doctors had restrained a patient for seven hours in violation of VA rules. Now she has been banished to an office cubicle, stripped of her nursing duties and supervisory role and faces a 30-day suspension without pay.

"That's really kind of barbaric."

- VA nursing supervisor Val Riviello

Riviello told FoxNews.com Wednesday that she reported her claim of whistle-blower reprisal to the U.S. Office of Special Counsel and the VA Inspector General, and divulged other disturbing practices she had seen over the years. She told authorities officials at the facility later restrained the same patient for 49 hours during a holiday weekend last February, in a gross violation of procedures.

“That’s really kind of barbaric,” Riviello said. She said restraints are for patients who are a threat to themselves and others and are supposed to come off when that is no longer the case.

Riviello also told FoxNews.com about the theft of 5,000 vials of morphine from a locked drawer. She said the vials were refilled with saline solution, which was given to veterans in hospice care and in dire need of pain management. Riviello said the thief was a nurse who just got caught.

“When you have a system this large with no oversight, you are going to have bad actors,” said Riviello’s attorney, Cheri Cannon of Washington.

Three weeks ago the OSC announced it was investigating claims of whistle-blower reprisals from 37 VA employees, including Riviello. A June 5 press release alluded to her case without mentioning her by name. The release said the disciplinary action against her had been stayed pending the results of the OSC investigation.

On Monday, Carolyn Lerner, the head of the Office of Special Counsel, sent a letter to President Obama stating that the embattled VA had not properly investigated more than two dozen cases in which employees alleged manipulated wait-times and improper care.

It was unclear if one of those cases involved Riviello. An OSC spokesman did not immediately respond to a request for comment.

Riviello worked for years on the psych ward, but said her troubles started when she showed up for work on Nov. 5. In restraints in one of the beds was a female vet from the Iraq War suffering from Post Traumatic Stress Disorder who had become disruptive before Riviello started her shift. The patient had been tied to her bed with straps around her legs, arms and waist.

By 1:30 p.m. the patient had calmed down. Riviello ordered the restraints removed after she spoke to her supervisor, despite a doctor’s order to keep them on.

“The point is you don’t need a doctor’s order to take a patient out of restraints,” she said. “It is up to us to reassess every 15 minutes for their ability to be released. Obviously, being tied down is not very therapeutic.”

The next day Riviello was assigned to her office and told she would be demoted. In March she was told she would be issued a reprimand for failing to follow a patient’s care plan.

A month later she was threatened with civil and criminal penalties for sharing the patient's records with her attorney. Cannon told the VA she had the right to see those records to assist Riviello in her defense.

In May, the VA told Riviello she was going to be suspended for 30-days without pay.

"Ms. Riviello has faced retaliation for trying to do the right thing for this patient and all VA patients subject to such harsh and unlawful treatment," Cannon said in an April 24 letter to the OSC.

A spokesman for VA Albany did not immediately comment.

Cannon said the VA scandal shows her client's situation is not unique.

"It's our observation there's a serious management breakdown in these VA facilities, where employees like Val are trying desperately to give these vets the best possible care they can and when they do so and it displeases management for whatever reason, the ones who are on the losing end are the vets and the staff trying to do the right thing," the attorney said.

Riviello told FoxNews.com that losing her job has caused her stress. "It makes me feel terrible," she said. "It makes me feel humiliated."

She said that by coming forward now she is hoping to help other VA employees who might find themselves in the same situation.

"I don't want there to be anyone else being asked to do things that are not in the best interest of the patients we take care of," she said.

Poor care at VA hospitals cost 1,000 veterans their lives, report says - Washington Times
\$1B in malpractice settlements as horror stories revealed

The problems at Veterans Affairs extend well beyond long wait lists, with a report Tuesday showing the department is plagued with poor care that has cost up to 1,000 veterans their lives and left taxpayers on the hook for nearly \$1 billion in malpractice settlements since the beginning of the wars in Iraq and Afghanistan.

Some of the problems detailed in the report by Sen. Tom Coburn of Oklahoma are downright ghoulish. They include the case of a former security chief at a New York Veterans Affairs medical center whom the FBI arrested on charges of plotting to kidnap, rape and murder women and children.

More standard is the nightmarish bureaucratic bungling that shows a department in disarray and a culture more concerned with punishing whistleblowers than with fixing the problems they pointed out, said Mr. Coburn, Senate Republicans' chief investigator who has earned a reputation as the top waste-watcher in Congress.

“The problems at the VA are worse than anyone imagined,” Mr. Coburn said. “Over the past decade, more than 1,000 veterans may have died as a result of VA’s misconduct and the VA has paid out nearly \$1 billion to veterans and their families for its medical malpractice.”

The VA has come under fire in recent months over reports that dozens of veterans died while stuck on secret waiting lists at a VA facility in Phoenix. Since then, an inspector general’s investigation has found widespread misuse of secret wait lists in a number of facilities. The department’s secretary has resigned.

But Mr. Coburn’s report, titled “Friendly Fire: Death, Delay and Dismay at the VA,” argues that problems go back well before the Phoenix scandal and run deeper than bogus wait lists and scheduling practices designed to help managers show that they are meeting performance goals. His exhaustive study, which combines previously reported problems and some new ones, highlights horrifying cases.

One involves a Philadelphia veteran who went in for a tooth extraction. Doctors went ahead with the procedure despite his dangerously low blood pressure. On his way home from the operation, he had a stroke and was left paralyzed.

Another veteran had annual chest X-rays, but doctors never spotted a growing lesion in his lung. It ultimately killed him.

A veteran in South Carolina had to wait nine months for a colonoscopy. By the time he underwent the procedure, cancer was diagnosed at stage three. In that case, the VA admitted that had he been treated earlier, his case might not have been as severe, Mr. Coburn said.

Mr. Coburn’s report appears to reject the claims of some VA defenders who acknowledge that problems exist but say they shouldn’t tarnish the image of care the health system provides.

Some lawmakers on Capitol Hill have said the VA problems will need to be solved with an infusion of funds.

But Mr. Coburn traced the problem to bad management and lax working standards, not to lack of money. In one finding, he said VA doctors average about half the workload that private-practice primary care physicians do, suggesting there is room for them to take more patients.

Among his other findings:

- Female patients received unnecessary pelvic and breast exams from a sex offender.
- Delays are endemic. In addition to care waiting lists, the VA is behind on processing disability claims and constructing facilities.
- Some VA health care providers have lost their medical licenses, but the VA hides that information from patients.
- The federal government has paid out \$845 million for VA medical malpractice settlements since 2001.

Mr. Coburn included a photo from one VA facility in North Carolina that couldn’t find proper storage for 37,000 benefit claim folders. They were piled on top of filing cabinets, apparently in random order, making it not only poor case management, but also a fire hazard, Mr. Coburn said.

In the stunning case of the police chief, Richard Meltz, head of security at the Bedford VA Medical Center, pleaded guilty in January to involvement in what the FBI called “two sadistic kidnapping, rape and murder conspiracies.” Meltz advised two others on how to avoid being tracked, such as not using toll roads, and where to dump bodies, according to the FBI.

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VA brass knew of false data for 2 years

Dennis Wagner, 10:28 a.m. EDT June 24, 2014

Acting Secretary of Veterans Affairs Sloan Gibson speaks during a press conference at the VA Medical Center in Phoenix on June 5, 2014. Gibson was in Phoenix to discuss immediate actions taken to address the recommendations outlined in the recent interim Inspector General report. (Photo: Cheryl Evans, The Arizona Republic)

PHOENIX -- Department of Veterans Affairs administrators knew two years ago that employees throughout the Southwest were manipulating data on doctor appointments and failed to stop the practice despite a national directive, according to records obtained by *The Arizona Republic* through a Freedom of Information Act request.

A 2012 audit by the VA's Southwest Health Care Network found that facilities in Arizona, New Mexico and western Texas chronically violated department policy and created inaccurate data on patient wait times via a host of tactics.

The practice allowed VA employees to reap bonus pay that was based in part on inaccurate data showing goals had been met to reduce delays in patient care, according to the VA Office of Inspector General. At the Phoenix medical center alone, reward checks totaled \$10 million over the past three years.

Top officials at the Phoenix VA Health Care System, including Sharon Helman, who was suspended as director last month, have repeatedly claimed they were not aware of scheduling misconduct until complaints by whistle-blower physician Sam Foote were made public in April.

But audit findings, based on a review of data from the second quarter of fiscal 2011, show the violations proliferated throughout the Southwest and were common nationwide.

The report notes that former VA Undersecretary Robert Petzel, who resigned under fire in May, convened a conference call with Health Administration Services leaders nationwide in September 2011 to confront the problem. According to the audit, Petzel pressed department executives "not to 'game' the system."

A year earlier, William Schoenhard, then a VA deputy undersecretary, described and prohibited various "gaming strategies" used nationwide to falsify wait-time data. His directive made top

regional administrators responsible for ensuring the integrity of medical appointment systems, and required annual reviews.

Acting VA Secretary Sloan Gibson last week directed all VA medical center and health care system directors to do monthly in-person site inspections and reviews of scheduling practices in every clinic within their jurisdiction to ensure adherence to policies.

That sort of scrutiny was supposed to have occurred after the 2012 audit. Helman became director of the Phoenix VA Health Care System in February 2012, a month after the Southwest audit was issued. She made timely medical appointments her system's No. 1 priority and implemented a "wildly important goal" program.

E-mails between Helman, Bowers and others — obtained via a public records request — verify that VA leaders in Arizona were intensely aware of scheduling compliance problems during 2013.

Yet, as late as last December, Helman continued to paint a rosy picture for outsiders. In a letter to Sen. John McCain, R-Ariz., Helman discounted allegations of a Phoenix whistle-blower who reported fraudulent record-keeping. By that time, investigators from the Office of Inspector General were in Phoenix, verifying that appointment data had been manipulated.

In her letter to McCain, Helman noted that she and VA staffers had met with Tom McCanna, the senator's liaison for veterans, months earlier "to discuss wait-time issues and scheduling concerns." Helman told McCain her compliance office had performed an audit in July 2013, and "the results validated local data collection efforts regarding EWL (electronic wait list) and access were correct."

Rep. Jeff Miller, R-Fla., who has spearheaded congressional investigations as chairman of the House Committee on Veterans' Affairs, said the new revelations in Arizona offer "continued proof of how VA leaders looked the other way while bureaucrats lied, cheated and put the health of veterans they were supposed to be serving at risk.

"Most disturbingly," Miller told *The Republic*, "those charged with enforcing VA policies and holding employees accountable for gaming the system never even lifted a finger to do so. The only way for Acting VA Secretary Sloan Gibson to rid the department of this widespread corruption is to pull it out by the roots, and he needs to begin that process right now."

Helman could not be reached for comment on the audit or e-mails. But Susan Bowers, who was forced to retire last month as director of the VA's Southwest regional health care office, said she ordered the compliance review in 2011 based on suspicions of false data on appointments.

"We knew scheduling was a high-risk area" for violations," Bowers said. "The compliance review was done and, as a result, we had a number of goals developed to address those issues.

"That was the thing to fix when (Helman) got to Phoenix. My first instruction to her was, 'We've got to deal with the wait-time issue.'"

Bowers and regional VA spokeswoman Jean Schaefer said action plans were developed based on the audit. They also said the findings were briefed during a network leadership meeting just days after Helman took command of the Phoenix VA medical center.

Bowers acknowledged her scheduling goals focused on reducing delays in care, rather than stopping the falsification of data. She also agreed that using untrustworthy statistics made it impossible to determine whether goals were met, and thus whether bonus pay was justified.

Bowers said she did not issue a regional directive specifically ordering compliance with VA scheduling rules, or warn employees they would be fired for violations, because such memos are not part of the agency culture.

"In retrospect, I wish I would have done that," she added. "But there were constant messages from my office that basically said, 'We don't game the system. We need to know how bad it is.'"

Hundreds of thousands of ex-military personnel nationwide have been affected by the massaging of data and cancellation of appointments at many of the VA's approximately 950 facilities. Appointment manipulations resulted in veterans' delayed care that sometimes resulted in negative medical consequences, according to the VA Office of Inspector General. They also created a false impression of timely patient services, obstructing improvements to the system.

The Southwest regional audit analyzed 573,000 appointments at 3,423 VA clinical offices in the three states. The audit uncovered a spider's web of tactics used to produce inaccurate wait-time data. Among them:

Appointments routinely were canceled in blocks by VA clinics, eliminating backlogs and artificially reducing wait-time statistics. But those same clinics indicated in data reports that the appointments had been canceled by patients. In El Paso, VA health care schedulers canceled one in four appointments during the period examined. Some clinics showed suspected cancellation clusters on more than half of the days during the quarter.

VA employees often recorded walk-in patients as scheduled visits to make it appear veterans were seen without any wait at all when, in fact, they showed up uninvited because they could not schedule appointments. In Phoenix, 77 percent of the walk-in patients were improperly listed as scheduled appointments. At Prescott's VA medical center, 85 percent of the clinics engaged in

the deceptive practice, which apparently skewed wait-time data. It also allowed veterans to collect round-trip travel expenses for their clinic visits, rather than one-way benefits authorized for walk-in patients under the VA claims system.

Appointments were entered into computers without listing a desired date, making it possible to insert an untrue date later. That form of manipulation occurred at all seven major medical centers investigated: Phoenix, Prescott and Tucson; Albuquerque; and El Paso, Amarillo and Big Springs, Texas.

When first-time appointments for new patients were not available within 90 days, those veterans' names were not even entered into the electronic wait system. The result? Protracted delays that were not counted in wait-time data.

Some VA facilities misrepresented wait times by incorrectly recording the date patients were seen by physicians as the desired appointment date. At the VA medical center in Prescott, administrators claimed four of five patients were seen on the date they wanted an appointment. Although auditors could not determine the data accuracy without analyzing each appointment, they concluded the numbers were "artificially high" and "could have the appearance of inaccurately capturing the patient's true desired date."

The audit contained a list of recommended changes.

Records show that, for at least four years, data manipulation was not just a Phoenix concern, but a national problem. The VA inspector general is now investigating similar conduct at more than 40 facilities.

Bowers said the dysfunction stems from an outdated, convoluted scheduling program that needs to be replaced with new software, but Department of Veterans Affairs headquarters failed to provide resources. "We need a new system," she said.

The 2012 audit was released to *The Republic* this week — more than three months after the newspaper filed a March 4 FOIA request for materials concerning wait-time falsifications.

In recent weeks, the VA has been a subject of Senate and House hearings, with scathing attacks by members of Congress and the media for perceived cover-ups and a lack of accountability.

Since the health care scandal was first exposed in April, VA Secretary Eric Shinseki and Petzel have resigned; Bowers was forced to retire early; and Helman was placed on administrative leave along with two other top administrators at the Phoenix VA. Termination proceedings have been initiated against the latter three.

Wagner also reports for The Arizona Republic

NYTimes.com: Investigator Issues Sharp Criticism of V.A. Response to Allegations About Care

Carolyn N. Lerner, head of the Office of Special Counsel, which investigates whistle-blower complaints. Her office is reviewing more than 50 pending complaints from Veterans Affairs workers.

In a blistering letter sent to President Obama on Monday, the head of the agency that investigates whistle-blower complaints in the federal government criticized the Department of Veterans Affairs for not digging deeper into widespread allegations made by its own employees of poor or severely delayed patient care for veterans. In the letter, Carolyn N. Lerner, head of the Office of Special Counsel, asserted that Veterans Affairs officials consistently had used a “harmless error” defense to dismiss as trivial numerous claims of shoddy patient care or long waiting times made by department employees in recent years. Ms. Lerner criticized the department, along with its Office of the Medical Inspector, for a longstanding pattern of refusing to use whistle-blower complaints to fix serious medical problems. The Office of Special Counsel, an independent agency within the executive branch, is reviewing more than 50 pending complaints from Veterans Affairs workers alleging harm to patient safety or health; 29 have already been forwarded to the department for further investigation. That is more than one-quarter of all the pending cases the Office of Special Counsel has referred for investigation across the entire federal government. The office is also investigating about 60 cases involving Veterans Affairs employees who alleged they faced reprisals for raising concerns about patient care.

The V.A.’s Problems, by the Numbers

Facts and figures behind the troubled Department of Veterans Affairs.

Ms. Lerner said she was encouraged by recent statements by the department’s acting secretary, Sloan D. Gibson, in support of whistle-blowers’ playing a critical role at the department. Mr. Gibson took over three weeks ago, after Eric Shinseki, who had led the department since President Obama took office, resigned amid a widening scandal over falsified waiting lists at several veterans hospitals and clinics. In a statement, Mr. Gibson said that he welcomed the letter from Ms. Lerner and that he was “deeply disappointed not only in the substantiation of allegations raised by whistle-blowers, but also in the failures within V.A. to take whistle-blower complaints seriously.” He said he had ordered a review of “all aspects” of the department’s Office of the Medical Inspector to be finished within two weeks, including a “consideration of personnel actions.” And he reiterated that any intimidation or retaliation against employees who raised questions or who pointed out problems would not be tolerated. Ms. Lerner’s letter does not provide specific evidence of clinical harm to patients as a result of poor or delayed care. But she said that in a number of cases, investigations by department medical inspectors that concluded no veterans faced greater health or safety risks because of poor care appeared to have been contradicted by the facts of the department’s own investigations. She cited one case that concerned a veteran who had a psychiatric condition resulting entirely from

his military service and who was a resident at the department's mental health facility in Brockton, Mass., from 2005 to 2013. During those eight years, he had only one psychiatric note written into his chart, in 2012. (A spokesman for her office said that the veteran's clinical condition worsened during the period his treatment was neglected.) Another veteran in Brockton was admitted in 2003 "with significant and chronic mental health issues," but did not have a comprehensive psychiatric evaluation until eight years later. Nevertheless, the department's medical inspector "failed to acknowledge that the confirmed neglect of residents at the facility had any impact on patient care," Ms. Lerner said. At the medical center in Jackson, Miss., the V.A. substantiated a host of problems pointed out by whistle-blowers, including "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." Officials at the facility also used "ghost clinics" to schedule patients for appointments even though no doctors were actually assigned to these "clinics" — a way for the medical center to cloak a chronic staffing shortage that led to long delays for veterans. Yet even as it confirmed these problems, the department "refused to acknowledge any impact on the health and safety of veterans seeking care" at the medical center, Ms. Lerner wrote. She also cited problems at the department's Fort Collins, Colo., site that led to 3,000 veterans' being unable to reschedule canceled appointments — nearly a third of them assigned to a single nurse practitioner. Though "routine primary care needs were not addressed," the department's medical inspector said it could not substantiate that the problems "resulted in a danger to public health and safety." That is a conclusion, Ms. Lerner said, "unsupportable on its own." Representative Jeff Miller, the Florida Republican who is chairman of the Veterans Affairs Committee, offered a blunter assessment of Ms. Lerner's findings. "In the fantasy land inhabited by V.A.'s Office of the Medical Inspector," Mr. Miller said, "serious patient safety issues apparently have no impact on patient safety." Ms. Lerner's letter may give fodder to critics of the department who have sought to tie potential cases of patient harm to the wait-list scandal that engulfed the department this year. So far, some of the most serious allegations have not panned out. In May, for example, officials from the department's inspector general's office said they had not been able to verify allegations that as many as 40 veterans had died because of delays in treatment while on an off-the-books waiting list at the Phoenix medical center. But in the aftermath of Mr. Shinseki's resignation last month, Veterans Affairs officials and the White House have readily acknowledged the depth of many problems at the department — troubles that prompted Mr. Shinseki to deplore what he had concluded was a "systemic, totally unacceptable lack of integrity" that he could not explain. In a message to department employees this month, Mr. Gibson, the acting secretary, went out of his way to assure workers that whistle-blowers would be protected. "Intimidation or retaliation against whistle-blowers — or any employee who raises a hand to identify a legitimate problem, make a suggestion, or report what may be a violation of law, policy or our core values — is absolutely unacceptable," Mr. Gibson said. Administrators who retaliate against whistle-blowers, he added, will be disciplined. A version of this article appears in print on June 24, 2014, on page A15 of the New York edition with the headline: Investigator Issues Sharp Criticism of V.A. Response to Allegations About Care.

Veterans neglected for years in VA facility, report says
By Nelli Black, Scott Bronstein and Drew Griffin, CNN Investigations
updated 5:52 PM EDT, Mon June 23, 2014

(CNN) -- Two veterans in a Veterans Affairs psychiatric facility languished for years without proper treatment, according to a scathing letter and report sent Monday to the White House by the U.S. Office of Special Counsel, or OSC. In one case, a veteran with a service-connected psychiatric condition was in the facility for eight years before he received a comprehensive psychiatric evaluation; in another case, a veteran only had one psychiatric note in his medical chart in seven years as an inpatient at the Brockton, Massachusetts, facility. Examples such as those are the core of the report released Monday by the OSC, an independent government agency that protects whistleblowers. The agency said it is still investigating more than 50 whistleblower disclosures involving patient health or safety allegations at the VA nationwide, and "these cases represent more than a quarter of all matters referred by OSC for investigation government-wide," according to the report.

Fear kept the VA scandal a secret

The report also slams the VA's medical review agency, the Office of the Medical Inspector, or OMI, for its refusal to admit that lapses in care have affected veterans' health. For example, when the office reviewed the Brockton psychiatric cases, it confirmed the patient neglect yet "denied that... (it) had any impact on patient care." "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," the OSC said. "This approach hides the severity of systemic and longstanding problems." In response to the OSC's letter, Sloan Gibson, the VA's acting director, issued a statement: "I respect and welcome the letter and the insights from the Office of Special Counsel. I am deeply disappointed not only in the substantiation of allegations raised by whistleblowers, but also in the failures within VA to take whistleblower complaints seriously." Gibson said he has directed a "comprehensive review of all aspects of the Office of Medical Inspector's operation, to be completed within 14 days."

As part of its review, the OSC looked at whistleblower allegations at 10 VA hospitals, where it found the VA's review of cases "appears to contradict its own findings." According to the OSC, at a VA hospital in Jackson, Mississippi, the Office of Medical Inspector substantiated a number of allegations, including "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," which led to the creation of "ghost clinics" in which veterans were scheduled for appointments without an assigned provider and as a consequence were leaving the facility without receiving treatment. Despite the numerous lapses in care at the Jackson VA, the Office of Medical Inspector did not acknowledge any impact on the health and safety of veterans, according to the OSC letter. Monday's letter also outlined whistleblower complaints ranging from unsterilized surgical equipment in Ann Arbor, Michigan, to neglect of elderly residents at a geriatric facility in San Juan, Puerto Rico, to a pulmonologist in Montgomery, Alabama, who "copied prior provider notes in over 1,200 patient records, likely resulting in inaccurate health information being recorded." Other facilities with substantiated complaints include Grand Junction, Colorado; Buffalo, New York; Little Rock, Arkansas; and Harlingen, Texas. The OSC said all these cases are "part of a troubling pattern of deficient patient care at VA facilities nationwide, and the continued resistance by the VA, and the OMI in most cases, to recognize and address the impact of health and safety of veterans." The agency also expressed concern that the VA hasn't adequately addressed whistleblower complaints of

wrongdoing. Referring to the scandal of a secret wait list at the Phoenix VA facility, the OSC found that "the recent revelations in 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." At a facility in Fort Collins, Colorado, the Office of Medical Inspector substantiated allegations made by a VA employee, including a shortage of providers that led schedulers to cancel veterans' appointments. It found that 3,000 veterans were unable to reschedule appointments and that staff was instructed to alter wait times. In May, CNN interviewed Lisa Lee, who worked as a scheduler at the VA clinic in Fort Collins. "We were sat down by our supervisor ... and he showed us exactly how to schedule so it looked like it was within that 14-day period," Lee told CNN. "They would keep track of schedulers who were complying and getting 100 percent of that 14 day(s) and those of us who were not." Despite its findings in Fort Collins, the Office of the Medical Inspector wrote that it "could not substantiate that the failure to properly train staff resulted in danger to public health and safety." In Monday's letter, the OSC disagreed with that determination, saying the VA's conclusion in this case "is not only unsupportable on its own, but is also inconsistent by other VA components examining similar patient-care issues." Since November 2013, CNN has been investigating and publishing reports of wait lists and deaths of veterans across VA hospitals across the country. In April, details of the secret wait list in Phoenix, and allegations of 40 veterans dying there while waiting for care, emerged when retired Phoenix VA physician Dr. Sam Foote stepped forward; Dr. Foote first appeared on CNN with details of what happened in Phoenix.

How the VA developed its culture of coverups | The Washington Post

About two years ago, Brian Turner took a job as a scheduling clerk at a Veterans Affairs health clinic in Austin. A few weeks later, he said, a supervisor came by to instruct him how to cook the books. "The first time I heard it was actually at my desk. They said, 'You gotta zero out the date. The wait time has to be zeroed out,'" Turner recalled in a phone interview. He said "zeroing out" was a trick to fool the VA's own accountability system, which the bosses up in Washington used to monitor how long patients waited to see the doctor.

BREAKING POINTS:

WHERE GOVERNMENT FALLS APART

Third in a series examining the failures at the heart of troubled federal systems. This is how it worked: A patient asked for an appointment on a specific day. Turner found the next available time slot. But, often, it was many days later than the patient had wanted. Would that later date

work? If the patient said yes, Turner canceled the whole process and started over. This time, he typed in that the patient had wanted that later date all along. So now, the official wait time was . . . a perfect zero days. It was a lie, of course. But it seemed to be a very important lie, one that the system depended on. “Two to three times a month, you would hear something about it,” Turner said — another reminder from supervisors to “zero out.” “It wasn’t a secret at all.”

But all this was apparently a secret to Secretary Eric K. Shinseki, perched 12 levels above Turner in the VA’s towering bureaucracy. Somewhere underneath Shinseki — among the undersecretaries and deputy undersecretaries and bosses and sub-bosses — the fact that clerks were cheating the system was lost. On Friday, Shinseki resigned and was replaced by his deputy. But his departure is unlikely to solve the VA’s broader problem — a bureaucracy that had been taught, over time, to hide its problems from Washington. Indeed, as President Obama said, one of the agency’s key failings was that bad news did not reach Shinseki’s level at all. This is an ironic development: Until recently, the VA had been seen as a Washington success story. In the 1990s, reformers had cut back on its middle management and started using performance data so managers at the top could keep abreast of problems at the bottom. Then that success began to unravel. As the VA’s caseload increased during two wars, the agency grew thick around the middle again. And then, when the people at the bottom started sending in fiction, the people at the top took it as fact. “Shinseki goes up to Capitol Hill, and says, ‘I didn’t know anything.’ I find it perfectly believable,” said Paul C. Light, a professor at New York University who has studied the bureaucracy of the VA and others in Washington. “And that’s a real problem.” For decades, the VA was a byword for bureaucracy itself, seen as Washington’s ultimate paper-pushing, mind-bending hierarchy. That reputation was rooted in the VA’s history: It came about because the agency’s first leader was an audacious crook. Charles Forbes was chosen to head the Veterans Bureau by his poker buddy, President Warren G. Harding, in 1921. He was a poor choice. Forbes took kickbacks. He sold off federal supplies. He wildly misspent taxpayer money — once buying a 100-year supply of floor wax, enough to polish a floor the size of Indiana, for 25 times the regular price (apparently as a favor to a floor wax company). Eventually, Forbes was caught. The president was unhappy. In 1923, a White House visitor opened the wrong door and found Harding choking Forbes with his bare hands. “You yellow rat! You double-crossing

bastard!” Harding was saying, according to historians. When he noticed the visitor, he let go of Forbes’s neck. Forbes was eventually convicted of bribery and conspiracy. But afterward, the VA’s next leaders built in layers of bureaucracy and paperwork — to be sure that nobody would ever have the same freedom to steal. Seventy years after Forbes was gone, the place was still wrapped in that red tape. That was clear on the day that Kenneth Kizer — a reformer appointed by President Bill Clinton — arrived at the VA’s health service. “I had to approve reimbursement of a secretary . . . purchasing a cable for her computer. I think it was something like \$11 or \$12,” Kizer said. There was a form. He had to sign it personally. “Here I’m running this multibillion dollar organization with — at that time — 200,000 employees. And I’m having to approve reimbursements for somebody.” Kizer set out to change that. He cut back on staffing at VA headquarters in Washington and at regional headquarters. He cut out layers in the chain of command. And he embraced the idea that statistics could allow the agency’s leaders to peer around those middlemen and see the bottom from the top. If patients at a certain hospital were waiting too long for appointments, they wouldn’t have to wait for the news to travel from a scheduling clerk to a supervisor, from the supervisor to a chief, from the chief to the hospital director, from the hospital director to the region, and from the region to Washington. Instead, Washington could just watch the numbers and see for itself.

In theory.

Today, 15 years after he left the VA, Kizer said he’s frustrated to see that one of his solutions — that numbers-based system — become the problem itself. Instead of alerting the bosses to problems in the field, it has been perverted to cover them up. “The measures have become the end,” Kizer said in a phone interview from California, “As opposed to a means to an end.” Today, even after a massive influx of Iraq and Afghanistan veterans that increased the number of VA patients by nearly 2 million, the VA health system still does many things well. The satisfaction rate for patients who have been treated by the VA is over 80 percent. But in many places, veterans were waiting too long to get the care they need. “When you actually get in the room with a doctor, it’s okay. But it’s what it takes to get to that point that I think is the problem,” said Stewart Hickey, national executive director of the veterans service group

AMVETS. “You’re sick today. Three weeks from now, you’re either cured or you’re dead.” One great test of any bureaucracy is whether it can effectively deliver bad news to the top of its chain of command. In recent years, the VA health system started to fail that test. “That’s what, to me, makes this event so shocking,” said Scott W. Gould, who spent four years as Shinseki’s second-in-command. Gould left the VA last year. Gould said that Shinseki tried hard to show he was open to bad news. Three times a year, in fact, Shinseki spent a solid week meeting with regional VA medical directors. That was 63 separate four-hour interviews, every year. But, apparently, his message of openness wasn’t enough: In those hours of meetings, nobody told Shinseki what so many people in his system apparently knew. “I find it shocking that anyone could believe that they were expected to dissemble” about performance measures, Gould said. This is how the system was failing: As the VA’s patient load grew, new layers of middle management slowly reappeared. And all the way at the bottom of the VA’s 12-level chain of command were the schedulers — the ones who actually had to match veterans with doctors. There were too many of the veterans. There were too few of the doctors. So what should they do? One choice was to tell the truth — tell the computer how long veterans were actually waiting for an appointment. That was what Shinseki said he wanted, 12 levels up and miles away in Washington. But, according to people with experience in scheduling, it was often the opposite of what lower-level bureaucrats wanted. In some cases, local officials’ bonuses depended on the numbers looking good. So, at some point years ago, they began asking clerks to change the numbers — with practices like “zeroing it out.” Cheating was made easier by the VA’s ancient computer systems, designed decades ago. For many clerks, the choice between the bureaucrats they knew and the secretary they didn’t was obvious. “They would say, ‘Change the “desired date” to the date of the appointment,’ ” said one employee knowledgeable about scheduling practices at a VA medical center. The employee, who spoke on the condition of anonymity for fear of retaliation, decided to go along with those requests. Fighting the order to lie wasn’t worth it. “You know, in the end, the veteran got the appointment that was available anyway,” the employee said. “It didn’t affect the veteran’s care.” Way back in 2005, federal auditors found evidence that clerks were not entering the numbers correctly. By 2010, the problem seemed to be widespread, the VA health service sent out a memo listing 17 different “work-arounds,” including the one that Turner was

taught in Texas. Stop it, the VA said. They didn't. By 2012, in fact, one VA official told Congress he wasn't sure how to force people to send in the real numbers. "Because of the fact that the gaming is so prevalent, as soon as something is put out, it is torn apart to look to see what the work-around is," said William Schoenhard, who was then the deputy undersecretary for health for operations and management, an upper mid-level official that VA employees call the "Dushom." "There's no feedback loop." That was the key. There was no feedback loop. The system that had been set up to let the top of the VA's bureaucracy watch the bottom was no longer working. It was sending back science fiction, and the VA's top brass seemed either ignorant of the deceptions or powerless to stop them. This week, federal auditors provided stark evidence of the problem that VA's leaders had missed. The auditors had studied 226 veterans who got appointments at the VA medical center in Phoenix. The official data showed they waited an average of 24 days for an appointment. In reality, the average wait was 115 days. Afterward, Shinseki called that finding "reprehensible." But, to the doctor who used to run the VA's Phoenix emergency room, the findings were no surprise. Katherine Mitchell said that the ER was often overburdened by patients with non-urgent problems, who simply couldn't get an appointment with their regular doctors. Mitchell said she's been shifted to another job at the VA after complaining about inadequate staffing and other problems with care in Phoenix. She said Shinseki's long experience in the U.S. Army had not prepared him well for the VA. "In the military, if you say, 'Do something,' it's done," said Mitchell, who has spent 16 years at the VA. "I suspect that he wasn't aware that in VA, it's not like that. If you say, 'Do something,' it's covered up. It's fixed by covering it up." Now, VA's leaders have been faced with a startling failure. The bureaucracy below them wasn't telling them the truth about wait times. The numbers system they set up to go around the bureaucracy wasn't, either. The only answer, now, has been to send people out to VA clinics to talk to schedulers, face to face. Before the auditors went out, they were warned they might hear evidence that clerks had been cheating the system. "If this occurs, remain calm," the VA counseled auditors in a memo. It suggested follow-up questions. "Have you brought this to anyone's attention? If needed, follow up with: What has been the response?"

The true VA scandal is shared across the federal government

By Editorial Board.

AT THE Department of Veterans Affairs, the federal government's largest employer (the Army ranks second), only 56.9 percent of employees believe they can disclose a suspected violation of law or regulation without fear of reprisal. Even fewer — 46.1 percent — feel “a high level of respect” for their senior leaders. Fewer still — 37 percent — are satisfied with the policies and practices of those leaders. Quite an indictment, you may say, one that confirms congressional demands for the summary firing of Eric K. Shinseki, the Cabinet secretary in charge of the VA. But the numbers for the government as a whole are barely more encouraging than for Mr. Shinseki's domain: 58.4 percent, 49 percent and 38.8 percent, respectively. We don't have a Shinseki problem, in other words. We have a President Obama problem. We have a Congress problem. We have a civil service system “in crisis,” as the Partnership for Public Service said in a recent report. The contours of the VA scandal, involving alleged deception about the waiting time for treatment at veterans hospitals, are depressingly familiar. Disclosure is followed by politicians' howls of outrage at perfidious civil servants, demands for firing and “accountability,” more investigations and more firings, until public attention wanes. The howls are particularly screeching this time, because everyone wants to be pro-veteran, and the proposed congressional solution — allowing any VA senior executive to be fired at will, with no due process and no protection for whistleblowers — is particularly appalling. But the trajectory was similar when it involved the Federal Emergency Management Agency and Hurricane Katrina or the Internal Revenue Service and the tea party or the Department of Health and Human Services and HealthCare.gov. Such “scandals” will recur, likely with increasing frequency, as long as government leaders ignore the underlying problem: a personnel system that has not been upgraded to suit the 21st-century knowledge economy. “Name an organization that is succeeding largely under the same system it had in 1949,” says Max Stier, president and CEO of the nonprofit Partnership for Public Service. “It doesn't exist.” It is a cumbersome system that can't recruit or compete for talent and doesn't reward top performers or punish poor ones. Some of the resistance to change is political: Democrats rely on government unions that are suspicious of merit-based policies, and Republicans are suspicious of government altogether. But Mr. Stier says the bigger obstacle to reform is structural. Political leaders want to influence policies that will bear fruit while they are in office. Civil service reform is hard work, requires sustained attention and would pay off mostly in future presidential terms. Beyond his anger at times of crisis, does Mr. Obama care? “I don't see it,” Mr. Stier said. “The administration as a whole has not led on these issues.” Congress's contribution, meanwhile, is a “combination of neglect and destruction.” Taking the VA back to the days predating the Pendleton Act of 1883 — yes, 1883 — is only the latest example. Some agencies do a better job, proving that even with all the political obstacles leadership makes a difference: NASA, the U.S. Patent and Trademark Office, the Bureau of Engraving and Printing. But these are islands. Less than 6 percent of the federal workforce is younger than 30, compared with 23 percent in the country. As the public workforce ages and retires, dysfunction will increase, unless someone gets serious about attracting and retaining talent.

VA expects to have more medical-care funding than it can spend for the fifth year in a row

This reveals exactly what I've been saying all along - the VA is an overly funded bloated bureaucratic behemoth sacred cow with an insatiable appetite gobbling up all available resources that are squandered instead of being put to use for veterans. There needs to be a fundamental change in this failing organization that has repeatedly failed in its core mission to provide quality timely efficient health care to vets.

1. Fire all top VA admin officials STAT!
2. Fire all executive VA officials at all of the under performing medical centers STAT!
3. Fire all executive VA officials at all medical centers involved in scandals STAT!
4. Force VA to pay back all monies that have not been spent directly on veteran care, benefits, etc. including but not limited to monies spent on under deserved bonuses, office furniture, interior decorating/design, surpluses, etc.
5. Remove as many bureaucratic layers as possible making the VA as flat a leadership system as possible.
6. The ratio of providers and clinical staff must be boosted whilst reducing the bloated bureaucracy of paper weight positions (the size of the VA workforce dwarfs the US Marine Corps).
7. All new hires hence forth must be veterans.
8. A requirement for all VA executive positions and senior officials MUST be veterans.
9. All VA medical centers must be aligned with an affiliate/associate active duty counter part medical center similar to the way the Army realigned all of their medical centers with their Corps to synchronize the medical mission with the war fighting capabilities.
10. The above would reduce redundancy.
11. Every veteran that is eligible for health care at the VA must receive a voucher card that gives that veteran the option of either receiving health care at the worst place possible i.e. the VA or selecting the best health care in the private sector that their VA entitlements allow. This would foster competition in the free market deciding the winners and the losers for these monies which the VA has a monopoly on.

12. The above would assist in eliminating by veteran choice the worst performing VA hospitals.

13. A 20 year moratorium must be enacted effective immediately on the service connected disability audits. This would greatly reduce the disability claims backlogs by repurposing and redirecting those resources to deal with the backlog in claims. Can you believe that despite this massive backlog the VA actually has an entire system devoted to screwing crippled veterans out of their entitlements by conducting random audits of these vets. Crippled vets periodically are re-evaluated to determine if their service connected conditions warrant a decrease in disability rating thus either reducing or eliminating their benefits; sometimes retroactively. And the courts have ruled that vets don't have due process rights - the VA can just do this at their whim. If a service connected veteran is satisfied with their rating then just leave them alone!

14. Bring in the DOJ and FBI to investigate these criminals.

15. Create an independent VA Czar or Ombudsman with an independent investigative body eliminating the VA IG which is nothing more than a clearing house for white washing scandals.

16. Fire all abusive maniacal officials and supervisors that are detrimental to the VA's core mission STAT!

17. Actually this should be #1 - force all federal politicians and their dependents to receive their health care from the VA - betcha things would change quickly!

VA expects to have more medical-care funding than it can spend for the fifth year in a row

By Patrick Howley

Published May 28, 2014

The Obama administration's Department of Veterans Affairs (VA) expects to have more money for medical care than it can spend for the fifth fiscal year in a row, The Daily Caller has learned. Republican lawmakers and veteran groups are currently calling for the resignation of VA Secretary Eric Shinseki over secret waiting lists kept at the Phoenix VA Medical Center that led to preventable veteran deaths. Despite liberal claims that VA needs more funding, based on a report from the labor union the American Federation of Government Employees (AFGE) that VA is underfunded, the scandal-plagued department actually has a surplus in medical-care funding. VA expects to carry over \$450 million in medical-care funding from fiscal year 2014 to fiscal year 2015. VA received its full requested medical care appropriation of \$54.6 billion this fiscal year, which is more than \$10 billion more than it received four years ago. This is part of an ongoing trend. VA carried over \$1.449 billion in medical-care funding from fiscal year 2010 to 2011, \$1.163 billion from fiscal year 2011 to fiscal year 2012, \$637 million from fiscal year 2012 to 2013, and \$543 million from fiscal year 2013 to 2014. The Daily Caller reported that VA

spent more than \$3.5 million on furniture the night before the government shutdown on the last day of fiscal year 2013 so as not to lose that money in the department's budget the next fiscal year.

Exclusive: Texas VA Run Like a 'Crime Syndicate,' Whistleblower Says - The Daily Beast

For years, employees at a Texas VA complained that their bosses were cooking the books. For years, the VA insisted there was no widespread wrongdoing.

Editor's Note: This story has been updated with new information.

Last week, President Obama pledged to address allegations of corruption and dangerous inefficiencies in the veterans' health-care system. But before the president could deliver on his pledge, the scandal has spread even further. New whistleblower testimony and internal documents implicate an award-winning VA hospital in Texas in widespread wrongdoing—and what appears to be systemic fraud.

Emails and VA memos obtained exclusively by The Daily Beast provide what is among the most comprehensive accounts yet of how high-level VA hospital employees conspired to game the system. It shows not only how they manipulated hospital wait lists but why—to cover up the weeks and months veterans spent waiting for needed medical care. If those lag times had been revealed, it would have threatened the executives' bonus pay.

What's worse, the documents show the wrongdoing going unpunished for years, even after it was repeatedly reported to local and national VA authorities. That indicates a new troubling angle to the VA scandal: that the much touted investigations may be incapable of finding violations that are hiding in plain sight.

“For lack of a better term, you’ve got an organized crime syndicate,” a whistleblower who works in the Texas VA told The Daily Beast. “People up on top are suddenly afraid they may actually be prosecuted and they’re pressuring the little guys down below to cover it all up.”

“I see it in the executives’ eyes,” the whistleblower added. “They are worried.”

The current VA scandal broke in Phoenix last month, when a former doctor at a VA hospital there became the first whistleblower to gain national attention. The doctor's allegations of falsified appointments—and veterans dying while they waited for treatment—unleashed a wave of similar claims from VA employees nationwide. In Cheyenne, Wyoming, Chicago, and Albuquerque, more VA whistleblowers came forward claiming that the same fraudulent scheduling was being used in the hospitals where they worked. At last count, the VA inspector general's investigation had expanded to 26 separate facilities.

The torrent of claims led to Senate hearings, calls for VA Secretary Eric Shinseki to resign, multiple investigations and President Obama's own public statement last week. Paul Rieckhoff, founder and chief executive officer of Iraq and Afghanistan Veterans of America (IAVA), believes that even more revelations are coming.

"This newest case just further illustrates that the scandal is much more far reaching than most people realize," Rieckhoff said, "Phoenix was just the tip of the iceberg. Scandal has become the new normal, it's the status quo at the VA right now."

But, despite the political uproar and the growing investigations, the root causes of the VA crisis have remained murky. New documents and whistleblower testimony obtained by The Daily Beast shed light on exactly how fraud is being perpetrated in the VA and its underlying causes.

There's enormous pressure to report favorable wait times for VA patients, the Texas whistleblower explained, even if those wait times are completely false.

"If [VA] directors report low numbers, they're the outlier. They won't stay a director very long and they certainly won't get promoted. No one is getting rewarded for honesty. They pretty much have to lie, if they don't they won't go anywhere," the whistleblower added. Weighted more heavily than other performance measures, the wait time numbers alone "count for 50% of the executive career field bonus, which is a pretty powerful motivator."

Though VA hospitals may be struggling with increasing patient loads and inadequate resources—including too few medical providers—they are punished for acknowledging those problems. The VA's current system appears to reward executives' accounting tricks that mask deep structural issues and impede real solutions.

The whistleblower—who will alternately be called "the clinician," referring to the job they have held with the Texas VA for almost a decade—asked to remain anonymous due to fear of losing their job or being otherwise punished for speaking out.

ANATOMY OF A FRAUD

The clinician has been alerting authorities to the wrongdoing at their facility for years but the corruption has persisted despite multiple reports and investigations by the VA's inspector general.

The case of Dr. Joseph Spann, a recently retired doctor who reported malfeasance in the Texas VA system, where he worked for 17 years, raises the possibility that official investigations may only be hiding the problems they were charged to root out.

After retiring in January of this year Spann sent a letter to VA investigators accusing a VA employee of manipulating patient wait lists to hide treatment delays for veterans. The rigged reporting scheme Spann described in his letter, which threatens veterans' lives by delaying their treatment, is the same method that has been exposed in Phoenix, Cheyenne, Albuquerque, and scores of other VA hospitals across the country.

According to Spann, Dr. Gordon Vincent, chief of radiology at Olin E. Teague Veterans Medical Center in Temple, Texas, didn't just break VA policy by manipulating veterans' appointments himself. He ordered VA employees across central Texas to engage in the same fraudulent practice.

The VA said it investigated Spann's charges, and, after, finding nothing to substantiate the claims, cleared Vincent and the Texas VA.

But documents obtained by The Daily Beast appear to show Dr. Vincent doing precisely what Spann accused him of—the activities the VA said it could not substantiate.

In the above document, taken from the VA's internal record system, you can see Dr. Vincent cancel an ultrasound appointment for a veteran suffering from cirrhosis. Vincent tells the doctor who submitted the original order to change the desired date—the day the provider selected for the procedure based on their diagnosis and clinical judgement—citing the facility's patient backlog.

Veterans are supposed to be seen within 14 days of their desired date, according to VA policy.

By changing the desired date, Dr. Vincent, a VA section chief, was violating well-established scheduling rules detailed in an official VA memo from April 2010 and re-emphasized in a separate policy directive from June of that year. But forging veterans' desired dates seems to have been widely considered a low-risk, high-reward form of cheating. Changing the dates made it seem as if patients were being seen within the prescribed 14-day window, which reflected well on the hospital and put its staff in line for bonuses.

For the veterans seeking care, however, it had no such benefits.

In his letter to the VA's Inspector General's Office, Spann wrote, "I cannot categorically say that I ever saw a patient die from such manipulated scheduling, but I did see several cancer patients have their possible surgery or chemotherapy treatments delayed awaiting the required radiology tests."

The VA whistleblower, who provided The Daily Beast with the records implicating Dr. Vincent, works as a medical provider for sick veterans. "It's plain and simple common sense," the

clinician said. "Every delay in a patient's diagnosis is an injury. The more severe the veteran's condition, the worse the injury caused by the wait as the disease is allowed to progress."

Now that the VA has exonerated Dr. Vincent, there may be no one left to evaluate the injury caused by the appointments he canceled.

NOTES ON A SCANDAL

The document described above is only one piece of evidence in a larger docket against Vincent, which is itself part of a larger record of corruption in the VA that extends far beyond Vincent or any one individual. In 2011, the VA's inspector general investigated the Central Texas health-care system in response to complaints it had received. The inspector general found that manipulated appointments were widespread and hid significant delays, but the report doesn't seem to have led to a single VA official being disciplined or officially held responsible for gaming the system.

This internal VA email chain from 2011, provided exclusively to The Daily Beast, clearly instructs medical providers to falsify their schedules in the same manner that was exposed in Phoenix three years later. Though a VA executive warns that the original message is encouraging fraud, by the email's conclusion two other doctors have written suggesting that it's a common occurrence. The email was originally sent to every medical provider in the Central Texas VA health-care network.

The first message in the chain comes from a scheduling coordinator, James Anderson, who tells doctors across the state to use January 2 as the desired date for veterans. The Central Texas VA Chief of Staff, William Harper, then reproaches Anderson, saying, "You cannot do this!!!! This is essentially fraud. The desired date is what it is and if we don't meet the standard then we will work to improve."

"For lack of a better term, you've got an organized crime syndicate. People up on top are suddenly afraid they may actually be prosecuted and they're pressuring the little guys down below to cover it all up."

(The Central Texas VA referred all questions to the national Department of Veterans' Affairs office in Washington, D.C. Representatives at the national VA declined to comment on the record for this story.)

After the warning from Harper and questions about scheduling from several other doctors, including Spann, the final comment in the thread concerns Dr. Vincent. The message reads: "It

doesn't help if you insist on a date that doesn't meet their 30-day criteria. Vincent just cancels the order. End of story. ”

In other words: it never mattered what was entered to show the “desired date” requested by the patient or the medical provider treating them. Despite Harper’s protestations, if the entry didn’t help meet the VA’s performance objectives it never made it into the system.

Nevertheless, the VA recently cleared Vincent of wrongdoing and, while acknowledging scheduling malpractice, blamed it on mistakes made by lower-level clerks.

“I saw the press release saying it wasn’t Vincent or any of the executives, that the schedulers were entering the desired dates incorrectly but they were not directed to do so by management. That’s just not true and we’ve got mountains of evidence proving it,” the clinician told The Daily Beast.

PERFORMANCE INCENTIVES

On the ultrasound request form, Dr. Vincent writes that he canceled the order because it was “entered in error.” But that would have come as news to the medical provider who actually interacted with the veteran and entered the date based on their evaluation of the patient’s needs. The real reason for canceling it, according to both Dr. Spann and the whistleblower who spoke with The Daily Beast, was to meet the VA’s performance objectives—whatever the cost.

Meeting the performance objectives, which made executives eligible for bonuses and put them in line for promotions, became the overriding imperative among VA executives, according to both Spann and the whistleblower.

The VA’s 2012 performance plan, provided to The Daily Beast by the whistleblower, contains five critical elements to evaluate success, each one containing multiple sub-criteria. But critical element No. 5, the “Results Driven” component that contains the “wait time” criteria, is worth 50% of the overall score. That’s as much as all the other elements combined.

And scoring high on the performance measures is of paramount consideration in a VA hospital. “This is what your bosses, the executives, are being evaluated for,” the whistleblower said. “So if you work for them you must support this because that’s how they’re prioritizing their evaluation of your job.”

The VA’s performance measures were originally established to provide uniform criteria for evaluating employees. The idea was to use the grading system to reward those who met the standard with bonuses and identify those who were lagging behind. But over time, VA executives realized that the wait time numbers they reported were almost more important than

anything else—including the actual care they provided veterans—in how they were judged by the VA’s leadership. At that point the measures became a perverse incentive, encouraging VA facilities across the country to hide problems by cheating their numbers. Eventually, cooking the books became an alarmingly regular procedure—a standard that might have remained if it hadn’t been exposed in Phoenix and unraveled over the past month.

COVER-UP?

The problems in the Central Texas VA system outlined here may be new to most readers, but they have been on the record for years. They are certainly no surprise to the VA’s Office of Inspector General (OIG), which has received multiple complaints about the facility and investigated it in 2011.

The inspector general’s report from January 2012 stated that, according to the hospital’s own staff, “appointments were routinely made incorrectly by using the next available appointment date instead of the patient’s desired date.” The improper scheduling “led to inaccurate reporting of GI [gastro-intestinal] clinic wait times,” the report concluded. But the IG stopped there, blaming the practice on lower-level scheduler error—and ignoring evidence that shows the fraudulent scheduling practices were pervasive and consciously directed by higher-level executives.

“Every doctor, nurse, and clerk in the hospital knows it’s true, but the VA’s investigative team wasn’t able to find any evidence,” the clinician said. “They didn’t interview any of us or really try to find out what was going on. This was reported in 2011 and it’s still not fixed today.”

The Central Texas management parroted the inspector general’s findings when the hospital applied for a “Robert W. Carey Performance Excellence Award.” According to the clinician, in the hospital’s award application they actually listed as an accomplishment that they had found “front line staff” incorrectly using desired dates in the scheduling process and fixed the problem. It must have been convincing. Despite the OIG investigation, the hospital won the award.

Reports of scheduling fraud and wait time cover-ups kept coming after the 2012 inspector general report. Utilizing an internal message board for VA workers called “Speak to the Director,” at least two additional complaints were sent about scheduling. On August 6, 2012, only months after the IG investigation, an employee wrote, “We have been instructed by management to manipulate veterans into accepting appointments beyond the 14 days.”

Another letter, from March 2014—a month before Phoenix broke the VA scandal nationally—asks, “is the OIG aware of the fudging of numbers on the desired dates?” The employee then wonders if “this fraud is as well known by OIG as it is here in the clinic.”

What does it say that a VA hospital with this many complaints has not only avoided an accounting—but actually received awards?

“If one person comes up with a way to cheat on a report to the government and profit from that lie, that’s defrauding the government,” the whistleblower said. “If [hundreds] of people are defrauding the government, it’s a conspiracy, and that’s what you’ve got now and it runs coast to coast and bottom to top.”

Fixing the VA’s problems may require serious changes to the approach used so far.

According to IAVA’s Paul Rieckhoff, the allegations about the Texas VA “underscores how deep and broad the VA’s problems are and why we need serious independent investigations.” The current investigations are not enough, Rieckhoff said. Having a White House political operative looking into this is not an adequate solution. This is not something that one of the president’s lieutenants should be handling.”

“There’s definitely reason to think there may have been criminal activity,” Rieckhoff said. “Maybe it’s time for Attorney General Holder and the Department of Justice to get involved, or for someone else trained to investigate criminal cases to take the lead on this.”

If you are a VA employee and have firsthand information about waiting lists, or other problems with patient care at the VA, we want to hear about it and can keep the details of your account confidential. Email your story to submissions@thedailybeast.com.

Medscape Article : The VA Way : Inefficiency at its Best

According to a 2010 Congressional Budget Office document, the Veterans Administration provides over \$48 billion in healthcare "at little or no charge for more than five million veterans annually." Services include "routine health assessment, readjustment counseling, surgery, hospitalization, and nursing-home care." Another less recognized but very valuable service to our country includes the provision of a fertile training ground for physicians, including the cardiologists of tomorrow.

I owe a lot to the Veterans Administration healthcare system. It was there in the early 1990s that I touched my first patient. Wearing a short white coat, I fumbled with the ophthalmoscope, more of an adornment than tool, and when I spied that ever-elusive optic disc for the first time, I felt a deep sense of satisfaction. This brief respite from the classroom was a joyful validation of my journey to becoming a physician, and the VA hospital for nine years would have a front-row seat to my metamorphosis.

To a young physician who was in love with the idea of the practice of medicine since kindergarten, it was a veritable Disney World of medical procedures, odd diagnoses, and clinical

scenarios. Toward the end of my residency and then into my fellowship, my time there evolved into an intense love-hate relationship. I loved the autonomy, the opportunity to learn procedures, and the great responsibilities given to young trainees. I literally skipped out of the cath lab after my first day, having been handed the manifold for the first time and "allowed" to inject my first coronary artery. But as much as I loved my training experiences there, I loathed even more the red tape and the "because-I-said-so" rules that made no sense from the standpoint of service, such as the limited number of cathes we could book on a daily basis.

Our cath-lab director was both a superb human being and a dedicated employee. The nurses and techs guarded the safety of our veterans with an iron fist, but there were long waits to get into our lab and even longer waits for interventional services that at the outset of my career had to be obtained out of state. Many veterans who needed a service had to fight hard to avoid falling through the widening cracks of that untouchable behemoth of a healthcare system. When I heard of the recent investigations into the Veterans Administration of healthcare, I breathed a sigh of relief. Scrutiny is so painfully long overdue.

My first serious disappointment involved the inability to get a patient with severe coronary artery disease to another facility in another state for more definitive care. I was an intern on the cardiology service. His family would call us weekly through an overhead page to ask whether we were making any headway. In turn, I made weekly phone calls to every entity I could think of to try to get that patient his procedure. My resident told me one day very matter-of-factly "not to bother," because he had died. I've never forgotten the sting of unnecessary death at the hands of inefficiency. Even as I write this note, my mind flashes back to a sea of white tile floors, shiny metal cabinets, glass fronts, the smell of alcohol, a stairwell, and the sound of a heavy steel door slamming against the silence of defeat. That sickening realization echoed in my subconscious night after night. I had failed to navigate the system for a patient in need, but in an odd way, this terrible defeat benefited others, as it bred a lifelong determination to never fail in that way again.

As our facility grew busier, patient-to-nurse staffing ratios grew, and routine care became more difficult. We had some very excellent and dedicated nurses who taught me much of what I know today, but many times they were simply overwhelmed. Even basic care was a challenge some days, and with a glaring lack of staffing, bed changes, routine water-pitcher maintenance, and the delivery of medication on time were difficult, to say the least.

As a resident, I interrupted my rounds one day and confronted the charge nurse about the shortcomings of the night shift who had left patients without urgent bed changes, without pain

relief, without even hydration. Pale and irritable from a long 12-hour shift, she tossed her clipboard down with a clang on the chair in front of me and said, "Here! You do it! Let's see you take care of 40 patients with one nursing assistant," and then walked off.

I wrote up a list of all the issues I had encountered at the request of a concerned respiratory therapist (also a veteran) who was fed up with the inefficiencies as well. Somehow, the list found its way to the desk of a local congressman. The crap hit the fan, and I was reprimanded gently by my superior, who asked a lot of questions. When I explained all the challenges of the past two months, he then smiled, having fulfilled his requirement for a necessary interrogation, and said, "Go back to work—and by the way, it helps that you are pregnant," my white coat no longer able to contain my enormous belly. My being pregnant should have had nothing to do with the outcome, but at that point, I'd take any perk I could get and drove back to the salt mines.

Proving that familiarity breeds contempt, our frustrations increased every year that passed at the VA. On numerous occasions, we contacted "Dr X," who had ascended the ranks of our VA system to achieve a cushy directorship position. He offered no help and denied there were any problems. He was a contentious hardheaded obstructionist who regularly announced his belief that coronary bypass surgery was a costly sham procedure and no veteran should be sent for it except perhaps those with left main disease, and then they were sent begrudgingly. The tension in our relationship peaked when he threatened to call security because I had transferred a patient with unstable angina to a downtown hospital for surgery. He caught me taking the patient's carotid ultrasound results to the surgeon who had requested them. Stupidly defiant, I replied, "There is the phone, doctor," pointing to the lobby desk. "I suggest you pick it up and make your call, because I'm going and I'm taking these images with me."

Though I put on a brave front, my eyes were glued to my rearview mirror as I floored my little white Honda Accord downtown, fully expecting to see blue lights. With every page for the next few days, I expected to be called back to my residency program office, but nothing ever happened. The patient got his surgery and recovered uneventfully, and I got a deep sense of satisfaction for outfoxing the ever-watchful Dr X.

After I entered private practice, I continued to occasionally wrangle with the VA system. There were stupid rules that some hospitals couldn't accept a patient "after 5 PM on a Friday." Others accepted "no transfers on the weekend," and worst of all, a patient died because there were no beds available at a VA facility. Even though the surgery program with which the VA dealt accepted this patient as a bypass candidate, I could not get the VA hospital officials to confirm

they would cover the bill. The bone of contention was that if I sent him directly from my community hospital to the bypass-surgery hospital they would *not* guarantee anything. They would cover the procedure only if I transferred him to their hospital and then to the bypass-capable facility, but their hospital had no beds. After numerous phone calls on behalf of his family and myself, the best the VA would do was to say, "Well, it will probably be covered, but there is no mechanism to address this, so just let him undergo the surgery and we will address it then." After a week of wrangling, he was so disgusted that he left our facility AMA and died soon afterward, ignoring my advice just to drive to their ER. He said he'd rather die than take the chance of sticking his family with a \$70K bill, so that's exactly what he did.

I could share enough training war stories to fill a book, but the real issue here is that men and women who have actual war stories to tell sometimes don't get the best medical care. Although one could argue that these issues could happen anywhere, it is shocking when they happen at a facility dedicated for the sole purpose of caring for its own.

The solution? I have long been an advocate for abolishing most of the VA healthcare system in favor of having veteran care funded at private facilities. I believe the larger specialty hospitals should remain open, specifically those that deal with all aspects of combat-related injuries, burns, rehab, and posttraumatic stress.

It is said that the fabric of a society can be judged by how well it treats the sick and the frail. We should also judge our integrity as a nation by how well we care for those who have been willing to sacrifice their lives and their health for their country. It is honor we owe to those who died in combat, but it is loyalty we owe to those who survived.

At this point in American medicine, where technology has surpassed caring and monetary conquests have trumped nurturing, even in the private sector, we can only hope the best and the brightest can come up with a solution we can admire. Maybe with the weaknesses in the VA system exposed and vulnerable, the greatest strategists in the world can flank the enemy of inefficiency and overcome the necessary obstacles to make the VA system the greatest system on earth.

Happy Memorial Day to all American veterans and their families. We owe you more than any of us could ever repay, but shoring up the failings of your healthcare system would be a great start.

A doctor tells the truth about the VA health care system

By Dr. Marc Siegel

Published May 27, 2014

FoxNews.com

The news that more than half our states have VA facilities with secret waiting lists that threaten the lives of our veterans is shocking.

But the more pervasive, less sensational, problem with VA hospitals is one I have experienced as a physician: They are fallback places, providing second tier medical care, with each facility serving meat and potatoes medicine to its community of needy veterans.

Many veterans know this and choose to get their health care elsewhere when they can, via Medicare or private insurance if they have it. For these veterans, the VA is a place to go for free prescriptions, lab tests and medical care only when they can't get in to see their regular doctors.

*Veterans as a group need more care, not less, because of the stress and risk involved in
defending and protecting our country.*

Veterans as a group need more care, not less, because of the stress and risk involved in defending and protecting our country. Injuries in combat and post-traumatic stress are accompanied by bad habits, including smoking. According to the Centers for Disease Control, 74 percent of veterans report a history of smoking. Almost 45 percent of military deployed to Iraq and Afghanistan smoke. That's double the rate of civilians.

Of course, smoking greatly increases the risk not only of heart disease and cancer, but also vascular disease. Wounds don't heal as well when you smoke.

I have worked in several VA hospitals – including Buffalo, N.Y., Manhattan, N.Y., Northport, N.Y., and Seattle – and I have discovered that the more closely affiliated with a university, the better in terms of quality of care – because doctors are shared and work in both places.

There is also great research going on in many of these VA centers. I conducted clinical research several years ago at the VA facility in Northport and found that the veterans I worked with were eager to be in the trials because of the extra attention they received.

According to the American Board of Physician Specialties, there are 1,400 unfilled doctor positions in the nation's VA health system. This contributes to the overall problem of inadequate quality of care. There are clearly some great doctors working at VA hospitals, but there also clearly need to be major improvements across the board.

What is the solution? Clearly, an administration that has already spent hundreds of billions of dollars on ObamaCare without improving access or quality or saving money isn't about to throw billions more at a dysfunctional system that won't look better with a coat of whitewash.

But I am not one who believes that a complete (exorbitantly expensive) remake is the best solution in any case. For one thing, private solutions for our veterans show more flexibility and personal commitment. The VA has been and always will be a big bureaucracy that may be insensitive to the needs of individual vets. It has been particularly ineffective, to give one prominent recent example, in addressing the impact of sexual assault on victims.

I think the best short-term solution would be to allow recent veterans continued access to our military hospitals that serve active duty soldiers for at least a year after being discharged from active duty, because the wounds of war don't go away instantly upon return to safe borders.

For a longer-term solution, the Feds should offer Medicaid or Medicare to all our veterans, to provide an alternative to the VA hospital for those who have no other insurance options.

It's the least we can do for those who fight for our freedom.

Dr. Marc Siegel, a practicing internist, joined FOX News Channel (FNC) as a contributor in 2008.

VA rotten to core: We owe it to our veterans to seek fundamental reform
By Rep. Bill Johnson

Published May 23, 2014
FoxNews.com

With Memorial Day upon us, more and more horror stories are emerging from the administration of the U.S. Department of Veterans Affairs. It's an administration that appears to be rotten to the core. A massive Washington, D.C.-based federal bureaucracy with an enormous budget and more than 340,000 employees charged with helping America's heroes when they take off their uniforms for the last time has failed its mission.

In Phoenix, Dr. Samuel Foote, a former VA doctor turned whistleblower says there are some 13,000 veterans without a primary care doctor. These veterans often wait months for an appointment – Dr. Foote revealed that some 40 veterans died while waiting for appointments in the Phoenix VA clinic.

In Florida, an internal criminal investigator said drugs would go missing from the VA pharmacy. He added, "I was instructed that I was to stop conducting investigations pertaining to controlled substance discrepancies."

Our troops protect our freedoms at the edges of civilization, and our veterans quietly suffer indignities at the hands of a federal agency that has grown too large, too cold, and unaccountable. This must change.

In Fort Collins, Colorado, a whistleblower there says that she was ordered to falsify records to indicate that veterans were receiving prompt treatment. More disturbing stories of fake waiting lists seem to emerge daily.

This scandal is bigger than the current VA Secretary Eric Shinseki. And, while the Obama administration failed to do anything -- despite the president's transition team being advised in 2008 of major problems at the VA -- the rot even goes beyond President Obama.

The Congressional committees charged with overseeing the VA receive small budgets, junior membership, and very little media attention. For too long those that served and defended have been afterthoughts in Washington -- ironic given that some of America's bravest lay under the grass and dirt of Arlington National Cemetery, less than two miles away.

President Obama's Chief of Staff Denis McDonough said in a recent interview with CBS' "Face the Nation" that President Obama was quote, "madder than hell" over the delays at VA hospitals throughout the country.

Good. He should be. We all should be. This should not be a partisan issue. This is an American problem that we need to fix.

As a veteran of over 26 years, I've become increasingly concerned with the deepening divide between our military and civilian populations. The following characterization and quote comes from a Washington Post interview that former Chairman of the Joint Chiefs, Admiral Mike Mullen gave upon his retirement in 2011.

What troubles Mullen is that this magnificent professional force (America's military) has become a separate tribe in America, too little connected to the rest of the country: "They don't know the depth and the breadth of what we have been through, the numbers of deployments, the stress on the force, the suicide issues, the extraordinary performance."

The men and women who've chosen to serve America are preserving our freedoms in near anonymity, often in dangerous shadows on the other side of the world.

It's not until movies like "Lone Survivor" are made do the American people get a glimpse of the heroism and sacrifice of our troops -- volunteer troops. But in today's culture, we have a tendency to move on to the next thing on our iPads, Washington moves on to its next partisan fight, the media moves on to a more sensational story, all while our troops protect our freedoms at the edges of civilization, and our veterans quietly suffer indignities at the hands of a federal agency that has grown too large, too cold, and unaccountable.

This must change.

This Memorial Day we should pledge to fix this. We owe it to our fallen, we owe it to those who made it back home, and we owe it to those future heroes who will serve that America will keep our promises to our veterans. From Lexington and Concord to Gettysburg; from Normandy to Korea, and from Vietnam to Iraq and Afghanistan. We owe it to them.

Americans in 2014 enjoy the highest quality of life that mankind has ever seen. It's been achieved through the hard work and innovation of the American people, and preserved by those relatively few Americans who have been willing to lay down their lives in service to their nation - our nation.

It's time to show our veterans how thankful we are for their service. It's time to fundamentally reform the VA.

Republican Bill Johnson represents Ohio's 6th District in the U.S. House of Representatives. He is a 26-year veteran of the United States Air Force and former Chairman of the House Veteran Affairs Oversight & Investigations Subcommittee.

Thank You for Being Expendable

A half billion dollars (that's right BILLION) spent in calendar year 2013 on lavish cherry wood office furniture suites for va management, interior decorators, interior design, fancy paint jobs, bells, whistles, gadgets, plaques, "memorials", etc. is NOT what veterans need. Quality, timely, sincere, respectful and compassionate care is what veterans need. The VA has repeatedly violated the social contract with America which is that the military takes care of America defending her freedom, lifestyle, honor and integrity and in turn America is tasked with the honorable responsibility of taking care of its veterans. Sadly the VA has failed dismally at their end of the bargain despite being the most over funded bloated bureaucratic behemoth with the average total bonus monies paid out to each facility is nearly 1 million dollars annually.

OP-ED CONTRIBUTOR

Thank You for Being Expendable

BY COLBY BUZZELL

The scandal over the care of veterans is really an old story. YEARS after I first returned from Iraq and started having thoughts and visions of killing myself, I'd call the Department of Veterans Affairs. They always put me on hold. First, an automated message would greet me to let me know there was an unusually long wait because of the large number of incoming calls. Then a recorded message played on a constant loop: "Welcome to the Department of Veterans Affairs ... The V.A. is here to serve you ... If this is a mental health emergency or you are thinking about committing suicide, please hang up and call 911 ... If you are having thoughts of hurting others or want to talk to a mental health professional hang up and dial the Veterans Crisis Line ... " I wasn't about to pull the trigger just then, I just wanted help, so I held on. The wait was long — sometimes 45 minutes to an hour — at which point someone would pick up and either put me on hold again or transfer me over to someone else to schedule an appointment to seek treatment for post-traumatic stress disorder. In my experience, the wait for an appointment was typically eight to 10 weeks, but sometimes as long as three to four months. Keep this in mind: If I'm calling the V.A., it's because I'm in really bad shape. But when I'd tell them I really needed to see somebody ASAP, sooner than that, they'd always tell me the same exact thing: "Sorry. But that's the earliest we can see you." I've since learned that when things are really bad, it's better to just show up at the V.A. emergency room. Before, I thought it was a miracle that I survived the Iraq war. Now I'm thinking it's a miracle I'm still alive after dealing with the V.A. for so long. The V.A. motto was taken from Abraham Lincoln's second presidential Inaugural Address, and can be seen etched on a huge metal plaque outside the Washington headquarters: "To care for him who shall have borne the battle and for his widow, and his orphan." Since my father is a retired lieutenant colonel — a highly decorated Vietnam veteran — I've been walking by this quote for as long as I can remember. I recall one day when I was about 7 years old and got sick, my father drove me to the V.A. hospital near Oakland, Calif. When the doctor asked me how much pain I was in on a scale of one to 10, I honestly told him it was about a six or a seven. In the waiting room lobby my father scolded me. He said that no matter what, I should always tell the doctor that my pain was at least a 10, even a 12, otherwise we'd be waiting around in the lobby all day to be seen. Which was exactly what happened. Same as it ever was. I enrolled in the V.A. health care system in 2004, soon after a year of service in Iraq. I've been to countless V.A. hospitals since, and they're all the same. If you want to know what the price of freedom looks like, go to a V.A. waiting room — wheelchairs, missing limbs, walking wounded, you get all of the above. One day not long ago, while waiting for my PTSD medication, I struck up a conversation with a Vietnam veteran, who told me the message he'd gotten from his treatment at the V.A., and his country, was not "Thank you for serving," but "Thank you for being expendable." I agreed with him. Soldiers are expendable in war, and veterans are expendable and forgotten about when they return. That's just the way it is. This recent V.A. "scandal" over prolonged wait time for veteran care doesn't surprise me one bit. Politicians and many hawkish Americans are quick to send our sons and daughters to go off to fight in wars on foreign soil, but reluctant to pay the cost. Once, nearly homeless and plagued with thoughts of jumping off the Golden Gate Bridge, I showed up at a V.A. hospital and told them I was in bad shape and needed

some help. I was holding a coffee cup. The doctor asked me how much coffee I drank in an average day. I told her; she then advised me to cut down to one cup a day. When I asked if she could possibly prescribe any medication to go with that one cup a day, she refused. "We used to prescribe drugs all the time," she explained. "OxyContin, Percocet, Dolophine, Methadose, Vicodin, Xodol, hydrocodone." But veterans were getting addicted, she said, even dying, from overprescription so doctors had been told to cut back on prescribing. Go down to one cup of coffee day, she told me again, and see how you feel. I think this recent scandal may be the best thing ever to happen to our veterans and hope some change will take place because of it. God knows it'd be nice for veterans to just call or walk into a V.A. hospital and see somebody and be taken care of the same day. I don't think that'd be asking a lot. There might be a lot more of us alive today if that was the case. Sadly, it's not. Even on Memorial Day, the wait at the V.A. goes on. Same as it ever was.

Colby Buzzell is the author of "Lost in America: A Dead-End Journey."

A version of this op-ed appears in print on May 26, 2014, on page A19 of the New York edition with the headline: Thank You for Being Expendable.

Treat Veterans With Respect, Not Pity

By

PHIL KLAY

Updated May 23, 2014 12:34 p.m. ET

A couple of years ago, I spoke at a storytelling competition about some Marines I'd known during our deployment in Iraq and my feelings on getting out of the Corps. After I left the stage, an older woman in the crowd came up to me and, without asking, started rubbing my back. Startled, I looked over at her. "It was very brave of you to tell that story," she said.

"Oh, thank you," I said, a little confused by what was happening. "I'm OK."

She smiled sympathetically but didn't stop. I wasn't sure what to do, so I turned to watch the next performer—and she remained behind me, rubbing me down as if I was a startled horse in a thunderstorm.

It was my first really jarring experience with an increasingly common reaction to my war stories: pity. I never thought anyone would pity me because of my time in the Marine Corps. I'd grown up in the era of the Persian Gulf War, when the U.S. military shook off its post-Vietnam malaise with a startlingly decisive victory and Americans eagerly consumed stories about the Greatest Generation and the Good War through books like "Citizen Soldiers" by Stephen Ambrose and movies like "Saving Private Ryan." Joining the military was an admirable decision that earned you respect.

Early on in the Iraq war, after I accepted my commission in 2005, most people did at the very least seem impressed—*You ever fire those huge machine guns? Think you could kick those dudes' asses? Did you kill anyone?* I'd find myself in a bar back home on leave listening to some guy a few years out of college explaining apologetically that, "I was totally gonna join the military, you know, but..." The usual stereotype projected onto me was that of a battle-hardened hero, which I'm not.

But as the Iraq war's approval levels sunk from 76% and ticker-tape parades to 40% and quiet forgetfulness, that flattering but inaccurate assumption has shifted to the notion that I'm damaged. Occasionally, someone will even inform me that I have post-traumatic stress disorder. They're never medical professionals, just strangers who've learned that I served.

One man told me that Iraq veterans "are all gonna snap in 10 years" and so, since I'd been back for three years, I had seven left. Another, after I'd explained that I didn't suffer from PTSD and that my deployment as a staff officer in Iraq had been mild, said that I needed to have an honest conversation with myself. And since I'm a writer, I've been asked more times than I can count whether my writing is an act of therapy.

I'm never offended; these are genuinely concerned people trying to reach out. But I find it all strange, especially since the assumption never seems to be that I have the actual *symptoms* of PTSD—intrusive memories of some traumatic event, numbing behaviors, a state of persistent hyperarousal. Instead, it is more in line with the Iraq veteran Brian van Reet's observation that "PTSD has graduated from a diagnosis into an idiom used by soldiers and civilians to talk about all kinds of suffering, loss, grief, guilt, rage, and unrewarded sacrifice." For a certain subset of the population, my service means that I—along with all other veterans—must be, in some ill-defined way, broken.

I suppose it is the lot of soldiers and Marines to be objectified according to the politics of the day and the mood of the American people about their war. I know a veteran of World War II who hates the idea of the Greatest Generation. "War ruined my life," he told me. "I couldn't date girls after the war. I couldn't go with people. I was a loner... It took years after the war for me to realize that the Earth is beautiful, not always ugly. Because I had so many friends killed in front of me, on the side of me, and how they missed me, I have no idea."

Vietnam veterans—who, like World War II veterans, were a mix of volunteers and draftees and probably expected, at least at the beginning of the war, a similar beatification—had the opposite problem. In "Recovering From the War," Patience H.C. Mason relates her husband's story: "Bob, who never fired a gun in Vietnam...who saved hundreds of lives by going in for wounded when it was too hot for the medevacs...got off the plane to buy some magazines in Hawaii. The clerk smiled at him and asked if he was coming back from Vietnam. He smiled back and nodded. 'Murderer!' she said."

Compared with that kind of reception, the earnest pity that Iraq and Afghanistan veterans often receive is awkward to complain about. It can sometimes even work to our advantage. When a friend of mine went apartment-hunting recently, he had a potential landlord cry and call him a "poor soul" because of his service. "I went along with it," he said sheepishly. He didn't want to blow his chances on the application.

Still, there is something deeply unsettling about the way we so often choose to think about those who served. "People only want to ask me about the worst things that happened," an Afghanistan veteran recently told me. "Never my best times in the Corps. Who were my favorite people I served with? Or even, hell, what was the biggest barracks rat I ever saw? It wasn't all bad."

The theologian Jonathan Edwards didn't consider pity an expression of "true virtue." Pity addresses the perceived suffering, not the whole individual. "Men may pity others under exquisite torment," Edwards wrote, "when yet they would have been grieved if they had seen their prosperity."

Pity sidesteps complexity in favor of narratives that we're comfortable with, reducing the nuances of a person's experience to a sound bite. Thus the response of a New York partygoer who—after a friend explained that the proudest moment of his deployment to Iraq came when his soldiers were fired on and decided not to fire back—replied, "That must make the nightmares even worse."

This insistence on treating veterans as objects of pity plays out in our national dialogue as well, whether it is Bill Maher saying on his April 4 HBO show, "Anytime you send anyone to war, they come back a little crazy," or a Washington Times article about PTSD claiming that, "Roughly 2.6 million veterans who serve in Iraq and Afghanistan suffer from PTSD-type symptoms." That is roughly the total number of veterans who served, which suggests that the reporter thought there might be a 100% saturation rate of PTSD among veterans.

Expert estimates of the actual prevalence of PTSD vary between 11% and 20% for Iraq and Afghanistan veterans, according to the U.S. Veterans Administration. A 2012 VA report concluded that 247,243 veterans had been diagnosed with the disorder at VA hospitals and clinics. (For some perspective on these numbers: According to experts cited by the VA, some 8% of the overall U.S. population suffers from PTSD at some point in their lives, compared with up to 10% of Desert Storm veterans and about 30% of those from Vietnam.)

Some of these diagnosed veterans are my friends, and though their injuries certainly deserve all the research and support that we as a society can give, the current narrative about PTSD does them no favors. Even the Pulitzer Prize-winning reporter David Finkel, who has produced some

of the bravest and most admirable reporting on the Iraq war and its aftermath, can fall into uncomfortable generalizations. In his recent book "Thank You for Your Service," he writes of a battalion of 800 men: "All the soldiers...came home broken in various degrees, even the ones who are fine."

I don't know what it means to be simultaneously "broken" and "fine." I do have friends with real PTSD, which they manage with varying degrees of success. I also have friends whose pride in their service is matched by feelings of sorrow, anger and bitterness. But I wouldn't classify them as "broken." If a friend of yours just died on his seventh deployment in a war that hardly makes the news anymore and you didn't feel sad, angry and bitter, perhaps that is what counts as "broken." Likewise, if the absence of any public sense that we are a nation still at war doesn't leave you feeling alienated, perhaps that means you're "broken" too.

Pity places the focus on what's wrong with veterans. But for veterans looking at the society that sent them to war, it may not feel like they're the ones with the most serious problem.

Experts think PTSD occurs:

- In about 11-20% of U.S. veterans of the post-9/11 wars in Iraq and Afghanistan
- In as many as 10% of veterans of the 1991 Gulf War (Operation Desert Storm)
- In about 30% of veterans of the Vietnam War

Worse, those warm feelings of pity toward us broken veterans can too easily turn ugly. After the April 2 shooting spree at Fort Hood that left three soldiers dead and 16 wounded, the Huffington Post ran an article titled "This Map Shows the Deadly Aftermath of War Right Here at Home," complete with a graphic showing killings committed by veterans.

Such "ticking time-bombs" articles usually fail to put their numbers in perspective. Indeed, one Marine who had trained as an intelligence analyst crunched the murder-rate numbers for a VA blog and found that, if the Huffington Post's numbers were accurate, the rate for veteran-committed homicide would still be a fourth of that for the general population. (The Huffington Post later took down the article, admitting that it was "incomplete and misleading.") While the exact numbers are difficult to measure, it appears that the crime rate for veterans is comparable to, if not lower than, the civilian crime rate, with veterans actually underrepresented in the U.S. prison population, according to Justice Department statistics.

As Sgt. Dakota Meyer, a young Marine and PTSD sufferer who was awarded the Medal of Honor for heroism in Afghanistan, explained after the Fort Hood shooting, "PTSD does not put you in the mind-set to go out and kill innocent people... The media label this shooting PTSD, but if what that man did is PTSD, then I don't have it."

Kristen Rouse, a veteran and blogger who was struck by another article alerting fearful readers to ZIP Codes that have large numbers of veterans with PTSD, wrote that the article treated a PTSD database "like a sex offender registry." A recent opinion piece in the New York Times even tried to link combat trauma with membership in the Ku Klux Klan. If vets are truly "broken," after all, there really is no telling what they might do.

This perspective is more than a little bizarre. Veterans rank among our most engaged, productive citizens. Just look at nonprofit groups such as The Mission Continues, which provides public-service fellowships for veterans across the country ("Reporting for duty in your community," their website says), or at the engagement efforts of groups such as the Iraq and Afghanistan Veterans of America (which strives to connect "the 99% of the population who haven't served in Iraq or Afghanistan with the 1% who have").

In New York, the contributions being made by veterans couldn't have been more apparent than after Hurricane Sandy. When the city failed to coordinate relief efforts in the Rockaways, the veteran-led relief group Team Rubicon filled the leadership gap by using a data-visualization program to map conditions and coordinate efforts to help people stranded after the storm. Veterans are used to creating order in chaotic environments—just the sort of people a city in a crisis needs.

But let's not see the veterans engaged in this work as a group of "healthy" veterans who can be contrasted easily with a second group of "broken" veterans. Some of our most inspiring veterans have been plagued by the same issues that tend to receive such hyperbolic press. One of the founders of Team Rubicon, Clay Hunt, was a Marine who served two deployments in Iraq, provided relief efforts after earthquakes in Chile and Haiti, raised money for wounded veterans and helped lobby Congress for veterans' benefits. He also, at age 28, joined the sad ranks of veterans who have taken their own lives.

I suppose that pity is one natural response to such a story. But I find it difficult to pity someone who, when his life is considered in its totality, achieved so much good and touched so many people.

War subjects some of its participants to more than any person can bear, and it destroys them. War makes others stronger. For most of us, it leaves a complex legacy. And though many veterans appreciate the well-meaning sentiments behind even the most misdirected pity, I can't help feeling that all of us, especially those who are struggling, deserve a little less pity and a little more respect.

Mr. Klay served in the U.S. Marine Corps from 2005 to 2009, including a tour of duty in Iraq from January 2007 to February 2008. He is the author of "Redeployment," a short-story collection recently published by the Penguin Press.

The VA's troubled history

By Michael Pearson, CNN

updated 2:06 PM EDT, Fri May 23, 2014

(CNN) -- Scandal, controversy and veterans care in the United States have gone hand-in-hand for virtually as long as there's been a republic.

After the Revolutionary War, for instance, payments promised by Congress to disabled veterans were left up to the states, and only a few thousand of those who served ever received anything, according to the Department of Veterans Affairs.

Here's a time line of the many scandals the department and its predecessors have faced:

1921 -- Congress creates the Veterans Bureau to administer assistance to World War I veterans. It quickly devolves into corruption, and is abolished nine years later under a cloud of scandal.

1930 -- The Veterans Administration is established to replace the troubled Veterans Bureau and two other agencies involved in veterans' care.

1932 -- Thousands of World War I veterans and their families march on Washington to demand payment of promised war bonuses. In an embarrassing spectacle, federal troops forcibly remove veterans who refuse to end their protest.

1945 -- President Harry Truman accepts the resignation of VA Administrator Frank Hines after a series of news reports detailing shoddy care in VA-run hospitals, according to a 2010 history produced by the Independent Institute.

1946 -- The American Legion leads the charge seeking the ouster of VA Administrator Gen. Omar Bradley, citing an ongoing lack of facilities, troubles faced by hundreds of thousands of veterans in getting services and a proposal to limit access to services for some combat veterans, according to the 2010 history.

1947 -- A government commission on reforming government uncovers enormous waste, duplication and inadequate care in the VA system and calls for wholesale changes in the agency's structure.

1955 -- A second government reform commission again finds widespread instances of waste and poor care in the VA system, according to the Independent Institute.

1970s -- Veterans grow increasingly frustrated with the VA for failing to better fund treatment and assistance programs, and later to recognize exposure to the herbicide Agent Orange by troops in Vietnam as the cause for numerous medical problems among veterans.

1972 -- Vietnam veteran Ron Kovic, the subject of the book and movie, "Born on the Fourth of July," interrupts Richard Nixon's GOP presidential nomination acceptance speech, saying, according to his biography, "I'm a Vietnam veteran. I gave America my all, and the leaders of this government threw me and others away to rot in their VA hospitals."

1974 -- Kovic leads a 19-day hunger strike at a federal building in Los Angeles to protest poor treatment of veterans in VA hospitals. He and fellow veterans demand to meet with VA Director Donald Johnson. The embattled director eventually flies to California to meet with the activists, but leaves after they reject his demand to meet in the VA's office in the building, according to Johnson's 1999 Los Angeles Times obituary. The ensuing uproar results in widespread criticism of Johnson. A few weeks later, Johnson resigns after President Richard Nixon announces an investigation into VA operations.

1976 -- A General Accounting Office investigation into Denver's VA hospital finds numerous shortcomings in patient care, including veterans whose surgical dressings are rarely changed. The GAO also looked at the New Orleans VA hospital, and found ever-increasing patient loads were contributing to a decline in the quality of care there, as well.

1981 -- Veterans camp out in front of the Wadsworth Veterans Medical Center in Los Angeles after the suicide of a former Marine who had rammed the hospital's lobby with his Jeep and fired shots into the wall after claiming the VA had failed to attend to his service-related disabilities, the New York Times reported at the time.

1982 -- Controversial VA director Robert Nimmo, who once described symptoms of exposure to the herbicide Agent Orange during the Vietnam war as little more than "teenage acne," resigns under pressure from veteran's groups. Nimmo was criticized for wasteful spending, including use of a chauffeured car and an expensive office redecorating project, according to a 1983 GAO investigation. The same year, the agency issues a report supporting veterans' claims that the VA had failed to provide them with enough information and assistance about Agent Orange exposure.

1984 -- Congressional investigators find evidence that VA officials had diverted or refused to spend more than \$40 million that Congress approved to help Vietnam veterans with readjustment problems, the Washington Post reports at the time.

1986 -- The VA's Inspector General's office finds 93 physicians working for the agency have sanctions against their medical licenses, including suspensions and revocations, according to a 1988 GAO report.

1989 -- President Ronald Reagan signs legislation elevating the Veterans Administration to Cabinet status, creating the Department of Veterans Affairs.

1991 -- The Chicago Tribune reports that doctors at the VA's North Chicago hospital sometimes ignored test results, failed to treat patients in a timely manner and conducted unnecessary surgery. The agency later takes responsibility for the deaths of eight patients, leading to the suspension of most surgery at the center, the newspaper reported.

1993 -- VA Deputy Undersecretary of Benefits R.J. Vogel testifies to Congress that a growing backlog of appeals from veterans denied benefits is due to a federal court established in 1988 to oversee the claims process, the Washington Post reports. The VA, Vogel tells the lawmakers, is "reeling under this judicial review thing."

1999 -- Lawmakers open an investigation into widespread problems with clinical research procedures at the VA West Los Angeles Healthcare Center. The investigation followed years of problems at the hospital, including ethical violations by hospital researchers that included failing to get consent from some patients before conducting research involving them, according to the Los Angeles Times.

2000 -- The GAO finds "substantial problems" with the VA's handling of research trials involving human subjects.

2001 -- Despite a 1995 goal to reduce waiting times for primary care and specialty appointments to less than 30 days, the GAO finds that veterans still often wait more than two months for appointments.

2003 -- A commission appointed by President George W. Bush reports that as of January 2003, some 236,000 veterans had been waiting six months or more for initial or follow-up visits, "a clear indication," the commission said, "of lack of sufficient capacity or, at a minimum, a lack of adequate resources to provide the required care."

2005 -- An anonymous tip leads to revelations of "significant problems with the quality of care" for surgical patients at the VA's Salisbury, North Carolina, hospital, according to congressional testimony. One veteran who sought treatment for a toenail injury died of heart failure after doctors failed to take account of his enlarged heart, according to testimony.

2006 -- Sensitive records containing the names, Social Security numbers and birth dates of 26.5 million veterans are stolen from the home of a VA employee who did not have authority to take the materials. VA officials think the incident was a random burglary and not a targeted theft.

2007 -- Outrage erupts after documents released to CNN show some senior VA officials received bonuses of up to \$33,000 despite a backlog of hundreds of thousands of benefits cases and an internal review that found numerous problems, some of them critical, at VA facilities across the nation.

2009 -- The VA discloses that than 10,000 veterans who underwent colonoscopies in Tennessee, Georgia and Florida were exposed to potential viral infections due to poorly disinfected equipment. Thirty-seven tested positive for two forms of hepatitis and six tested positive for HIV. VA Director Eric Shinseki initiates disciplinary actions and requires hospital directors to provide written verification of compliance with VA operating procedures. The head of the Miami VA hospital is removed as a result, the Miami Herald reports.

2011 -- Nine Ohio veterans test positive for hepatitis after routine dental work at a VA clinic in Dayton, Ohio. A dentist at the VA medical center there acknowledged not washing his hands or even changing gloves between patients for 18 years.

2011 -- An outbreak of Legionnaires' Disease begins at the VA hospital in Oakland, Pennsylvania, according to the Pittsburgh Tribune-Review. At least five veterans die of the disease over the next two years. In 2013, the newspaper discloses VA records showed evidence of widespread contamination of the facility dating back to 2007.

2012 -- The VA finds that the graves of at least 120 veterans in agency-run cemeteries are misidentified. The audit comes in the wake of a scandal at the Army's Arlington National Cemetery involving unmarked graves and incorrectly placed burials.

2013 -- The former director of Veteran Affairs facilities in Ohio, William Montague, is indicted on charges he took bribes and kickbacks to steer VA contracts to a company that does business with the agency nationwide.

January 2014 -- CNN reports that at least 19 veterans died at VA hospitals in 2010 and 2011 because of delays in diagnosis and treatment.

April 9 -- Lawmakers excoriate VA officials at a hearing. "This is an outrage! This is an American disaster!" says Rep. Jackie Walorski.

April 23 -- At least 40 veterans died while waiting for appointments to see a doctor at the Phoenix Veterans Affairs Health Care system, CNN reports. The patients were on a secret list designed to hide lengthy delays from VA officials in Washington, according to a recently retired VA doctor and several high-level sources.

April 28 -- President Barack Obama calls for an investigation into the situation in Phoenix.

April 30 -- Top officials at the Phoenix VA deny the existence of a secret appointment waiting list.

May 1 -- Shinseki places the director of the Phoenix VA and two aides on administrative leave pending the investigation into the veterans' deaths.

May 5 -- Veterans groups call for Shinseki's resignation. American Legion National Commander Daniel Dillinger says the deaths reported by CNN appear to be part of a "pattern of scandals that has infected the entire system."

May 6 -- Despite the clamor for Shinseki's ouster, White House spokesman Jay Carney says Obama "remains confident in Secretary Shinseki's ability to lead the department and take appropriate action." Shinseki tells the Wall Street Journal he will not resign.

May 8 -- The House Veterans Affairs Committee votes to subpoena Shinseki and others in relation to the Phoenix scandal.

May 9 -- The scheduling scandal widens as a Cheyenne, Wyoming, VA employee is placed on administrative leave after an email surfaces in which the employee discusses "gaming the system a bit" to manipulate waiting times. The suspension comes a day after a scheduling clerk in San Antonio admitted to "cooking the books" to shorten apparent waiting times. Three days later, two employees in Durham, North Carolina, are placed on leave over similar allegations.

May 15 -- Shinseki testifies before the Senate Veterans Affairs Committee. "Any allegation, any adverse incident like this makes me mad as hell," he says. At the same hearing, acting Inspector General Richard Griffin tells lawmakers that federal prosecutors are working with his office looking into allegations veterans died while waiting for appointments.

May 19 -- Three supervisors at the Gainesville, Florida, VA hospital are placed on paid leave after investigators find a list of patients requiring follow-up care kept on paper, not in the VA's computerized scheduling system.

May 20 -- The VA's Office of Inspector General says it is investigating 26 agency facilities for allegations of doctored waiting times.

May 21 -- Obama says he "will not stand" for misconduct at VA hospitals, but asks for time to allow the investigation to run its course. The same day, Shinseki rescinds Phoenix VA director Sharon Helman's \$8,495 bonus. Helman got the bonus in April, even as agency investigators were looking into allegations at the facility.

May 22 -- The chairman of the House Veteran Affairs Committee says his group has received information "that will make what has already come out look like kindergarten stuff." He does not elaborate.

Researcher Caitlin Stark, Scott Bronstein, Nelli Black, Drew Griffin, Greg Botelho, Elliott C. McLaughlin, Ashley Fantz, Ray Sanchez, Patricia DiCarlo, Dana Ford and Tom Cohen contributed to this report.

We are all veterans now

The national scandal and disgrace at the VA (Department of Veterans Affairs) is the perfect example of the disaster that awaits America with ObamaCare. We're about to find out what it's like to receive health care from the government.

The VA scandal is proof that with government in charge of health care, it will bankrupt the entire country.

Countless Americans will die through bureaucratic incompetence, neglect, long waiting lists and fraud.

Just like what our veterans have already experienced.

The VA scandal is proof that with government in charge of health care, it will bankrupt the entire country.

Sadly, the VA scandal is nothing new. Conservatives have warned about the dangers of government-run health care for many years, often using the VA as Exhibit A.

My bestselling book, "The Ultimate Obama Survival Guide" was released in April of 2013. Here's what I wrote then:

"Take Veterans Affairs. A federal appeals court has ruled the VA suffers from 'unchecked incompetence.' That incompetence is killing our brave veterans. I bet you didn't know 18 veterans commit suicide per day. Or that 85,000 vets are on waiting lists for care. Even a severely depressed vet can wait eight weeks to see a psychiatrist. *Still want government to run your health care?*"

I hate to say it but... "I told you so." So why didn't America see this disaster coming? Just look at what we've been hearing about the mess at the VA. There are tales of government mismanagement, substandard health care, vets being treated horribly, vets dying after waiting on long lists to get care. Vets committing suicide.

We have known about some of this for a long time. About the only thing we didn't know was that there was outright criminal negligence which could lead to murder charges.

We didn't know government employees kept secret waiting lists to cover up the long delays -- even though they knew patients had life-threatening illnesses. That sounds like murder to me.

What a surprise! Conservatives like Sarah Palin and I screamed about "death panels" and "death by rationing" under ObamaCare years ago.

Government is a walking disaster. Government screws up everything it touches, while losing billions of dollars in other people's money.

How could putting government in charge of health care for 330 million Americans possibly work out?

All the wars in America's history have cost about \$7 trillion. Yet the war on poverty has cost \$20 trillion and counting (adjusted for inflation)...and poverty is still at a record high. What a massive failure and waste of taxpayer money.

The Federal Reserve has one main job -- to protect the value of our dollar. Yet the dollar has lost 98% of its value since the Fed was founded.

The same government that brought you failing post offices, failing trains, and pretty much failing everything else is now in charge of your health care (as well as 17% of the U.S. economy).

The same government employees who brought us \$17 trillion in national debt are in now in charge of health care -- yet Obama promised ObamaCare would save money and reduce the deficit. He also promised you could keep your health insurance if you liked it. And you could keep your doctor. And your insurance premiums would not go up.

Now do you understand what Obama has done to America's health care system?

Forget the threat of losing your insurance, or your doctor, or your medicine. The real threat with government in charge is losing your life!

At this point, either government's incompetence or criminal behavior will kill you. Or, after dealing with the idiots who run the government, you'll just kill yourself.

Happy Memorial Day weekend. We're all veterans now.

Wayne Allyn Root is capitalist evangelist, entrepreneur, and Libertarian-conservative Republican. He is a former Libertarian vice presidential nominee.

Dr. Manny: American tax dollars paying for poor service, bad outcomes in VA hospitals

Over the years, I've become aware of numerous stories highlighting the many instances of poor care given to our veterans within the veterans affairs (VA) hospital system. And in my opinion, the Obama administration has only made things worse within the VA hospitals, because of its lack of accountability and poor transparency over the past 5 1/2 years. Ironically, President Obama was elected on the principles of transparency and accountability. Yet, the records clearly show this has been one of the least transparent administrations ever. If not for the outcry coming from the families of veterans, journalists and congressional legislators, many of the horror stories coming out of VA hospitals may never have seen the light of day. In 2012, malpractice payments to U.S. veterans reached a 12-year high. That year, \$91.7 million was paid out to patients who were allegedly injured during the course of their medical treatment in VA hospitals, according to records obtained by **Bloomberg News** through a Freedom of Information Act request. And

according to data obtained by the Center for Investigative Reporting, in the 12 years since September 11, 2001, more than \$200 million in wrongful death payments have been made by the Department of Veterans Affairs. Of course, there are thousands of well qualified health workers in the VA health system – including doctors, nurses and technicians. However, there are also physicians and health care providers who appear to be failing to meet their professional responsibilities in providing good care. And because VA hospital workers are government employees, it is extremely difficult to discipline, monitor or fire these people. In fact, if a patient wants to sue for medical malpractice at a VA hospital, they must sue the federal government, not the individual physician or health care worker. Suing the federal government is not an easy task. Many lawyers who deal with regular malpractice are not knowledgeable about federal malpractice rules. And it gets worse: The American taxpayer is being forced to pay for the medical negligence being incurred upon our veterans by these government health professionals. VA records showed that taxpayers have spent at least \$700 million to resolve claims filed against the VA since 2001. Perhaps one of the saddest aspects of this story is that over the past 12 years, thousands of new veterans have needed to rely on health services provided by the federal government after returning from wars in Afghanistan and Iraq. Many of these patients are young. They need good outcomes. This generation of veterans has paid a hard price in fighting for our freedom – often well beyond the call of duty. Why has providing for these veterans, along with ensuring that instances of malpractice or wrongful death within the VA system are properly addressed, not been a priority for the Obama administration?

Dr. Manny Alvarez serves as FOX News Channel's (FNC) Senior Managing Editor for Health News.

DRAFT FACTS

Mr. Fasano explained that he is a veteran and has 100% service-connected disabilities. As a result of these disabilities, Mr. Fasano receives ongoing care from private healthcare providers, although he is eligible for care through the VA. When he is required to undergo Compensation and Pension Exams as a condition of his disability benefits, he sees providers located at the Brooklyn Campus of the VA New York Harbor Healthcare System in Brooklyn, New York. He does not receive care at the Northport VAMC.

Mr. Fasano stated that he initially interviewed for his current position at the Northport VAMC in July 2007. He was interviewed by a three-person panel, including Eleanor Hobbs, a Nurse Practitioner. According to Mr. Fasano, Ms. Hobbs initially voted against hiring him and the position was offered to another individual, who declined. Thus, in October 2007 the job was offered to Mr. Fasano. He accepted the position but did not begin work until August 2008, following completion of the agency's vetting process. Mr. Fasano noted that from early on in his employment, other VA employees were aware of his disabilities, and commented on them to him. He stated that this concerned him, as his disabilities were not public knowledge or obvious. In 2011, Mr. Fasano began requesting access logs for his medical files through the Northport VAMC Privacy Office. He noted that he did not receive full responses to his requests, and ultimately filed a Freedom of Information Act request to obtain the full logs. Upon receiving the logs, Mr. Fasano found that a number of individuals had accessed his medical records during the vetting process. A list of those individuals, along with their titles, where available, and the dates of access are attached to this letter.

On May 28, 2013, Mr. Fasano was informed that a complaint had been filed against him by his former sister-in-law, also a Northport VAMC employee. He was escorted off the VA campus and placed on paid administrative leave. According to Mr. Fasano, an Administrative Investigation Board (AIB) was convened to review the allegations made against him. He was advised that he could only return to the Northport VAMC campus if he provided 24 hour notice and was escorted by VA police. On June 27 and 28, 2013, Mr. Fasano was interviewed by the AIB, comprised of Paul Haberman, Registered Nurse (RN) Chair, Steven Wintch, Privacy Officer, and Barbara Albanese, RN. Mr. Fasano stated that during the hearing, the AIB repeatedly and specifically referred to his service-connected disabilities in a humiliating and discriminatory manner.

Mr. Fasano noted that during the period of time shortly before the complaint was made against him and continuing through his administrative leave, a variety of Northport VAMC employees have accessed his medical records. A list of the employees who engaged in the access, their titles, where available, and the dates of access are attached to this letter. Mr. Fasano noted that a significant portion of these employees are not healthcare providers, but serve in administrative or law enforcement roles.

Based upon the foregoing, Mr. Fasano alleged that Northport VAMC employees have improperly accessed his medical records in violation of the Privacy Act of 1974 (Privacy Act), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and Veterans Health Administration (VHA) Handbook 1605.2, Appendix A, *Functional Categories Identifying Appropriate Levels of Access to Protected Health Information* (January 23, 2013), which limits the access of particular employees to patients' full medical records. Further, Mr. Fasano alleged that the improper access constituted an abuse of authority.

The Privacy Act is codified at 5 U.S.C. § 552a. Section 552a(b) prohibits agencies from disclosing any record contained in a system of records except with prior written consent of the individual to whom the record pertains. While § 552a(b)(1) allows for disclosure to officers and employees of the agency maintaining the record in performance of their duties, we note that in this instance, Mr. Fasano was not receiving care at the Northport VAMC, and thus, no access to his medical records could have been in connection with a provider's job duties. Further, the HIPAA Privacy Rule, found at 45 C.F.R. §§ 160 and 164, requires that covered entities, including the VA, "ensure the confidentiality... of all electronic protected health information the covered entity... maintains." Further, 45 C.F.R. § 164(a)(2) requires covered entities to protect against reasonably anticipated threats to the security of such information.

VHA Handbook 1605.2 provides mandatory guidelines for the use and disclosure of patients' individually-identifiable health information. Handbook 1605.2 explains that VHA constitutes a covered entity and, as such, VHA is required to implement the "minimum necessary standard." This standard requires covered entities to establish policies to limit the use or disclosure of protected health information to the minimum amount necessary. To accomplish the goal of limiting the use of protected health information, VHA divides employees into functional categories, each with an appropriate level of minimum access. See VHA Handbook 1605.2, Appendix B, *Functional Categories Identifying Appropriate Levels of Access to Protected Health Information*. Individuals in administrative support positions, as outlined in Appendix B, have limited access to medical records when necessary to complete an assignment. VHA Handbook 1605.2, para. 6, specifically states that all VHA personnel must use no more protected health information than is necessary to perform their specific job function, and must not access information that exceeds the limits of their functional category. Paragraph 6 further notes that,

even if an employee's position allows for greater access, the employee should only access the information necessary to perform their official function.

As Mr. Fasano does not receive care at the Northport VAMC, it appears that any access to his medical records by providers is unrelated to the completion of their job duties. Further, access to Mr. Fasano's medical records by Northport VA administrative and law enforcement personnel is necessarily unrelated to the provision of care regardless of whether Mr. Fasano received care at the Northport VAMC. Thus, such access appears to be related to his employment at the Northport VAMC, which may violate his right to privacy under the Privacy Act, the HIPAA Privacy rule, and VHA Handbook 1605.2.

It is of note that such access to medical records is not likely possible for non-veteran VA employees. Permitting access to the records of employees who are veterans places those employees at a disadvantage during administrative employment proceedings. OSC has received similar allegations of improper access to veteran-employee medical records in the past. See OSC File Nos. DI-11-2679 and DI-11-2798. In those matters, disclosed by employees of the VA Boston Healthcare System (VABHS), the agency indicated that additional training was provided for VABHS employees on the privacy needs of veterans who are employed by and receive care at the VA. In its supplemental report, the agency indicated that "24 percent (and rising) of VA's employees are Veterans..." Based upon the foregoing, OSC is concerned that the privacy protections for veterans employed by VA, regardless of whether they receive care at the VA, may be compromised at other VHA locations, in addition to the Northport VAMC and VABHS. Thus, to extent that the VA may substantiate Mr. Fasano's allegations, OSC is hopeful that corrective action is nation-wide, in order to avoid future breaches.

BORN ON THE FOURTH OF JULY

My name is Joe Fasano, I am a 100% service connected disabled American veteran as a result of selfless sacrifice in service to this county. I served with honor and distinction in elite United States Army Airborne and Joint Special Operations units. I continue that proud tradition in service to my fellow brothers in arms at the VA. Despite severe brutal disparate treatment during most of my employment I have made significant meaningful impact to patient care improving the quality of care and service to my fellow veterans and positively influenced the overall care rendered to our nations heroes. I am painfully reminded of my personal sacrifice having devoted my late teens and an entire decade of my 20's to this nation - I am literally riddled from head to toe inside and out to an overall service connected disability rating of 220%, however, I gracefully persevere the cruelty of others at the VA as the guidon bearer for my comrades that no longer can, with valor, honor and the courage of conviction losing a popularity contest with great personal harm in the process. Not all disabilities are obvious. Not all disabilities are glamorous. Not all disabilities are pleasant. Not all disabilities are convenient. Not all disabilities have a heroic story. Not all disabilities can be turned off and tuned out. However, they are very real for the countless veteran victims that suffer in silence as a result of the stigmata of their conditions being blamed by a system that falsely advertises that it is "pro-veteran." And let's face it, the VA historically doesn't have a good track record when it comes to service to veterans. The worst part of living with these disabilities is facing the overwhelming ignorance and ignoble treatment in the form of daily workplace prejudice, ad hominem including gossiping, rumor mongering and slander having to endure a tirade of snide remarks ridiculing and mocking everything from the way I speak, how I speak, my cultural mannerisms, gestures, my posture, my stance and gait, my massive size, my stature, etc. reinforcing a stereo type threat. I am virtually defenseless; like a

bear that has been declawed, defanged and hobbled by the discriminatory employment practices of the VA towards veterans. Only 18% of the VA Northport NY workforce are veterans sharing the same concerned disenchantment of a system that is only "pro-veteran" when it is convenient during a sleazy dog and pony glitzy political photo op. We are forced to speak to each other and support one another in hushed tones in dark shadows of the VA catacombs suffering in silence by a largely hostile civilian workforce that is clueless and insensitive to our daily struggles and obstacles that we must face, endure and overcome being further ostracized and wounded by a system that applies psychological fracture mechanics on a presumption of disability; particularly Post Traumatic Stress Disorder reinforcing the shameful stigmata of mental health disease and blaming the victim for their disabilities. Veteran employees are at a distinct disadvantage compared to their civilian counterparts since our VA and DOD medical records and military service records screens can be freely accessed by any VA employee with all of our Protected Health Information on display for all to see; unfortunately, I've been the victim of this inappropriate and illegal accessing on multiple occasions. The agency acted unilaterally based on the corroborated lies of my ex sister in law (who holds a bitter family grudge) and a social worker; lining up a handful of detractors and stooges to vent their personal grievances and proclivities in the form of institutional discrimination against me in the absence of any wrong doing and without ever counseling me or asking for my side of the story. I have been presumed guilty before proven innocent of all the phony bogus "charges." This abhorrent unilateral personnel action which negatively effects me as a veteran and a patient was taken against me based solely on hearsay, lies, fake accusations, hyperbole and confabulated allegations labeling me a dangerous person due to the information gleaned by the VA police force et al when my VA medical records were illegally accessed without a warrant, court order, subpoena, consent or release form. I've not received any sort of statement of charges so I have no idea what I'm facing or up against. Preparing an adequate defense/ response has been impossible since I've been restricted from the campus and access to any potential supportive witnesses, documents, e-mails, information, etc. The severity of the police escort restriction is so awful that it prevents me from accessing my health and benefits entitlements by law as a 220% service connected disabled American veteran since it exacerbates my PTSD. It is very humiliating for me to be paraded around like a criminal without due process like a grotesque circus freak show in front of all my friends, colleagues and fellow veterans. The social contract with America has been broken and this sacred trust desecrated by the abusive and disparate treatment that I am receiving as a 100% disabled American veteran. That social contract is that the military takes care of America and America takes care of its veterans, however, the moral fabric that this has been imprinted on has been torn to shreds - I have become nothing more than a human punching bag with a tattered American flag draped over it for the VA Northport NY administration run amok with their seething jealousy and outright contempt for all things veteran at the behest of Mr. Phil Moschitta (VA Northport director). It is my duty and moral obligation as a veteran to expose this corruption since it discredits you, dishonors all who have sacrificed for this nation and reflects poorly on the VA's commitment to provide world class care to its veterans. This should conjure images of the book and movie, "Born on the Fourth of July." Since I've not received any responses from your office, I sincerely hope that this is not just an anemic bureaucratic cowardly acquiescence of a greater moral dilemma. This impenetrable bureaucratic phalanx whose tarnished shields have become nothing more than rusted chamber pots emblazoned with the logo of government corruption and incompetence is in lock step with all things anti-American and anti-veteran. The command situation has deteriorated so badly at the VA Northport NY that it is tantamount to the

American flag being flown upside down, whereby the tenants, virtues and values built on the backs of courageous men like me that define this great nation has been hijacked by a band of evil corrupt flunky civilian bureaucrats led by the ogre Mr. Moschitta. I am a role model to many on and off the field - the decisions you make in this matter will define who you are. There is a Japanese proverb that a fish starts to rot at the head. This moral compass is off course without any leadership or direction - its needle and bezel spinning aimlessly in the black hole of logic, reason, ethics and morality that is the vortex of corruption at the VA Northport NY. I don't know what kind of grid to magnetic course correction can get the VA Northport's moral obligatory bearings back on track again other than to start with the immediate termination of Mr. Moschitta and his cruel henchman. I consider this action retaliation for the current and prior EEO cases that I have filed against the VA as well as whistle blower retaliation according to the Office of the Special Counsel's Prohibited Personnel Practices having informed the director of serious patient safety issues in Long Term Care whose reporting and documentation was being brutally suppressed by management to the extent that the service chief would convulse into a temper tantrum screaming and threatening anyone for filing 2633 incident report forms prior to the electronic version ePers; creating a culture and climate of fear of reprisals v. doing the right thing for veterans. It's no small wonder that Long Term Care has received the absolute worst possible ratings by the Long Term Care Institute Surveys for nearly three consecutive years without any sense of course correction. It was this mess and broken environment that I was forced to conduct business on a daily basis fighting a Sisyphean task eventually being crushed by the boulder of retaliation to force a submissive capitulation.

HIPAA Violations/ Privacy Breach at VA Northport NY

Please be advised that I have some disturbing updates regarding a hostile personnel action which was unilaterally taken against me by the VA Northport NY negatively effecting my status as a patient & a veteran from accessing my health care & benefits that I am entitled to by law as a 100% service connected disabled American veteran. A unilateral hostile personnel action was taken against me by the VA Northport NY on 5/28/13 in the absence of any wrong doing & without any statements of charges. The VA Northport NY labeled me a dangerous person based on liable, slander, hearsay, character defamation & false allegations based on the pre-text of my multiple service connected disabilities including but not limited to Post Traumatic Stress Disorder. On 11/2/12, 5/21/13, 5/24/13, 6/11/13, 6/18/13 & 6/26/13, multiple VA Northport NY employees including Gino Nardelli (a VA police officer who illegally accessed my medical records without a warrant, subpoena, court order, summons or privacy release form signed by me on 5/24/13 @ 1612 hours) illegally & inappropriately accessed my medical records; using my Protected Health Information in a destructive, biased & prejudicial manner against me which may very well result in my termination pending an Administrative Investigation Board as an employee. **Please consider that my 4th & 14th amendment rights were violated by the VA Northport NY; especially since my employer is also the maintainer of my PHI including all of my disabilities, ratings, military service & C-file.** It's very disturbing that this hostile personnel action was taken against me less than one business day after the above named VA police officer illegally accessed my VA medical records without a legitimate medical reason. So, what other types of sensitive personal data including my military service record screen has been illegally accessed by VA employees including the VA police force? Have they accessed my personal data on their personal computers which lack the mandatory VA firewall cyber security protections? What other nefarious reasons has my personal data & demographic data been used

for? How else has my PHI been misused or compromised? With whom & what other agencies has my PHI been shared? How extensive has this HIPAA violation/privacy breach been? My PHI was also printed to an unknown extent, however, the VA can't account for the volume & copies of the sections of my medical record that were printed & copied, the VA can't account for how this hardcopy PHI was stored, logged, documented &/or destroyed using proper methods. Some of these individuals even accessed my medical records after normal duty hours commonly referred to as WHEN hours at the VA (weekends, holidays, evenings, nights) as evidenced by the date/time group of when the accessing occurred. What are the sinister broader implications of the HIPAA violation? Why did they access my medical records? By whose authority? Is it part of a broader investigation? It was very obvious that the majority of the accessing occurred around the time of this investigation. Did the VA employees use other means of copying my medical records such as taking screen shots with the camera application of their cell phones? Did they print my PHI & if yes, did they log the printed sections, did they make additional copies, how are they going to store & destroy the hard copies? Why is a file clerk in the files section accessing my medical record on 5/21/13 - three business days prior to the personnel action? It's beyond a mere coincidence that a patient relations assistant in social work accessed my medical records when the majority of complaints against me were generated by social workers? Why is a supervisory program specialist accessing my medical records during WHEN hours? **This retaliatory tangible action wouldn't have taken place had the VA not illegally accessed my medical data since the VA unfairly & unjustly interpreted & applied a harsh disparate treatment against me strictly on the basis of my psychological disability as a form of discrimination which is a violation of the Americans with Disabilities Act; this info was gleaned from the multiple illegal accessing of my VA medical record.** As a veteran employee, I'm at a distinct disadvantage compared to my civilian employee counterparts since any VA employee can access my PHI which in this instance has been used against me; my medical records are at the fingertips of any VA employee to access, however, VA employees including the VA police officer wouldn't have had the same ease of access to a civilian employees' private medical records. Furthermore, the privacy officer Steven Wintch only released the by-name list of folks that have accessed my medical records to me on 6/28/13 for a limited run date starting 8/1/12 - 6/27/13, however, he has refused multiple requests on prior occasions including FOIA requests to furnish the entire list starting 9/1/05 - present date. I was only made aware of this privacy breach on 6/28/13. It's very disturbing that many VA Northport employees have intimate knowledge of my service connected disabilities due to the multiple illegal accessing of my PHI & rumor mongering in a prejudicial manner that has led to widespread discrimination against me as a veteran, a patient & an employee. Enclosed please find a copy of the by-name list of these individuals that illegally accessed my PHI on the above listed dates. It's not VA protocol, policy, procedure or regulation to have a VA police officer access an employee's &/or veteran/patient medical records as well as any of the other VA employees that illegally accessed my PHI without a legitimate medical reason & without a warrant, court order, subpoena, summons or release form signed by me. My PHI has been used in a derogatory, humiliating, abusive, discriminatory & damaging manner against me during the course of my employment since my VA medical records have been illegally & inappropriately accessed on multiple prior occasions without a legitimate medical reason with the full knowledge of the VA Northport administration & the privacy officer including this personnel action & as a patient & veteran in this instance. I'm barred from returning to the VA Northport NY campus as an employee, patient & veteran without a VA police escort. This humiliating restriction is so devastating to me that it

exacerbates my PTSD to the extent that I'm prevented from accessing my health care/benefits entitlements as a 100% disabled veteran. The VA Northport administration refused to provide any sort of special accommodation despite multiple pleas to the patient advocate. I'm forced to either be paraded around like a criminal without due process; like some sort of grotesque circus freak show in front of all my friends, fellow veterans & colleagues or I am forced to drive a greater than 100 mile round trip to the other VA campuses (Manhattan, Brooklyn, Bronx, Hudson Valley) which I've explained to the administration is impossible due to the severe pain caused by such an arduous commute & the fact that I can only drive for limited distances due to my multiple disabilities. The VA Northport administration even refused multiple requests to have my health care contracted privately on what's called a "fee basis" service. Please advocate for my rights & all other veterans to make positive change since the VA didn't interpret or apply their own regs & the law in taking this hostile unilateral personnel action against me & negatively extending to me as a patient & a 100% disabled veteran. The severity of the restrictions are so severe that it prevents me from accessing my health care service & benefits that I am entitled to by law.

AIB DISCRIMINATION/ ADA VIOLATIONS

Please be advised that the Administrative Investigation Board at the VA Northport NY that convened to interrogate me on 6/27/13 - 6/28/13 was comprised of Paul Haberman RN chair, Steven Wintch Privacy Officer & Barbara Albanese RN. This board mocked, ridiculed & made fun of my service connected disabilities including but not limited to Post Traumatic Stress Disorder, hearing loss & multiple orthopaedic and neurological conditions. They humiliated me & taunted me with their inappropriate, unprofessional, insensitive, offensive, discriminatory & prejudicial line of questioning regarding my disabilities. Their tone was very aggressive & disrespectful with Paul Haberman yelling at me often times. Mr. Haberman's paternalistic attitude with yelling, intimidating & threatening me during the course of my testimony was not within the scope & guidelines of the AIB & I consider this to be an administrative bully tactic to intimidate & otherwise suppress my testimony in the AIB's efforts to provoke my PTSD. They humiliated me by blaming me for my disabilities & the effects that my disabilities have had on my job. Paul Haberman AIB chair was laughing at me whilst smiling & smirking during this line of questioning to the extent that this disrespect angered Richard Thomesen NFFE union president as my rep during the interrogation. Paul Haberman stated, "...well why don't you just get a hearing aid...if you can't hear...then just get a hearing aid..." Barbara Albanese's line of questioning was along the same lines taunting me for my hearing loss, my speech, my mannerisms, my manner of speech, my massive size, my gestures, my height, my stature, my stance & gait, my posture, etc. asking me in a humiliating tone, "...have you done anything to modify this..." like I'm able to change any of these non modifiable physical & disabling features. The board was then very irate & defensive again blaming me the victim of these disabilities when we pleaded with them to cease & desist with this highly insensitive & inhumane line of questioning that was not germane to the AIB scope & purpose. Their cruel & humiliating actions were taken immediately after I read a heart felt & emotional statement regarding the severe obstacles and difficulties of living & working with disabilities including cruel & insensitive remarks & behaviors from others & the lifelong struggle of assimilating back into civilian life as a disabled veteran. I told them that not all disabilities are obvious. Not all disabilities are glamorous. Not all disabilities are convenient. Not all disabilities have a heroic story. Not all disabilities are pleasant. However, they are very real for the victim that has to suffer with them

on a daily basis. We stated that they would never think to blame a blind person for their visual impairments or a paralytic for their physical limitations, so why did they think that they had the liberty & latitude to make fun of me? Mocking my disabilities & blaming me for my disabilities went way beyond the mandate & scope of the AIB. We told the board that we found their remarks & behavior to be cruel, offensive & disrespectful. The board also made absolutely no provisions to accommodate my multiple disabilities having endured six hours of interrogation on 6/27/13 & three hours of interrogation on 6/28/13. Because of the blatant & obvious discrimination & prejudice by the board & without any special accommodations due to my disabilities this board has been poisoned to the extent that I cannot receive a fair & impartial verdict. The board was not comprised of my peers; they were all management officials, there were no veterans & no disabled persons on the board. The AIB refused to interview crucial witnesses to aid in my defense. The AIB failed to make any sort of arrangements for me to access crucial documents & e-mails to aid in my defense since the VA police escort restriction is so severe that it exacerbates my PTSD. The AIB's line of questioning was riddled with presumed embedded guilt that was very aggressive, abusive, elusive & vague with extremely limited information provided in their vague questions preventing any sort of comprehensive & coherent responses. The AIB wouldn't have had such intimate detailed knowledge of my medical conditions & disabilities which they have adversely used & applied against me if my medical records were not illegally accessed.

AIB BRADY VIOLATIONS VA NORTHPORT NY

Please be advised that the Administrative Investigation Board at the VA Northport NY that convened to interrogate me on 6/27/13 - 6/28/13 was comprised of Paul Haberman RN chair, Steven Wintch Privacy Officer & Barbara Albanese RN. As your office is well aware as per prior correspondence, this board mocked, ridiculed & made fun of my service connected disabilities including but not limited to Post Traumatic Stress Disorder, hearing loss & multiple orthopaedic & neurological conditions. They humiliated me & taunted me with their inappropriate, unprofessional, insensitive, offensive, discriminatory & prejudicial line of questioning regarding my disabilities. Their tone was very aggressive & disrespectful with Paul Haberman yelling at me often times. Mr. Haberman's paternalistic attitude with yelling, intimidating & threatening me during the course of my testimony was not within the scope & guidelines of the AIB & I consider this to be an administrative bully tactic to intimidate & otherwise suppress my testimony in the AIB's efforts to provoke my PTSD. They humiliated me by blaming me for my disabilities & the effects that my disabilities have had on my job. Paul Haberman AIB chair was laughing at me whilst smiling & smirking during this line of questioning in a very disrespectful manner. The AIB used illegally obtained information about my multiple disabilities & medical conditions when multiple VA employees including a VA police officer illegally accessed my medical records multiple times whose temporal proximity to the investigation is way beyond a mere coincidence. The AIB committed repeated Brady violations in all three parts of the scope regarding a Brady requirement since the evidence that was illegally gleaned was from a law enforcement source. In the 1963 case of Brady v. Maryland, the U.S. Supreme Court determined that the 5th & 14th amendments provide for the availability of all evidence in a case. This holds true even if the prosecution or police do not intend to withhold evidence. Because of the blatant & obvious discrimination & prejudice by the board & without any special accommodations due to my disabilities this board has been poisoned to the extent that I cannot receive a fair & impartial verdict. The board was not comprised of my

peers; they were all management officials, there were no veterans & no disabled persons on the board. The AIB refused to interview crucial witnesses to aid in my defense. The AIB failed to make any sort of arrangements for me to access crucial documents & e-mails to aid in my defense since the VA police escort restriction is so severe that it exacerbates my PTSD; barring me from the campus is a form of evidence suppression. The AIB's line of questioning was riddled with presumed embedded guilt that was very aggressive, abusive, elusive & vague with extremely limited information provided in their vague questions preventing any sort of comprehensive & coherent responses. The AIB wouldn't have had such intimate detailed knowledge of my medical conditions & disabilities which they have adversely used & applied against me if my medical records were not illegally accessed; especially by law enforcement. The board was then very irate & defensive again blaming me the victim of these disabilities when I pleaded with them to cease & desist with this highly insensitive & inhumane line of questioning that was not germane to the AIB scope & purpose. Their cruel & humiliating actions were taken immediately after I read a heart felt & emotional statement regarding the severe obstacles & difficulties of living & working with disabilities including cruel & insensitive remarks & behaviors from others & the lifelong struggle of assimilating back into civilian life as a disabled veteran. I told them that not all disabilities are obvious. Not all disabilities are glamorous. Not all disabilities are convenient. Not all disabilities have a heroic story. Not all disabilities are pleasant. However, they are very real for the victim that has to suffer with them on a daily basis. I stated that they would never think to blame a blind person for their visual impairments or a paralytic for their physical limitations, so why did they think that they had the liberty & latitude to make fun of me? Mocking my disabilities & blaming me for my disabilities went way beyond the mandate & scope of the AIB. I told the board that we found their remarks & behavior to be cruel, offensive & disrespectful. The board also made absolutely no provisions to accommodate my multiple disabilities having endured nine hours of interrogation on 6/27/13 & 6/28/13 under duress with a constant VA police escort even to use the bathroom.

BRADY VIOLATIONS VA NORTHPORT NY

As your office is well aware, the AIB at VA Northport committed numerous Brady violations as outlined in this enclosed memo & prior correspondence to your office. The privacy officer Steven Wintch refuses to release any of the FOIA documents to aid in my defense with requests dated 6/14/13 and 7/1/13. Both requests are way past due of the 20 business day requirement. Again, this is a Brady violation since the nature of their allegations/charges involve work place violence, patient abuse and a VA cop illegally accessing my medical records which was used illegally against me in the AIB interrogation in a biased & discriminatory manner as your office is aware.

GAG ORDER

Please be advised that Dr. Younghee Limb continues to taunt, harass & humiliate me at the VA Northport NY. The certified letters that she sends me are riddled with condescending meanness that belies management's outright contempt & bias against me for my multiple service connected disabilities. My 4th Amendment rights were violated when a VA police officer et al illegally accessed my VA medical records as your office is aware is a Prohibited Personnel Practice. This constitutes illegal search & seizure since the VA Northport management used this illegally obtained information against me in a damaging, twisted & criminal method during this AIB debacle; just because my employer is also the maintainer of my medical records does not excuse

the VA going through legitimate legal procedures to access my Protected Health Information & how that information will be used against me. My 14th Amendment rights were violated since I was denied due process with the above illegally obtained information used against me as a veteran & a patient denying access to my benefits that I am entitled to by law as a 100% disabled veteran. My 1st Amendment rights have been continually violated since Dr. Limb acting as management's mouthpiece has threatened & harassed me with a gag order to prevent me from contacting your office; again this obstruction interferes with my rights as an American citizen & my rights as a 100% disabled veteran from contacting your office to inform you of the corruption & criminality that is going on at the VA Northport NY in this instance since a hostile personnel action was extended to me as a veteran & a patient. Dr. Limb & management express no remorse for their heinous & egregious inhumane treatment of me as a 100% disabled veteran. Dr. Limb taunts me in her letters by repeatedly & sarcastically stating that management is "concerned" for me. According to the VA Northport patient advocates Mr. William Marengo & Ms. Fran Maida, senior management's only concern in this matter is my termination. I've filed multiple complaints with the patient advocate office including patient abuse since the severity of the police restriction exacerbates my PTSD to the extent that it is a barrier for me to access the counseling that I so desperately need at this stressful time. Yet Mr. Moschitta's & Ms. Joanne Anderson's response to a fee basis request to obtain treatment & counseling privately & locally for my multiple service connected disabilities was an emphatic, "...tough shit..." according to the patient advocate's office. Mr. Marengo stated that management's reply was, "...too bad...Mr. Fasano has two options...he can either be a man about it with a police escort at Northport...or he can go to the other hospitals in the VISN [3 - Manhattan, Brooklyn, Bronx, Hudson Valley]...where he doesn't need a police escort..." According to Dr. Bernard Hinkel with the VA Office of the Medical Inspector, my chart is not flagged. This deeply flawed hostile action against me as a veteran & patient makes no sense - since I'm labeled a "dangerous person" by Dr. Limb & Mr. Moschitta requiring a police escort at the VA Northport (based on the corroborated lies of my ex sister in law who holds a bitter family grudge & a disgruntled social worker that illegally conducted background checks on veterans as a pre-text to deny access to the Palliative Care Unit), why can I freely access the other VA facilities without a police escort? I explained to the patient advocate, Mr. Shinseki's office & my federal politicians that the round trip commute to the other VA facilities is greater than 100 miles. This is an arduous & painful journey due to my multiple service connected disabilities & I can only drive limited distances as a result of my 100% disabling conditions. However, management claims to be "concerned" about me with Dr. Limb taunting & mocking me that they "acknowledge" that this is stressful - I bet they all have a good laugh at morning report since they've extended the AIB to at least 8/1/2013 - so how much longer must I suffer without any counseling, treatment or access to my entitlements? This is cruel & unusual punishment in the absence of any wrong doing based solely on lies, hearsay & false allegations. This denies my 6th Amendment right to face my accusers & to face the "charges." This denies my right to a fair & speedy trial. This denies my right to life, liberty & the pursuit of happiness since I'm stuck in this VA imposed limbo state. How can you tolerate Dr. Limb's & Mr. Moschitta's lies in prior written correspondence that management was trying to "expedite" this AIB? Is this treatment of a 100% disabled veteran the VA's way of expressing concern? Is this what Mr. Shinseki intended in the I-CARE initiative? Is this Mr. Shinseki's plan of VA transformation to make the care "veteran centric?" Is this Mr. Shinseki's plan to bolster the VA workforce with 40% veterans only to terminate them based on illegally obtained disabilities that are used against us by an AIB that is wholly anti-veteran & anti-disabilities? Is illegally

accessing my medical records & using that information against me during nine hours of grueling interrogation by an AIB that was biased, prejudiced & racist showing "genuine concern?" Does Mr. Shinseki know that the VA Northport director, Mr. Phil Moschitta authorized, sanctioned & approved this entire illegal effort to have me removed lining up a bunch of management stooges that sold their souls to the devil of self promotion/ preservation to trump up bogus "charges" against me? Does Mr. Shinseki know that Mr. Moschitta & Dr. Limb are retaliating against me for exposing the corruption & fraud in the facility; especially the climate & culture of appalling patient safety/hazards in long term care that they instilled? Management brutally suppressed the filing & documentation of patient safety issues with the long term care service chief convulsing in a temper tantrum any time that a patient safety incident report was filed to force a submissive capitulation hiding the dangers & flaws in long term care. I consider this whistle blower retaliation according to the Office of the Special Counsel's Prohibited Personnel Practices having informed the director of serious patient safety issues in Long Term Care whose reporting & documentation was being brutally suppressed by management to the extent that the service chief would convulse into a temper tantrum screaming & threatening anyone for filing 2633 incident report forms prior to the electronic ePers version; creating a culture & climate of fear of reprisals v. doing the right thing for veterans. I also exposed & reported a dangerous & pervasive drug problem in long term care; especially CLC 4 with substantial amounts of illegal drugs, contraband & weapons amongst patients, visitors & staff, however Dr. Limb flipped out on me for doing the right thing stating, "...you should've just ignored it...now I have to deal with the fall out..." It's no small wonder that Long Term Care has received the absolute worst possible ratings by the Long Term Care Institute Surveys for nearly three consecutive years without any sense of course correction. It was this mess & broken environment that I was forced to conduct business on a daily basis fighting a Sisyphean task eventually being crushed by the boulder of retaliation to force a submissive capitulation. This is also reprisals for reporting to the union office & the patient safety officer serious safety issues with the Mobile Health units since they had toxic exhaust leaks with the fumes permeating the exam rooms & very loud generators exceeding acceptable decibel levels. Does Mr. Shinseki know that VA Northport long term care service has never met any of the VA performance measures rating the absolute worst score on the Long Term Care Institute surveys for three consecutive years? As a cadet & officer in the Army, I was always taught that the standard is what you allow to tolerate around you. My personal standards are very high setting the bar high - it's too bad that the VA Northport promotes & fosters the opposite to maintain the status quo. Does Mr. Shinseki tolerate this behavior & dismal performance rating from his subordinate supervisors? Does Mr. Shinseki tolerate & foster discrimination & biased against disabled veterans? Does Mr. Shinseki tolerate & foster the taunting, humiliation & prejudice against disabled veterans by a largely apathetic civilian VA workforce that has outright contempt & seething animosity towards all things veteran? To borrow a quote from the ANZAC troops on the shores of Gallipoli in WWI, the VA command ship has run aground on empty gin bottles referring to a quip often used by the grunts for their disdain of a command that was remote, detached, incompetent & indifferent to the dire situation & suffering faced by the men in the trenches.

VETERAN ABUSE VA NORTHPORT NY
100% DISABLED VETERAN DENIED ACCESS TO CARE

As your office is fully aware, I continue to be victimized repeatedly by senior management at the VA Northport NY with scores of VA employees on multiple occasions illegally accessing my

VA medical records. My Protected Health Information (PHI) including but not limited to my service connected disabilities (Post Traumatic Stress Disorder) was illegally used by VA Northport senior management at the direction of the facility director Mr. Phil Moschitta when he levied a unilateral hostile personnel action against me as a 100% disabled veteran/patient labeling me a dangerous person in his maniacal retaliatory efforts that I've communicated to your office. Senior management's attempts to illegally rid me of federal employ & illegally discharge me as a veteran was based in large part on the lies of my ex sister in law (who holds a bitter family grudge) & senior management weaponizing my racist detractors allowing them to vent their personal grievances & prejudicial proclivities against me to prop up their empty accusations. This was authorized, sanctioned & orchestrated by the facility director Mr. Phil Moschitta who has an open express personal animus against me. Any attempt to contact Mr. Michael Sabo, the VISN 3 director's office for help has been equally rebuffed & refused with his complicit condoning of the illegal conduct of his subordinate supervisors. In so doing this, the VA Northport senior management violated many laws, federal statutes & VA regulations that I've fully communicated to your office in detail on many occasions. On 5/28/2013, Dr. Limb (Long Term Care service chief) at the behest of Mr. Moschitta had me escorted off the campus grounds by the VA police placing me under de facto house arrest. I was humiliated & shamed being paraded around like a POW in front of my colleagues, friends & fellow veterans to satisfy Mr. Moschitta's grotesque vengeful retaliatory lust conjuring up images of dead Rangers being dragged through the streets of Mogadishu Somalia in 1993. Mr. Moschitta has denied my access to health care & impeded my ability to access my benefits that I'm entitled to by law despite having filed many complaints with elected congressional officials, Mr. Shinseki's office, the VA Northport patient advocate, etc. Mr. Moschitta has obstructed my ability to receive emergency medical care including but not limited to mental health counseling for my service connected PTSD. Mr. Moschitta continues to taunt, embarrass & humiliate me in his wicked attempts to provoke my PTSD by claiming in his congressional response letters to the above action that he & other senior management officials that engaged in this gross criminal misconduct were "concerned" about me when he ordered the VA police to illegally detain me without charges & without due process denying my access to health care & benefits that I'm entitled to by law. However, they NEVER took the proper steps to ensure & demonstrate their "concern." They violated the VA mental health protocol when they rushed to make a "clinical judgment" about me in the absence of a clinical evaluation/exam, however, Mr. Moschitta blames his decision to take this gross action against me on "a clinical decision" on behalf of Dr. Michael Marino (chair disturbed behavior committee). Mr. Moschitta based his vicious actions solely on a presumption of disability rooted in lies with information illegally gleaned from my VA medical records. However, Dr. Marino et al NEVER performed a medical/psychiatric evaluation. Dr. Marino et al NEVER assessed my risk of suicidal ideation (which is a mandatory requirement given that I am 220% service connected of which 70% is PTSD). By gross negligence as a supervisor & licensed medical professional, Dr. Limb et al endangered my mental, emotional & physical well-being in the absence of an evaluation under this duress. This blame should also extend to Dr. Michael Marino (psychologist, chair Workplace Violence/Disturbed Behavior Committee), Ms. Heidi Vandewinckel (social worker Employee Assistance Program), Mr. Nick Squicciarini (VA Northport police chief), Mr. William Marengo RN (patient advocate) & Ms. Fran Maida (patient advocate) since I pleaded with them on multiple occasions to have a fee basis request approved for counseling since the severity of the VA police escort restriction that Mr. Moschitta imposed was so crippling that it exacerbates my service connected PTSD to the extent that I can't return to

the VA Northport campus. The director is culpable since his responses to the multiple fee basis requests was an emphatic, "...tough shit..." preferring to humiliate me instead, parading me around like a circus freak show & to have me drive greater than 100 miles to the other VA campuses located in VISN 3 (a commute that I cannot endure to the nature of my service connected disabilities which VA Northport senior management is aware of since the patient advocate documented my complaints in full detail in the Patient Advocate Tracking System). Mr. Moschitta's logic is obviously flawed since he blames his decision on a "clinical decision labeling me a dangerous person" in the absence of any legal clinical evaluation. So if I'm deemed so "dangerous" that he levied this action against me, then how can Mr. Moschitta explain that I can freely go to any other VA facility within VISN 3 without the VA police escort restriction? Is my "danger to self & others" that he falsely alleges limited to the 11768 zip code of the VA Northport campus? Mr. Moschitta also granted a special accommodation to access my e-mail at the VA Bayshore NY satellite clinic without a restriction for 1 hour, so does this mean that I was not a "danger" during that 1 hour? This crazy rationale is so illogical that it proves my point that Mr. Moschitta has a personal animus against me that evinces himself & the agency's actions against me in the absence of any wrong doing, in the absence of a clinical exam & without due process! Mr. Moschitta did this in retaliation for an EEO complaint filed against his assistant Ms. Joanne Anderson RN. Mr. Sabo, Mr. Moschitta, Dr. Limb, Dr. Marino, Mr. Marengo RN, Ms. Anderson RN, Ms. Vandewinckel SW, Mr. Squicciarini & Ms. Maida NEVER did a suicidal risk assessment & they NEVER referred me to the crisis line should I need it. All the licensed professionals should be reported to their respective state licensing boards for misconduct, abuse, sanctions & disciplinary action. Is this the type of VA that you've envisioned? As a retired General, Mr. Shinseki should know that authority can be delegated but not responsibility. Is this the type of "concern" that you expect from your subordinate senior supervisors towards 100% disabled veterans? Is this the type of customer service that 100% disabled veterans should expect by VA senior management? Do you expect 100% disabled veterans be denied access to their entitlements based solely on lies, hearsay & the venting of personal grievances? This is clearly disparate treatment. The director and the agency is fully aware that the restrictions so severely exacerbate my SC PTSD that I cannot return to the VA campus which interferes with my rights and abilities to access my benefits that I am entitled to by law. Desperate pleas to the patient advocate which was recorded in the Patient Advocate Tracking System (PATS) for fee basis health care was equally rebuffed with an emphatic "tough shit" by the director - I was given the option of either going to Northport with the restrictions or to any of the other facilities within VISN 3 without the restrictions (the director was fully aware that neither option was feasible - I cannot endure the greater than 100 mile round trip commute to the other facilities since my service connected disabilities prevent this arduous journey in NYC metro traffic, again preventing me from accessing my benefits). Their logic is also flawed since they labeled me a dangerous person based solely on hearsay & baseless complaints with a "clinical decision" rendered by the Workplace Violence Committee in the absence of any wrong doing & a clinical evaluation. So is my danger only limited to the 11768 zip code of the VA Northport campus? The restriction prevents me from accessing emergency treatment since it clearly states that I must contact the VA police 24 hours in advance & coordinate an escort with them. So if I am in any sort of emergency I cannot go to Northport since it would violate the terms of the restriction. Emergencies are right now without the luxury of 24 hour advance notification. By design the restrictions prevent me from accessing even emergency mental health counseling. An ongoing OSC investigation into the wide spread illegal accessing of my VA medical records is proof

positive that the agency adversely used this illegally obtained Protected Health Information against me. Many comments made about me regarded me "dangerous" based solely on my massive physical appearance and features, cultural gestures & mannerisms, my SC PTSD resulting in me "snapping" & knowledge of my Airborne & Special Forces background. The disparate treatment of how I was abused compared to other employees including convicted felons. The director refuses to have my Workplace Violence complaints investigated. I filed workplace violence complaints against individuals that committed significant threats/actions against me leading up to Mr. Moschitta's AIB against me (the individuals are Ms. Cathy Fasano RN, Ms. Maryanne Tierney SW, Dr. Maureen Welsh psychologist, Mr. John Sperandeo SW, Ms. Melanie Brodsky SW, Mr. Matthew Bessel SW & Ms. Fran Ciorra SW). How come no action was taken against them when the director refused to have my workplace violence complaints investigated? Why did the director decide to dismiss my safety & well being in favor of his maniacal unilateral attempts to terminate me? The director's position has been clearly stated that his action taken against me was a "clinical decision on behalf of Dr. Marino." They can't just pick & choose which complaints to investigate. The director's clearly stated position in response to all of my complaints has been, "...AIB process was to protect all parties..." How does dismissing my complaints en masse protect me & my rights? The director also falsely alleges that he, "...had to keep moving me around because of all the problems I was causing..." Yet I was transferred to the Health Screening clinic in 2010 after sustaining wicked brutal abuse in Primary Care despite an exemplary performance as the Pain Specialist having implemented unprecedented improvements to care & health care operations. In fact every single management effort to terminate me as a probationary employee in 2009 - 2010 failed (7 fact finding investigations, 5 professional standards boards) - every single board disagreed with the false accusations against me. I excelled under the supervision of normal people like Marge Mitchell & Joe Ciulla having received three consecutive outstanding performance evals with three consecutive supplementary outstanding evals. Problems were again encountered when Mr. Moschitta moved his pet Joanne Anderson RN to oversee Community Relations to cover for her sham & failed Rural Health program. I was selected among others that interviewed & competed for the Long Term Care NP position in 8/2012 - Mr. Moschitta never moved me to that position as he so falsely alleges. Mr. Moschitta's timeline & authenticity is completely fraudulent. The director gloats & initially takes full credit for coordinating this AIB against me before soiling himself on the record, however, the AIB results had no findings to support his bogus claims or actions against me. It's riddled with lies & contradictions as expected. When reviewing Mr. Phil Moschitta's (facility director) lies, it's interesting to note that at first he plays the tough guy & takes full responsibility for the unilateral hostile action against me, however, he soils his pants when confronted on disparate treatment re: comparing similarly situated instances. He then does a complete 180 & blames the Workplace Violence Committee for influencing his decision making process to the extent that he states that the decision to take this wicked action against me was a "clinical decision" based solely on the "clinical assessment" of the Workplace Violence Committee including Dr. Marino (chief psychology), Heidi Vandewinckel social worker (EAP rep) & Mr. Nick Squicciarini (VA police chief). He repeats this shared blaming several times citing his decisions were based on a "clinical assessment", however, NO assessment was ever performed on me, supporting my claims that this was a unilateral action in a complaint letter that I sent to many elected officials since the VA endangered my well being in the absence of a clinical/psych eval & the director ignoring my desperate pleas for fee basis counseling. This statement further supports my claims that the director ordered others to illegally access my VA

medical records using that info adversely against me, hence, the ongoing Office of the Special Counsel investigation into the privacy breaches. However, when under a FOIA request all documentation regarding same, the facility privacy officer responded that no such documents existed. My union president had a meeting with the director & HR re: the AIB results on Friday 9/27/13, "...It's to my understanding in conversations with Mr. Moschitta (VA Northport director), HR & others that the AIB where Mr. Fasano was the subject/witness resulted in no findings of any kind...As we have always contended our position is that the allegations were false & baseless & the AIB report were consistent with our position clearing Mr. Fasano of any wrong doing. Therefore we humbly ask for a return date to reinstate Mr. Fasano without incident immediately. Thank you in advance for your cooperation & support..." I am very upset & frustrated that the VA Northport senior management, administration & VA law enforcement continues to violate my privacy & has weaponized my PHI against me. In addition to repeat offenders, there are new culprits. I was interviewed by the agency's Office of the Medical Inspector team on 9/10/13 for approximately 1 hour. A copy of the access logs (SPAR) was provided to them. It seems as if they are not interested in how the illegally obtained medical information has been & continues to be adversely used against me - this fact is inextricably linked to the continued illegal accessing of my medical records (mostly at the behest of the facility director Mr. Phil Moschitta). I sincerely hope that your office has the moral & testicular fortitude to directly intervene & resolve this matter favorably for me. Since your office has failed to personally respond/ intervene despite repeated correspondence from a 100% disabled veteran, I'll fulfill my patriotic duty by informing the American voting public via a press release of your apathetic anemic cowardly impotent acquiescence to this debacle. You shamefully tout your mantle of veteran advocacy when it's convenient only during a sleazy photo op that you can exploit for a dog & pony show but your just as big a phony as the rest of the corrupt elected officials for true involvement to improve a hopelessly broken VA. You're welcome that you sleep well at night due to my sacrifices & those of my fellow brothers in arms.

NATIONAL SECURITY BREACH VA NORTHPORT NY

My medical records have been illegally accessed repeatedly by many VA Northport NY employees without a legitimate medical reason in clear violation of any & all known applicable privacy laws, HIPAA regulations & VHA Handbooks 1605, 1605.1, 1605.2 & 1605.03. In addition to breaking the law, this represents a critical national security issue, since all veterans' sensitive & classified information can be easily accessed by America's enemies; particularly Al Qaeda (operatives, infiltrators, collaborators, sympathizers, terrorist informants, sleeper cells, etc.). The VA has already used this information adversely against me as a veteran employee & as a 100% disabled veteran. Sensitive information via the VA's Department of Defense portal can be easily accessed using this method on all of America's active, guard, reserve, retired & disabled veterans including but not limited to members of elite units such as the Navy's SEAL Team Six, the Army's Special Operations (Green Berets, CAG [Delta Force], Rangers, Task Force 160th, etc.), the Marine's Force Recon & MARSOC units & Air Force PJ's to name a few. Yet the VA does nothing to safeguard this critical vulnerability. This weakness remains unsecured with many foreign nationals employed by the VA in various capacities. A plethora of information can be easily gleaned & exploited using social engineering by America's foes including but not limited to collating data to determine the efficacy of their tactics against selected targets, refining, developing & enhancing their tactics based on this feedback/data since very detailed information is contained within the VA & DOD medical records such as the veteran's demographics, SSN,

DD Form 214, units, training, deployment history, assignments, wounds/injuries, wartime activities & locations, dates, names & ranks of comrades, etc. The enemy can even count the number of overall wounds they've inflicted on both personnel & equipment & the number of fatalities their tactics have caused. Since I've been victimized by the VA so many times by VA employees illegally accessing my medical records, how many other veterans & veteran employees have been victimized? How many veterans & veteran employees have been exploited whilst under the effects of sedatives or anaesthesia to fleece this classified info? What's the protocol to safeguard against this form of de facto interrogation? What is the full extent of this victimization & exploitation? The VA has weaponized this fundamental security flaw against veteran employees, however, without a full & proper investigation by your office it still remains unanswered how this info can be used in other nefarious ways that poses a clear & present danger to national security at home & abroad against US interests. Any intelligence analyst can easily develop & implement a devastating strategic anti-American endeavor both domestically & abroad using this massive privacy/security breach exploiting this hitherto unknown treasure trove of data. This information is printed onto unsecured unclassified public printers, multiple copies are made on unsecured unclassified copy machines & today's tech allows anyone to save & transmit screen shots with their cell/smart phone cameras & even mini I-pads/tablets making tracking, monitoring & regulating of this data very difficult to secure given the VA's current sloppy System of Records, criminal corruption from senior management & shoddy command & control with violating privacy breaches. The level of detail & minutiae required of veterans by the VA to prove that they have certain service connected conditions such as Post Traumatic Stress Disorder when filing for disability claims is astounding. The VA requirement for the veteran to prove their disabilities in light of the current backlog gives everyone a blueprint into how the American military operates in explicit detail. To ignore this would be complicit with a potential threat to our nation's security & that of our deployed troops overseas. Although the VA Northport privacy officer has known about this in my case for over two years, Mr. Steven Wintch refuses to investigate, report & carry out due diligence in this HIPAA violation which represents a critical systems breach as outlined above.

PRIVACY BREACH CONTINUES VA NORTHPORT NY

The only thing that evil needs to prevail is for good men like you to remain silent

As your office is well aware, my medical records have been illegally accessed repeatedly by many VA Northport NY employees without a legitimate medical reason as a result of the unilateral discriminatory & hostile personnel action that was taken against me in part due to VA Northport senior management & others who negatively influenced these biased actions against me because they stated that "...he (Joe Fasano) has PTSD (as a result of serving in the Army)...he's crazy...he must have just snapped...he (Joe Fasano) was Airborne...Special Forces...he's (Joe Fasano) is a big guy...he (Joe Fasano) must be dangerous..." This detailed information regarding my multiple service connected disabilities, injuries & service was illegally obtained & adversely used against me when my VA medical records were illegally accessed by multiple VA Northport employees whose temporal proximity to the illegal activity with the Administrative Investigation Board was beyond a mere coincidence. As a 100% disabled veteran employee, I am at a distinct disadvantage compared to my civilian employee counterparts since my Protected Health Information is easily accessible to all VA (Northport) employees. Alas, my employer is also the maintainer of my medical records. Prior to my employment at the VA Northport NY, no VA employee accessed my medical records, however, my medical records

have been illegally accessed many dozens of times since the start of my employ & continues unabated to the present (see the enclosed Sensitive Patient Access Report detailing the names, dates & times of all VA Northport employees that have illegally accessed my medical records - with many occurring at the direction of senior management). As I have noted in prior correspondence with your office, other VA Northport employees were aware of my disabilities & commented on them to me. I stated that this concerned me, as my disabilities were not public knowledge. In 2011, I began requesting access logs for my medical files through the Northport VAMC Privacy Office. I noted that I did not receive full responses to my requests & was ultimately forced to file a Freedom of Information Act request to obtain the full logs (although it is my right as a veteran, the facility privacy officer has placed this unnecessary hardship & burden upon me). Upon receiving the logs, I found that many individuals had accessed my medical records during the vetting process. A list of those individuals, along with their titles, where available & the dates of the illegal access have been faxed/ mailed to your office. On May 28th 2013, I was informed that a (bogus) complaint had been filed against me by my former sister-in-law, also a Northport VAMC employee (management). I was escorted off the VA campus by the VA police force in the absence of any wrong doing & placed on administrative leave without an investigation based strictly on lies & my disabilities which were adversely used against me by senior management. My disabilities are not obvious so it follows that senior management used my medical information by illegally accessing my medical records. An Administrative Investigation Board (AIB) was convened to review the fake allegations made against me. I was advised that I could only return to the Northport VAMC campus & all satellite & affiliate clinics if I provided 24 hour notice & was escorted by VA police. On June 27th & 28th 2013, I was brutally interrogated by the AIB, comprised of Paul Haberman Registered Nurse (RN) Chair, Steven Wintch Privacy Officer & Barbara Albanese RN under duress with VA cop intimidation. During the hearing, the AIB repeatedly & specifically referred to my service-connected disabilities in a humiliating & debasing manner. They denied any sort of special accommodation to have the interrogation conducted in a neutral/ sterile milieu opting instead to publicly humiliate me in a heavily trafficked highly public location as a form of agency bullying & intimidation tactics to force a submissive capitulation in attempts to stress & provoke my PTSD applying psychological fracture mechanics. During the period of time shortly before the complaint was made against me & continuing through my administrative leave, a variety of Northport VAMC employees including a VA police officer have illegally accessed my medical records whose temporal proximity is beyond a mere coincidence. A list of the employees who engaged in the access, their titles, where available & the dates of access have been faxed/ mailed to your office. A significant portion of these employees are not healthcare providers, but serve in senior management, administrative & law enforcement roles. Based upon the foregoing, Northport VAMC employees have improperly accessed my medical records in violation of the Privacy Act of 1974 (Privacy Act), the Health Insurance Portability & Accountability Act of 1996 (HIPAA) & Veterans Health Administration (VHA) Handbook 1605.2, Appendix A, *Functional Categories Identifying Appropriate Levels of Access to Protected Health Information* (January 23, 2013), which limits the access of particular employees to patients' full medical records. Further, the improper access constituted an abuse of authority. The Privacy Act is codified at 5 U.S.C. § 552a. Section 552a(b) prohibits agencies from disclosing any record contained in a system of records except with prior written consent of the individual to whom the record pertains. While § 552a(b)(1) allows for disclosure to officers & employees of the agency maintaining the record in performance of their duties, please note

that in this instance, I was not receiving care at the Northport VAMC, & thus, no access to my medical records could have been in connection with a provider's/ employees job duties. Further, the HIPAA Privacy Rule, found at 45 C.F.R. §§ 160 & 164, requires that covered entities, including the VA, "ensure the confidentiality... of all electronic protected health information the covered entity... maintains." Further, 45 C.F.R. § 164(a)(2) requires covered entities to protect against reasonably anticipated threats to the security of such information. VHA Handbook 1605.2 provides mandatory guidelines for the use and disclosure of patients' individually-identifiable health information. Handbook 1605.2 explains that VHA constitutes a covered entity &, as such, VHA is required to implement the "minimum necessary standard." This standard requires covered entities to establish policies to limit the use or disclosure of protected health information to the minimum amount necessary. To accomplish the goal of limiting the use of protected health information, VHA divides employees into functional categories, each with an appropriate level of minimum access. See VHA Handbook 1605.2, Appendix B, *Functional Categories Identifying Appropriate Levels of Access to Protected Health Information*. Individuals in administrative support positions, as outlined in Appendix B, have limited access to medical records when necessary to complete an assignment. VHA Handbook 1605.2, para. 6, specifically states that all VHA personnel must use no more protected health information than is necessary to perform their specific job function, & must not access information that exceeds the limits of their functional category. Paragraph 6 further notes that, even if an employee's position allows for greater access, the employee should only access the information necessary to perform their official function. As I did not receive care at the Northport VAMC, it appears that any access to my medical records by providers/ employees is unrelated to the completion of their job duties. Further, access to my medical records by Northport VA administrative & law enforcement personnel is necessarily unrelated to the provision of care regardless of whether I received care at the Northport VAMC. Thus, such access appears to be related to my employment at the Northport VAMC, which violates my right to privacy under the Privacy Act, the HIPAA Privacy rule, & VHA Handbook 1605.2. It is of note that such access to medical records is not likely possible for non-veteran VA employees. Permitting access to the records of employees who are veterans places those employees at a disadvantage during administrative employment proceedings. This appears to be a systemic pattern of improper access to veteran-employee medical records. See OSC File Nos. DI-11-2679 & DI-11-2798. In its supplemental report, the agency indicated that "24 percent (& rising) of VA's employees are Veterans... ." Based upon the foregoing, I am concerned that the privacy protections for veterans employed by VA, regardless of whether they receive care at the VA, may be compromised at other VHA locations, in addition to the Northport VAMC. Since law enforcement (VA police) was involved in the privacy breaches, I'm not sure if withholding any information, evidence or even restricting access to that information constitutes a Brady violation. Who authorized the VA police department to access my VA medical record? Did Gino Nardelli VA cop have the authority & the CPRS access codes to enter my VA medical records multiple times? This exceeds/ violates VA Handbooks 1605, 1605.1, 1605.2 & 1605.03 regarding the definitions of categories of job descriptions with associated levels of access & the minimum necessary standard in violation of my 4th, 5th, 6th & 14th Amendment rights without my consent & without a court order, subpoena, summons or warrant. It is important for me to note that Fasano is a common Italian surname to the extent that there is a town in Italy named Fasano. In dialect, Fasano means either dove or pheasant depending on the translation (hence my family coat of arms). Joseph Fasano is a very common Italian name so anyone that accessed my medical records would also have had

detailed knowledge of such demographic information including my full SSN because just doing a key word search by typing in the name Joseph Fasano or Fasano would list many hundreds of potential Fasano veterans. This may indicate a broader more sinister management implication. I am the only Joseph A Fasano 100% disabled veteran employed at the VA Northport NY & VISN 3. Any folks that accessed my medical records bypassed an alert page indicating my protected sensitive patient status. Prior to my employment no VA Northport employees accessed my medical records! According to the Sensitive Patient Access Report that I received under a FOIA request, my medical records continue to be illegally accessed by VA Northport employees including but not limited to Gino Nardelli a VA cop who illegally accessed my medical records on 5/24/13, again illegally accessed my medical records on 8/8/13 violating my 4th, 5th, 6th & 14th Amendment rights. Please advise & help ASAP - this has to stop; especially since a VA cop keeps going into my medical records (being a veteran employee places me at a distinct disadvantage v. my civilian counterparts since the agency has ease of access to my medical records being the maintainer of my medical records as my employer). The question is, if I was a civilian employee, would all of these people have easily accessed my private medical records? What reason & what information was obtained in my medical records that if I was a civilian the agency would've obtained from other legal/ legit sources? I want the illegal accessing of my medical records to STOP! The VA cop keeps accessing my medical records. The new SPAR reveals the same folks continuing to illegally access my medical records & additional employees as well who are seemingly not deterred being directed by senior management officials. Just because the VA can easily access my medical records doesn't give them the right to do so & the agency can't just bypass applicable agency regs, privacy laws & HIPAA regs. Tom Sledge illegally accessed my medical records on 8/7/13 - he is Joe Sledge's brother who is the Public Affairs Officer for the facility & the director's confidant. As you are aware after the agency took a unilateral discriminatory & retaliatory hostile personnel action against me as an employee & extended the ridiculous police escort restriction to me as a 100% disabled veteran preventing me from accessing my VA benefits on 5/28/13, that I've only returned to campus when compelled to do so during 9 hours of a grueling AIB interrogation on 6/27/13 & 6/28/13. So why are all these people constantly accessing my medical records? The illegal accessing of my medical records by VA Northport senior management, administration & a VA cop was NOT in the performance of official duties/ healthcare operations so they cannot apply that vague ambiguity to justify their criminal employment practices against me. Mr. Steven Wintch (VA Northport privacy officer) continues to taunt & humiliate me with his FOIA responses; especially the response dated 8/28/2013 whereby he blames me the victim of the agency's continued illegal accessing of my medical records with his stupid comments regarding the justification for the multiple violations of exceeding the minimum necessary standard of accessing my medical records - Mr. Wintch blames me for my proud military service for which I am 100% disabled, my service connected disabilities & my injuries - this is no excuse to illegally access my medical records. I am writing to you for immediate assistance to retain me as an employee at the Veterans Administration in Northport, NY. I am a 220% service connected disabled American veteran and DAV Life Member who served his country honorably, faithfully and with distinction. The VA Northport has imposed a severe hardship on accessing my benefits and healthcare that by law I am entitled to with an unjust police escort requirement. I was placed on a non paid duty status pending an investigation of me based on false accusations and allegations in my current duty assignment. I don't know how, whom or what to respond to since I've not been charged with any misconduct or wrong doing and I've received nothing in writing. I am being falsely accused of

misconduct which may very well lead to my termination according to rumors that are circulating the facility. To make matters worse, without due process or being formally charged with any wrong doing, I am barred from returning to the campus as an employee and as a veteran without a police escort interfering with my rights by law and abilities to access benefits and healthcare that I am entitled to based on my Priority Group I rating. It is very humiliating to be paraded around like an animal or a common criminal reinforcing the stigmata of mental health disease in the veteran population. These accusations are false and slanderous. I am unjustly and unfairly being treated as a criminal in the absence of any misconduct merely on hearsay and innuendos. I desperately plea towards your compassion and intervention to save me from the malicious and unjust treatment that I am enduring. There has been a groundswell of outrage amongst my colleagues and fellow veterans who overwhelmingly support me, however, the administration has only selectively questioned those that are antagonistic and biased against disabled veterans with mental health issues such as PTSD for which I suffer as a consequence of service to my country. Not all disabilities are glamorous. Not all disabilities are convenient. Not all disabilities have a heroic story. However, the stigmata of mental health disease amongst the veteran population and sad statistics are sobering. Since this unjust and shameful punishment has exacerbated my PTSD, I find it difficult to access the health care that by law I am entitled to since I am being paraded around in a grotesque freak show like a shackled circus animal on display for all to mock and snicker at. This should conjure up images of American POWs being paraded around the streets of Hanoi, Vietnam or the dead Rangers being dragged around the streets of Mogadishu, Somalia. I am humiliated and intimidated by this disparate treatment since the police escort is required even when accessing health care. My local chain of command is broken, biased and corrupt thus forcing me to contact you directly. This is no longer just a VA employee issue, this is about a 220% service connected disabled American veteran being discriminated against for his PTSD. I was featured in the Sine Pari Special Operations Forces 2000 edition since I was the first to introduce medical simulations training technology in the training of Special Operations Forces combat medics. I am also listed as a co-author and contributor to the Special Operations Forces Medical Handbook June 2001 and 2008 editions. How exactly does this disparate treatment fit into Mr. Shinseki's I-CARE initiative? Exactly how does this accomplish Mr. Shinseki's goals of boosting the VA workforce with veterans? Exactly how does this fit into Mr. Shinseki's agenda to reduce the unemployment, homeless and suicide rates for disabled veterans? This is very discouraging for all other veterans since I am held in high esteem and regard amongst my fellow veteran employees and the veterans that I serve. Is this fundamental leadership failure being promoted and tolerated from the top or is it just a local catastrophe?

PATIENT ABUSE

I am again contacting your office for immediate assistance in this matter as a 100% service connected Priority Group I veteran. The VA Northport, NY has imposed severe, brutal, draconian and maniacal restrictions on me to the extent that they significantly interfere with my ability to access my healthcare and benefits that by law I am entitled to. This represents a hardship that I cannot overcome without your help since the VA Northport administration refuses to work with me. I have fond memories of meeting you at the Hicksville VFW event on 1/25/2013 since I truly believe that you are a strong veteran advocate (it was your office that was instrumental in my 100% service connected rating). The administration refuses to produce in writing (which is my right as a patient) the exact reasons for the wicked sanctions barring me

from access to my healthcare and entitlements. Furthermore, the patient advocates Fran Maida and Bill Marengo conveyed management's callous disregard to seek medical attention at VA facilities that are greater than 100 miles round trip from my home instead of providing a local fee basis service. I consider this patient abuse since I've done nothing wrong and I've not been charged with any sort of wrong doing that would prohibit my rights to access care without any sort of due process. Also, my service connected conditions would make this arduous journey very painful. This patient abuse that I'm enduring was imposed by Dr. Limb who isn't even my VA provider and Mr. Philip Moschitta the facility director. The social contract with America has been broken and this sacred trust desecrated by the abusive and disparate treatment that I am receiving as a 100% service connected disabled American veteran. That social contract is that the military takes care of America and America takes care of its veterans, however, the moral fabric that this has been imprinted on has been torn to shreds - I've become nothing more than a human punching bag with an American flag draped over it for the VA Northport administration run amok with their seething jealousy and outright contempt for all things veteran. It is my duty and moral obligation as a veteran and American taxpayer to expose this corruption since it discredits you, dishonors all who have sacrificed for this nation and reflects poorly on the VA's commitment to provide care for its veterans. Since I've not received anything in writing from the VA, I sincerely hope that this is not just an anemic bureaucratic cowardly acquiescence of a greater moral dilemma. This seemingly impenetrable bureaucratic phalanx in lock step whose tarnished shields have become nothing more than rusted chamber pots emblazoned with the logo of government corruption and incompetence. The command situation has deteriorated so badly at the VA Northport that it is tantamount to the American flag flying upside down, whereby the tenants, values and virtues built on the backs of courageous men like me that define this great nation has been hijacked by a band of evil corrupt flunky bureaucrats. This moral compass is off course without leadership or direction - its needle spinning aimlessly in the black hole of reason, logic, ethics and morality that is the vortex of the VA Northport. I don't know what kind of grid to magnetic azimuth course correction can get the VA Northport's moral obligatory bearings back on track again. Please lead the way!

REASSIGNMENT RETALIATION

I am not at all thrilled or happy with my illegal reassignment - it is considered an adverse action & retaliation according to VHA handbook 5021 Disciplinary Actions for Title 38 employees & it violates the Master Agreement between NFFE & management, Article 26, Section 3, Part B, #2, "A major adverse action is a transfer taken against an employee"; especially in the absence of any wrong doing. The NFFE union doesn't agree with the reassignment as it is punitive. As a member of management Kristen Sievers will be in the new chain of command & she illegally accessed my medical records multiple times in 8/2013. Some of my new co workers such as Marie Irwin illegally accessed my medical records multiple times between 5/2013 - 9/2013 which is extremely awkward, uncomfortable, humiliating & intimidating; especially in light of the ongoing OSC investigation into the wide spread invasive privacy breaches. This will only enable continued agency discriminatory practices & various forms of workplace violence/hostile work environment against me so much so that I have been warned/advised that I am being set up for failure & not success in this new unsupportive work environment instead of placing me in a clinical milieu that highlights my strengths such as under Dr. Nasir in the Anesthesia Pain Clinic as per prior email correspondence - I do not feel safe going anywhere alone without Mr. Thomesen NFFE union president since I am afraid that Mr. Moschitta's stooges will file false

allegations against me now that they are well armed with the knowledge of my service connected disabilities such as PTSD. NFFE shares these serious misgivings since Mr. Moschitta refuses to have any of my Work Place Violence complaints properly investigated. I am being advised by my union to remain in the NFFE union office to complete the necessary training modules for the Comp & Pension exam certification recognizing that since the agency imposed such a brutal restriction for 6 months my reintegration will take many weeks with outstanding TMS mandatories requiring completion, reviewing hundreds of emails, prepping for EEOC hearings, active participation in the ongoing OSC privacy breach investigations, involvement in other protected activities, reviewing of AIB materiel, etc. - this is the work environment that I am returning to. Despite a return to work letter stating that the AIB was concluded, the AIB remains unresolved & open ended since NFFE feels that Mr. Moschitta wants to "screw Joe Fasano any way he can" by having an "outside" (unsure if external to the agency or just another VA entity) "review" the AIB report to support Mr. Moschitta's wrongful suspension notice. This also violates VHA handbook 0700 regarding AIBs & VHA handbook 5021 regarding disciplinary/adverse actions against Title 38 employees. NFFE is concerned that regardless of the findings there has been no progressive discipline violating VHA handbook 5021 & the Master Agreement between NFFE union & VA management, Article 26 Section 1 along with the fact that Mr. Moschitta (as the deciding official) threatened Mr. Fasano into a suspension in the absence of any wrong doing since there were no findings. This "external review" is an unprecedented form of disparate treatment consistent with a Prohibited Personnel Practice. The conflicting agency information is purposely deceitful. To reassign me in the absence of any wrong doing is retaliation; especially with the agency's refusal to provide the AIB report. To take an adverse action against me such as a reassignment requires 30 days advanced written notification with the terms, conditions & basis for the adverse action without written notification violates the agency's own regulations. Taking adverse actions against me without an AIB conclusion is a retaliatory Prohibited Personnel Practice since the agency is clearly delaying this sending conflicting deceitful signals. NFFE requests the AIB report & findings that support Mr. Moschitta's proposed suspension & Mr. Fasano's reassignment which is a change in work conditions. NFFE requests that Mr. Fasano's office will be in the NFFE union office until such time that the agency can provide a secured private office for Mr. Fasano to complete his requirements whilst maintaining his comfort & safe well being away from Mr. Moschitta. Mr. Fasano also requires a special accommodation to work at his own pace since his service connected migraine headaches preclude prolonged excessive working/viewing a computer monitor due to the extreme eye fatigue & exacerbating nature of same. Mr. Fasano requires an office space where the flourescent lighting can either be dimmed or shut off because of same service connected disability. Mr. Fasano's supervisory, clinical & administrative service line is way too convoluted & complicated with too many supervisory overseers pulling Mr. Fasano in too many competing directions. NFFE requests a clarification on Mr. Fasano's supervisory, clinical, disciplinary & administrative service line & a linear service line in keeping with all other employees.

VETERAN ABUSE VA NORTHPORT NY
100% DISABLED VETERAN SHAMED BY VA

Please be advised that I was informed today by Mr. Richard Thomesen (NFFE union president VA Northport NY) that Mr. Phil Moschitta (VA Northport director) has proposed a suspension in the absence of any wrong doing & without providing any written notice, terms, conditions or

basis for the proposed hostile action against me. This may prevent me from renewing my RN & NP licenses in NY state. Your office is fully aware of the atrocious nefarious unilateral hostile personnel action that Mr. Moschitta levied against me as a 100% disabled veteran. Mr. Moschitta has prevented me from accessing the health care & benefits that I am entitled to by law for five months & has denied my access to mental health counseling, benefits, etc. I am very worried that this will negatively effect my re-credentialing & re-privileging (a process that all VA providers have to go through every two years) - the suspension + being out of work on a paid non duty status may prevent my ability to get re-certified thus ending my VA employment along with stymieing my ability to renew my RN & NP licenses will result in me being unemployed with the VA & I will be unemployable anywhere else without a license as a disabled veteran. I will also be unable to renew my DEA registration number effectively making me further unemployable. This will raise my malpractice insurance premiums incurring further costs that I cannot afford. Mr. Moschitta continues his personal animus against me since he loathes all things veteran by reassigning me under Dr. Tank (whom I have an active EEO case against) to do C + P exams. This is another disaster in the making setting me up for failure. Please advocate on behalf of this 100% disabled veteran by sending a very strong & assertive correspondence to the VA (regional counsel, Mr. Michael Sabo VISN 3 Director & Mr. Eric Shinseki VA Secretary) regarding your stance as my elected official & your proposed courses of actions to include but not limited to a press release exposing what Moschitta has done to a 100% disabled veteran. Despite the fact that I am getting paid, I have sustained substantial damage since Mr. Moschitta's restrictions interfere with my rights & abilities to access my VA benefits including but not limited to health care since they are well aware that the restrictions that he so savagely imposed severely exacerbate my PTSD. Also, by design, Mr. Moschitta's restrictions prevent me from accessing VA health care in an emergency since I am forced to coordinate a VA police escort 24 hours in advance; an impossibility during an emergency since emergencies by definition cannot be predicted 24 hours in advance. **This CANNOT be legit & this will not go over well with the American public since this maniac has been enabled to violate & humiliate me - this shameful disgrace will be exposed to the American voting constituents in a press release. The American public will also be informed of all of the nefarious & terrible patient safety hazards that Mr. Moschitta has negligently condoned/ignored during his reign of terror; a fact that I exposed internally, alas, he decided to retaliate against me when I brought these patient safety issues to his attention rather than correcting the situation.** The restriction prevents me from accessing emergency treatment since it clearly states that I must contact the VA police 24 hours in advance & coordinate an escort with them. So if I am in any sort of emergency I cannot go to Northport since it would violate the terms of Mr. Moschitta's restrictions so by his design the restrictions prevent me from accessing even emergency mental health counseling. An ongoing OSC investigation into the wide spread illegal accessing of my VA medical records is proof positive that the agency adversely used this illegally obtained Protected Health Information against me. Many comments made about me regarded me "dangerous" based solely on my massive physical appearance & features, cultural gestures & mannerisms, my service connected PTSD & knowledge of my Airborne & Special Forces background. This is disparate treatment of how I was abused by Mr. Moschitta compared to other employees including convicted felons. The director refuses to have my Workplace Violence complaints investigated so how can Mr. Moschitta claim that his actions are, "...protect all parties involved..." - how is he protecting me & my rights; especially against the parties that

I've filed workplace violence complaints against by dismissing my complaints en masse refusing to have them properly investigated?

VA NORTHPORT ADVERSE ACTION

As your office is well aware, the VA Northport senior management at the direction of Mr. Phil Moschitta (director) continues to harass, abuse, bully & intimidate me. I have been reassigned upon my return to work which is considered an Adverse Action; especially in the absence of any wrong doing having been cleared by the AIB resulting in no findings. In a meeting today 11/13/13 with the associate director Ms. Maria Favale & the chief of Human Resources Mr. William Sainbert, they refuse to provide me & my union the basis for the reassignment which is an Adverse Action against me & they refuse to provide me & my union with a copy of the AIB report justifying this Adverse Action. I was also told that my new office will be "in a location where I can be watched closely" by Ms. Favale who falsely accused me of not reporting to work, falsely accused me of doing union work in the NFFE union office & not knowing my whereabouts despite the fact that my reintegration after 6 months of a paid non duty status will require extensive computerized training to catch up on mandatory annual training requirements AND to be "certified" in my illegally newly reassigned position. A Return to Work letter that I received clearly states that I will report to Dr. Ed Mack (Chief of Staff), however, Ms. Favale & Mr. Sainbert insist that I report to Ms. Nancy Mirone as my supervisor in the business office. Ms. Mirone CANNOT be my supervisor since she is not a health care provider & is not a clinician. Since I am a Title 38 Nurse Practitioner Health Care Provider, I can only be supervised by another clinician (Ms. Mirone lacks the clinical competencies & academic/clinical credentials required to properly evaluate me). The meeting was very toxic & confrontational with Ms. Favale & Mr. Sainbert's yelling, lying, falsely impugning me, dismissing my concerns, etc. with Ms. Favale frequently stating, "I don't care...I don't want to hear it...it's not my problem." I was informed that the AIB report is now being "externally reviewed" by another VA facility, however, this is tantamount to "double jeopardy" since there were no findings at the local level – simply put they're taking another bite at the same apple. I also expressed serious misgivings regarding my new work environment since many employees in this department were involved in the illegal accessing of my VA medical records including but not limited to Marie Irwin, Tom Sledge & Kristen Sievers (all of whom report to Ms. Mirone) representing a severe conflict of interest in light of an ongoing OSC investigation. This is just another management tactic of humiliating, intimidating & bullying me since they have extensive knowledge of my service connected disabilities due to the widespread massive systematic privacy breaches of my Protected Health Information. This exposes me to increased discrimination, harassment, ridicule, scrutiny & bias just as this illegal action taken against me has been. I will not have my office in Building 10 or any other location within the proximity of Mr. Moschitta & his henchmen since it increases my vulnerability to management's hostilities towards me as a 100% disabled veteran. Quite frankly I am very frightened of Mr. Moschitta & his stooges since I am the victim of his veteran/patient abuse which still has not been investigated by the agency. Mr. Moschitta also dismissed my numerous Work Place Violence complaints – I feel unsafe anywhere outside of the NFFE union office. It will take me quite a while to reintegrate involving extensive computer based training which can be done anywhere on campus, so this locality restriction is just another form of spying & increased surveillance which is a Prohibited Personnel Practice & an extension of Mr. Moschitta's illegal police escort restriction against me as a veteran. Mr. Moschitta will continue to direct others to scrutinize & falsely report my every gesture, inconvenient disabling

features, cultural expressive mannerisms, facial features, voice intonations, speech pattern, etc. just as he has already adversely used these against me as a 100% disabled veteran. I also requested a special accommodation based on my disabilities including but not limited to pacing myself with computer based training since this platform along with glaring fluorescent lighting exacerbates my headaches causing excessive eye fatigue (as part of my service connected disabilities). My service connected PTSD is exacerbated by exposure to stress and noxious frightening triggers such as my aforementioned feelings of compromised safety & well-being by the director's express personal animus against me. My orthopaedic/ neurological service connected disabilities require stretching, walking & changing positions to alleviate the pain, however, I am afraid that the director will continue to use this adversely against me as a 100% disabled veteran illegally denying my access to care as he did for 6 months. I require a zone of privacy which was previously violated by management in light of the required involvement to participate freely in protected activities such as interacting with investigators for active & pending investigations against the agency, with attorneys, elected officials, union reps, etc. Your prompt assistance in this matter is greatly appreciated & quite frankly demanded as a 100% service connected veteran.

VETERAN DISENROLLMENT

As your office is aware, many employees at the VA Northport NY continue to illegally access my medical records including non-clinicians in senior management, administration & VA police officers. I have some additional updates & information regarding the director's illegal accessing of my VA medical records with disturbing new revelations regarding the continued illegal accessing of my VA medical records. According to a high ranking confidential source, Mr. Thomas Sledge (who illegally accessed my medical records in August 2013) whilst working in veteran registration & enrollments was directed by his supervisor Ms. Kristen Sievers (who illegally accessed my medical records four times in August 2013) on behalf of the facility director Mr. Phil Moschitta (who has orchestrated & directed the unilateral hostile discriminatory retaliatory biased action against me based on illegally obtained info from my medical records) was ordered to remove me from the patient registration & eligibility profile in attempts to desperately wipe out any sort of evidence & electronic foot print of the illegal accessing of my medical records at the behest of Mr. Moschitta. The timing of this is ominous since Mr. Sledge carried out this action on 8/6/13 - the day prior to the agency's Office of the Medical Inspector team's initial site visit investigation into the wide spread illegal accessing of my VA medical records. The ramifications & implications are highly criminal & will obstruct my ability to access my healthcare including but not limited to emergency care should I need it in the event of a medical crisis. Mr. Moschitta already has denied my access to all of my entitlements that I am guaranteed by law as a 100% disabled veteran when Mr. Moschitta levied a unilateral hostile biased personal discriminatory retaliatory action against me. Mr. Moschitta by doing so intentionally interfered with my ability to access all of my veterans benefits & entitlements including but not limited to healthcare & PTSD counseling that I so desperately need as a result of Mr. Moschitta's maniacal attempts to vent his personal hatred of me since he loathes all things veteran. Mr. Sledge was ordered by the director's office to "eliminate all traces of Joe Fasano" & when Mr. Sledge queried why he had to eliminate me from the system he was told, "...just do what your told...he (Joe Fasano) doesn't work here any more...the director (Mr. Moschitta) wants him out of the system now...to prevent any more accessing of his (Joe Fasano) records...& to wipe out any trace of him (Joe Fasano)..." Mr. Thomas Sledge is the brother of Mr. Joseph

Sledge who is the facility Public Affairs Officer working as the director's consigliere/confidant akin to Joseph Goebels of the Third Reich spewing forth the director's evil propaganda against me. Tom Sledge was told that he was "...covered..." due to his consanguineous affiliations. I believe the technical term for this deviant action is to "inactivate" & "disenroll" me from the system as a veteran & an employee; although I am still employed as a 100% disabled veteran. Also, the facility privacy office is refusing to release any further access logs including September 2013 to prevent me from filing additional complaints. This was done by Mr. Phil Moschitta to retaliate against me for filing the Office of the Special Counsel complaint since he has openly verbalized/vented his disdain, personal animus & anger regarding my filing of congressionals, EEO complaints & this OSC complaint - Mr. Moschitta thought that if he, "...got rid of Joe Fasano...this whole mess would disappear..." It appears the director's continued actions/hostilities towards me evinces him & the agency's retaliation for exercising my rights as a veteran.

WEINGARTEN RULE VIOLATION
PROHIBITED PERSONNEL PRACTICE
MAJOR ADVERSE ACTION

As your (OSC) office is well aware, I have been reassigned upon my return to work in the absence of any wrong doing; management refuses to provide any sort of rationale &/or justification for this Major Adverse Action. My newly assigned supervisors are Ms. Nancy Mirone (chief business office) & Ms. April Esposito (assistant chief business office) - neither has the credentials nor clinical competencies to be my supervisor.

As per the enclosed letter that I received on 11/15/2013, my newly assigned office is embedded in a heavily trafficked conference room with frequent constant disruptions used as a short cut by all staff. This was intentionally done by Mr. Phil Moschitta (facility director) in a statement uttered in an angry rage by Ms. Favale with a karate chop gesturing of her hands in a hostile meeting on 11/13/13, "...to closely watch you...where you can be closely monitored...to make sure you're doing what you're supposed to be doing..." This is just another form of Mr. Moschitta's (police) restrictions against me interfering with my rights as an employee, a patient & as a 100% disabled veteran.

The transfer/reassignment (Major Adverse Action) is further complicated by the fact that many new co workers including my new supervisor (April Esposito) illegally accessed my VA medical records multiple times recently as part of an agency targeted retaliatory discriminatory abusive hostile action against me - this massive privacy breach & these individuals are currently under investigation by the Office of the Special Counsel Disclosure Unit case # DI 13-3661. These individuals include April Esposito (my new supervisor), Kristen Sievers (chief eligibility & enrollment), Marie Irwin, Thomas Sledge, Nyny Romero, Omaidia Wilson, etc. (there may be others).

The conditions that I was presented with this letter (see attachment) supplants for a supervisory meeting proposed by Ms. Mirone (see attached email string) that was opposed by myself & my NFFE union in the absence of any union representation. Ms. Esposito presented this letter to me under premises of an interaction on the morning of 11/15/13 which supplants for the meeting that was protested. Thus union rules & the Weingarten rule were violated. The email from Mr. Carl Schramm (NFFE union steward) clearly states, "...one of NFFE's BUE's (bargaining unit employee), has requested union representation for this meeting. With the current

climate of this situation NFFE & Mr. Fasano feel that he is in need of representation at any meeting with management. As per current Labor Master Agreement between the U.S. Department of Veterans Affairs & the National Federation of Federal Employees, Article 2: Union Rights & Representation, Section 1 & Section 2 & under the Weingarten Rights a BUE has the right to request union representation if that BUE feels it is necessary. Unfortunately due to patient care responsibilities there is no one available tomorrow, Friday 11/15/13, to attend this meeting to represent Mr. Fasano. This meeting will have to be rescheduled." This meeting was not rescheduled & I was denied my union rights as described (see email).

My new assignment is very bad. I will be involved doing mostly fee basis non-VA care reviews & some Compensation & Pension exams. The very bad part is that Dr. Tank (whom I had a EEOC case against that was settled) oversees every aspect of each operation. I will be considered the 1st level reviewer & he is the 2nd level reviewer who will take every single opportunity to make my life miserable as he has constantly harassed & terrorized me in every capacity throughout the facility forming the basis for my 2nd EEO case against him. This is a repeat disaster scenario that they are clearly setting me up for failure.

I have very legit concerns, fears & serious misgivings that many supervisors & employees in the Business Office, Fee Basis Office, Eligibility/Enrollment Office & Compensation/ Pension Office were involved in the illegal accessing of my VA medical records since this could set the stage for a retaliatory adverse action negatively effecting/down grading my 100% disability rating.

Mr. Moschitta violated the Enrollment & Eligibility regulations by having Ms. Kristen Sievers & Mr. Thomas Sledge illegally disenroll me. Mr. Moschitta violated the Fee Basis referral policy regarding Fee Basis Care Requirements/Criteria when a veteran can access fee basis non-VA care. This process must include a clinical reviewer under the auspices of the Chief of Staff. The criteria are:

1. Veteran cannot safely travel to a VA facility due to a medical reason when Mr. Moschitta forced the option of either enduring an arduous greater than 100 mile round trip commute in heavily congested NYC metro traffic to the New York Harbor Health System campuses (Brooklyn, Manhattan, Bronx) or to have my service connected PTSD exacerbated under his illegal police escort restriction at VA Northport - despite his awareness which was well documented in the Patient Advocate Tracking System (PATS - you have been provided with the copies previously) by Mr. William Marengo RN (patient advocate) that my service connected disabilities preclude either option.

2. Veteran cannot travel to a VA facility due to geographical inaccessibility due to above. There is no policy on above regarding distance & time, therefore Mr. Moschitta by his own judgment circumvented the process in the absence of a clinical decision to vent his personal express animus against me.

3. The VA facility cannot timely provide the required service(s) when I begged Mr. Marengo for fee basis PTSD counseling when the director's response was an emphatic "...tough shit..." Since there is no policy of what "timely" is, if waiting for the VA care will put the patient at risk, then it becomes medically necessary. Waiting for PTSD counseling during a stressful crisis is dangerous patient abuse at the direction of Mr. Moschitta; especially when I've expressed the desire for counseling, Mr. Moschitta jeopardized my safety & well-being. Only the Chief of Staff can approve or disapprove based on a clinical decision; NOT the director as part of a hostile personnel action. By disenrolling me Mr. Moschitta interfered with my rights & abilities to a non-VA care fee basis referral & due process under same; especially in an emergency

setting. This reckless irresponsible behavior violated 38 CFR 17.106 & VA policies & procedures regarding fee basis referrals & restricting veteran access to care. Mr. Moschitta also violated the Hierarchy of Care decision matrix, Medical Necessity & Clinical Review processes. Mr. Moschitta further violated my patient/veteran's rights as codified in law 38 CFR Part 17 Ss 17.33 Patient's Rights; 38 CFR is the governing law for VA pensions, bonuses & Veteran's Relief - it provides guidance for medical care eligibility (see 38 CFR attachment). The police escort restriction must be ordered & reviewed by the Chief of Staff & reviewed every 30 days by same - Mr. Moschitta illegally circumvented this process which is illegal patient & veteran abuse. By usurping the Chief of Staff's clinical & administrative authority, placing me in great harm jeopardizing my safety & well being - you have a scanned copy of Mr. Moschitta's EEO ROI testimony where he lies about blaming this on a "...clinical decision made by the Disturbed Behavior Committee..." illegally extending a unilateral hostile personnel action against me as a 100% disabled veteran.

Further information regarding Title 38 employees can be found in VHA handbook 5021, the Labor Master Agreement between the U.S. Department of Veterans Affairs & the National Federation of Federal Employees & Title 38 U.S.C.: <http://www.law.cornell.edu/uscode/38/>

The Northport Center Memos are located under Northport VAMC Resources on the right side of the Frequently Accessed Resources page at:
<http://vaww.fwp.v03.med.va.gov/FrequentlyAccessedResources.html>

Attached to this response will be e-mail correspondence I received from my union president that was generated by VA management regarding the OMI investigation. I have some serious concerns with the transparency, legitimacy, fairness, conduct, objectivity and accuracy of the investigation since according to senior management the interviews/ meetings will not be recorded without any formal depositions or swearing in. So the investigation will be based solely on the agency's notes? I thought that all VA employees had to be sworn in on a notarized VA form 4505 granting the interviewees qualified immunity - otherwise management can influence the investigation to the extent that it will be "white washed." Also, in the absence of any formal depositions, oaths or recordings, how can the validity and accuracy of the proceedings/ testimonies be ensured, accessed or even FOIA'd since the implications can include criminal charges? This allows the culprits and management wiggle room without having been read or sworn in under oath for perjury including but not limited to Garrity warnings, Kalkines warning or even Miranda warnings.

There was a major conflict of interest at the local level regarding this investigation. Alas, the VA Northport facility director appointed Ms. Joanne Anderson to spearhead and coordinate the investigation at the local/ facility level. I have some serious misgivings with this since the potential for bias, interference and tampering is great since I had an open and active EEO case/ complaint against Ms. Anderson and added the agency's unilateral hostile personnel action against me as retaliation and discrimination to amend the complaint against her. Also, the facility director on many occasions since taking the hostile personnel action against me has voiced his extreme anger and displeasure with my EEO case involving Ms. Anderson that was eventually settled.

The VAs OMI team tasked with conducting the investigation re: the illegal accessing of my medical records initially refused to grant/ honor a reasonable accommodation request based

on my disabilities including but not limited to PTSD that they (OMI) and the agency were well aware of. I explained that the agency's unilateral discriminatory and retaliatory hostile personnel action levied against me included a VA police escort restriction any time I accessed the VA Northport's main facility and satellite clinics. This hardship severely exacerbated my PTSD to the extent that it is crippling and debilitating which is tantamount to senior management's bullying and intimidation tactics to force a submissive capitulation. The agency's OMI team wanted to conduct an in-person interview with me, however, they refused my reasonable accommodation request to have the interview conducted in a venue that didn't require the VA police escort. They were very rude and abrupt with me. Dr. Ed Huycke and Ms. Gladys Felan were very callous and disrespectful and fully dismissive of my disabilities. They refused to cite any rule, regulation or policy in their insensitive and discriminatory denials and failed to articulate any undue hardships that this request would impose. I explained that it is my right as a veteran, a 100% disabled person and an employee to make this request. It took a tremendous effort on my behalf, that of my union president and the OSC to have the request finally approved after several phone calls from Ms. Felan from the VA OMI team who reiterated their refusal by providing me options that only included a venue requiring a VA police escort restriction which exacerbates my disability; especially since a VA cop illegally accessed my medical records I am very fearful of the VA police force (I will develop flu like symptoms, nightmares and severe insomnia). Denying a reasonable accommodation request seems to be complicit with the agency's discriminatory practices. I was compelled to ask for this via the OMI team since they represent the agency as the investigating body re: the illegal accessing of my medical records. I've expressed my serious misgivings re: major conflicts of interest since it's the proverbial fox guarding the hen house scenario; especially with Ms. Joanne Anderson (whom I had a EEO complaint against that was settled) coordinating the efforts at the local level and how Dr. Ed Huycke OMI lead was treating me in a demeaning, humiliating and unprofessional manner. I've had several phone calls with the OMI team and they remained steadfast in their refusals placing an undue hardship and onus of responsibility upon myself as the complainant and a disabled person. I was very upset and shook up with how badly I was rough housed by Dr. Huyke (OMI lead) - his tone was very harsh, condescending, paternalistic, unprofessional and he hung up on me stating that he was "terminating the phone call" despite the fact that I remained a polite cordial gentleman during the entire humiliating encounter with him and the OMI team. I was eventually intervened by the agency's OMI team on 9/10/13 for approximately 1 hour. It seems as if they are not interested in how the illegally obtained medical information has been and continues to be adversely used against me - this fact is inextricably linked to the continued illegal accessing of my medical records (mostly at the behest of the facility director Mr. Phil Moschitta).

According to a high ranking confidential source, Mr. Thomas Sledge (who illegally accessed my medical records in August 2013) who works in veteran registration and enrollments was directed by his supervisor Ms. Kristen Sievers (who illegally accessed my medical records four times in August 2013) and the facility director (Mr. Phil Moschitta who has orchestrated and directed the unilateral hostile discriminatory retaliatory biased action against me based on illegally obtained info from my medical records) to remove me from the patient registration and eligibility profile in attempts to desperately wipe out any sort of evidence and electronic foot print of the illegal accessing of my medical records at the behest of Mr. Moschitta. The timing of this is ominous since Mr. Sledge carried out this action on 8/6/13 - the day prior to the agency's OMI team's initial site visit. The ramifications and implications are highly criminal and will

obstruct my ability to access my healthcare including but not limited to emergency care should I need it in the event of a medical crisis. Mr. Sledge was ordered by the director's office and when Mr. Sledge queried why he had to eliminate me from the system he was told, "...just do what your told...he (Joe Fasano) doesn't work here any more...the director (Mr. Moschitta) wants him out of the system now...to prevent any more accessing of his (Joe Fasano) records...and to wipe out any trace of him (Joe Fasano)..." Mr. Thomas Sledge is the brother of Mr. Joseph Sledge who is the facility Public Affairs Officer working as the director's consigliere/ confidant. Tom Sledge was told that he was "...covered..." due to his consanguineous affiliations. I believe the technical term for this action is to "inactivate" and "disenroll" me from the system as a veteran and as an employee - this was done by Mr. Phil Moschitta to retaliate against me for filing the OSC complaint since he has openly verbalized/ vented his disdain, personal animus and anger regarding my filing of EEO complaints and this OSC complaint - Mr. Moschitta thought that if he, "...got rid of Joe Fasano...this whole mess would disappear..." It appears the director's continued actions/ hostilities towards me evinces him and the agency's retaliation for filing an OSC complaint. The VA Northport director continues to escalate his personal animus towards me with his increasing hostilities including a proposed suspension in the absence of any wrong doing - his express open animus regarding the OSC complaint as per prior correspondence evinces him and the agency in retaliation/ reprisals. I fear that this will otherwise discourage many others from coming forward with similar complaints of privacy breaches as a form of VA Prohibited Personnel Practices (PPP) since the agency has so fiercely retaliated against me as a 100% disabled veteran (the logic being that if they can do it to me they can do it to anybody since being a 100% service connected disabled veteran is very rare). I will forward a formal memorandum for record seperately. I've been denied care and benefits by design of the director's severe restrictions:

*the police escort restriction so severely exacerbates my PTSD that I cannot return to the facility under any circumstances - this was clearly communicated to the agency to the extent that the patient advocate documented such in the Patient Advocate Tracking System (which I can scan and email to you). The exacerbation is very crippling and incapacitating.

*the director's response to multiple fee basis requests to have my health care benefits including but not limited to mental health counseling by private physicians paid for by the VA (which is an option for a 100% disabled veteran) was met with an emphatic "...tough shit..." as per the patient advocate. The director further stated, "...Joe Fasano can either man up and come to Northport with the police escort...or he can go to the other VISN hospitals..." according to the patient advocate. I've explained many times that I cannot endure this arduous 100 mile round trip commute in NYC metro traffic in light of the painful condition of my disabilities and the director denied transportation arrangement requests to the other facilities which I am entitled to as a 100% disabled veteran. This would still be a major inconvenience since I have the right to choose which facility I receive care/benefits. So again I was denied health care, benefits and alternative requests. I've incurred private medical and travel expenses as a result without reimbursement.

*the severe restrictions clearly state that I must coordinate 24 hours in advance with the VA police prior to setting foot on the Northport campus. This denies my health care and benefits in the event of an emergency since by definition an emergency cannot be predicted and/or

planned 24 hours in advance. So by design I cannot return to the campus in an emergency/crisis since I would be violating the severe terms and conditions of his restrictions.

*the removal appears to be limited to Northport. I've confirmed this via a confidential high ranking source who spoke directly to Mr. Tom Sledge regarding his access to my medical record on 8/6/2013.

*according to the union president I am the only employee that this has ever occurred to. I can provide you a by name list of employees that are convicted felons who did not face this type of personnel treatment and were never disciplined by the agency.

*the agency has mostly denied most of my FOIA requests for any documentation so it may be difficult at my level to obtain certain documents, however, an OSC investigation by the Complaints Examining Unit may shed light on this debacle.

I may have reviewed the many ways that I have been adversely affected by the VA including public and professional liable, slander, character defamation, humiliation, exacerbation of my disabilities, disruption of my personal, family and professional life, financial impact of spending nearly \$30K in legal expenses and now a proposed suspension with a reassignment despite no wrong doing.

Enclosed please find a notification of VHA privacy practices that I received. The VA Northport NY has consistently and criminally violated their own privacy policies, procedures, practices and regulations in addition to other federal laws, statutes and regulations governing privacy targeting me at the behest of the director. Mr. Moschitta ruthlessly used that illegally obtained Protected Health Information (PHI) against me as an employee and a veteran/ patient consistent with a PPP. The enclosed documents titled VANoPP1 - 8 clearly shows that the director and his henchmen were involved with evidence tampering since VA central office indicates that I was enrolled in VA health care as of 7/1/2013 which pre-dates the OSC investigation file # DI 13-3661 and the director's subsequent attempts on 8/6/13 - 8/7/13 to disenroll me from the VA to cover up his illegal activities against me the day prior to the agency's OMI initial site visit (the temporal proximity beyond a mere coincidence). This also appears to be tampering with and obstructing/ interfering with an OSC investigation by directing others to disenroll me and by appointing Joanne Anderson (whom I had an EEO complaint against that was settled) to be in charge of the investigation at the local level despite a pending hearing before the EEOC representing a conflict of interest. Furthermore, the letter that I received from VA central office dated 3/1/2013 (document titled VA NoHC1 - 3) clearly shows that the director clearly violated the VA policy, practice, procedure and regulation regarding emergency vs. non-emergency care by placing me on such a barbaric restriction (see also enclosed document titled VApg4). Finally the VA practice of flagging all veteran employee's charts with a warning cover page titled, "Sensitive Patient" includes such information as my disabilities and my disability rating (100%) so by design even if an employee doesn't actually bypass this alert page they will still obtain detailed health information about me, however, it is impossible to capture the employees that just merely clicked on the alert page cover sheet without actually going into my chart since the tracking system is designed only to capture those individuals that bypass the alert cover page and delve into the medical records representing a fatal fundamental privacy flaw/ vulnerability

jeopardizing my rights to privacy. This only serves to reinforce the handicapped/ disabled stigma. Laws, regulations, policies, procedures, practices, etc. are only as good, credible and valuable as the integrity of those enforcing them, however, in my case the criminal conduct of VA management and VA law enforcement has jeopardized this process as it was adversely used against me in a tangible employee action. Deliberately placing Mr. Steven Wintch (privacy officer) on the AIB as Mr. Moschitta testified to in the EEO ROI intentionally represented a retaliatory process since I've had issues for years with my privacy breaches that Mr. Wintch and Mr. Moschitta ignored, instead they decided to retaliate against me for whistle blowing rather than fixing a problem constituting a PPP.

Enclosed please find e-mail correspondence between Dr. Ed Mack the COS and HR re: the Adverse Action (suspension). 00 refers to the director Mr. Moschitta. I was informed by my union president that Dr. Mack was forced to sign off on the 3 day suspension under duress, however, Dr. Mack will be submitting a Report of Contact (ROC) that he was threatened with actions tantamount to retaliation if he refused to sign off on the suspension. I have included a copy of that ROC. Also, upon review of 38 CFR 17.106 and Part 1 Chapter 17, it appears that many laws were broken re: the police restrictions and other adverse actions taken against me as an employee and being extended to me as a veteran.

I will forward a series of email correspondence from the VA Northport privacy office regarding the massive privacy breach of my medical records. Please note the date/ time group pre-dates that OSC investigation DI # 13-3661. Mr. Wintch is the same privacy officer who was "hand picked" by the director as an AIB member. This is clearly stacking the deck as a retaliatory discriminatory agency practice since I raised these issues with the agency. Alas, most of the email correspondence has been deleted making the retrieval all but impossible for me at my level since Mr. Wintch and the agency have refused multiple FOIA requests for same. Mr. Wintch also lied under AIB testimony AND FOIA responses that he was unaware of my privacy concerns further eroding his credibility.

Enclosed please find a series of VA regulations to cite as further violations of my privacy, Protected Health Information forming the basis for the agency's PPP's against me:

Emergency Care Provision: Mr. Phil Moschitta (VA Northport director), violated this by design of his illegal police escort restriction interfering with my rights and abilities to access my entitlements and benefits by law including but not limited to health care. By refusing multiple pleas for fee basis care including but not limited to PTSD counseling he further violated these regulations jeopardizing my health, safety and well-being consistent with patient/veteran abuse by constantly breaking these laws; by doing so, Mr. Moschitta violated Section 402 of Public Law 110-387 according to the definition of emergency (see attachment). As I've previously contended, it's impossible to predict emergencies 24 hours in advance as Mr. Moschitta's police escort restrictions required 24 hour advance notification.

References: NNPO website - National Non-Va Care Program Office.
38 U.S.C. 1703 Pre-Authorized Non-VA Care
38 U.S.C. 1728 Emergency Treatment for Service Connected Veterans

38 C.F.R. 17.36 - Mr. Moschitta violated this law when he had Thomas Sledge illegally disenroll me on or about 8/6/2013 (see attachment). I far exceeded just about every categorical enrollment/eligibility requirement as a 100% disabled veteran.

38 C.F.R. 17.37 Enrollment not required - Mr. Moschitta violated this law since as a 100% disabled veteran I far exceeded any and all threshold requirements for eligibility and enrollment (see attachment).

38 C.F.R. 17.38 Medical Benefits Package - Mr. Moschitta violated this law by denying my rights to access care by disenrolling me and applying illegal police restriction interfering with my rights set forth in 38 C.F.R. 17.33 and 38.17.106 (see attachment).

VHA Handbook 1601A.04 - Mr. Moschitta violated this regulation by restricting access to my benefits and health care; denying Fee Basis care, due process and excluding the Chief of Staff Dr. Ed Mack from same (see attachment). Mr. Moschitta denied any due process rights and jeopardized my health, safety and well-being tantamount to patient abuse and veteran abuse.

VHA Handbook 1601A.04 Eligibility Determination - Mr. Moschitta violated this when he ordered Kristen Sievers, April Esposito, Pat Helgesen and Thomas Sledge to disenroll me.

Other pending privacy breach issues: the individuals involved in the massive systematic illegal privacy breach of my VA medical records and others may have also committed further privacy breaches by illegally accessing other sensitive data in the process such as the Veterans Information Solution (VIS) a.k.a. VBA or SHARE - a web based software for non-clinicians (management, supervisors, cops, clerks, etc.) to verify a veteran's military service and service connected disabilities/ ratings. VIS is a limited access system limited to Eligibility and Enrollment staff, however, the access MUST be for a legitimate medical/ business reason. Other potential privacy breaches involved alternate ways to access my data and PHI consistent with the privacy breaches by going into the Hospital Inquiry (HINQ) - this provides information on: military service, service connected disability ratings, eligibility, etc. The response to the FOIA request remains outstanding from the facility privacy office Mr. Steven Wintch.

Mr. Moschitta (VA Northport director) violated VHA Directive 2007-015 when he disenrolled me and forced me to seek care at other venues and VA facilities as reported many times and as documented by Mr. William Marengo RN Patient Advocate in the Patient Advocate Tracking System (PATS). This directive provides policy regarding the transfer of patients to and from the Department of Veterans Affairs medical facilities i.e. Northport, Brooklyn, Manhattan, Bronx, Hudson Valley. Mr. Moschitta violated 38 U.S.C. 1703 when he disenrolled me and refused fee basis requests denying my right to due process under same. According to 38 USC 1703 the VA purchases care from Non-VA providers when care is: not available, not economical, not available from another federal facility, not available under a contract/ shared agreement or the veteran cannot come to the VA (as was the case with me since Moschitta extended a unilateral hostile employee action against me as a 100% disabled veteran with his illegal police escort restriction). I very clearly established that Moschitta violated 38 CFR 17.106 with his illegal police escort restriction preventing me from accessing care and benefits. Going to the VA New York Harbor Health System as he proposed as one of only two "take it or leave it" responses to desperate pleas for fee basis care and PTSD counseling is both not economical due

to the increased travel costs and unreasonable as described many times since the long NYC metro traffic commute is painful and arduous due to my orthopaedic/ neurological service connected disabilities. In both instances (police restriction and fee basis denials) only the Chief of Staff (COS) Dr. Ed Mack can be involved and ultimately decide, however, Moschitta illegally circumvented the COS in the absence of a clinical decision making process by taking a unilateral hostile personnel action against me and illegally extending that to me as a 100% disabled veteran, therefore the Network Director Mr. Mike Sabo is ultimately responsible and culpable for the illegal actions of his subordinate director Moschitta according to law, code, regulation, policy and procedure. Since the VA Northport is the nearest VA facility to justify a fee basis claim a.k.a. Facility of Jurisdiction (FOJ) it is law that Moschitta would be obligated to pay for this care and offer me due process due to the geographical proximity to my residence. VA Northport would be the facility responsible for payment of Non-VA Medical Care utilizing Primary Service Areas (PSA), counties and zip codes.

References:

NNPO website under NVCC - Non-VA Care Coordination
website:<http://nonvacare.hac.med.va.gov/nvcc/>

Facility Locator: http://vaww.pssg.med.va.gov/PSSG/search_zipcode.html

When a HIPAA complaint is filed with the HHS, the first determination made is whether there was a possible privacy violation and whether it was of a criminal nature. If it was determined to be criminal, the case is referred to the Department of Justice for investigation and possible prosecution. If it was determined that it was not a criminal issue (as in this case) the violation is investigated by the OCR. If it is determined that a HIPAA violation did, in fact, take place, the OCR can either obtain voluntary compliance, corrective action or some other voluntary agreement with the offender, or the OCR can issue a formal finding of violation and force the offender to change its practices.

Enclosed please find some documentation that may be of some benefit. They are the director's EEO ROI testimony and the patient advocate's notes known as the Patient Advocate Tracking System (which are separate from my VA medical records). Precious little documentation has been released to me despite many FOIA requests. I am hopeful that the OSC Disclosure and Complaints Examining Units will accept my new complaints for investigation which would open up a treasure trove of data and dirty little agency secrets. At my level it is nearly impossible to go up against the monolithic bureaucratic behemoth that is the VA.

VETERAN ABUSE VA NORTHPORT NY
100% DISABLED VETERAN DENIED ACCESS TO CARE

I continue to be victimized repeatedly by senior management at the VA Northport NY with scores of VA employees on multiple occasions illegally accessing my VA medical records. My Protected Health Information (PHI) including but not limited to my service connected disabilities (Post Traumatic Stress Disorder) was illegally used against me by VA Northport senior management at the direction of the facility director Mr. Phil Moschitta to levy a unilateral hostile personnel action against me as a 100% disabled veteran/patient labeling me a dangerous person in his maniacal retaliatory efforts that I've communicated to your office. Senior management's attempts to illegally rid me of federal employ & illegally discharge me as a

veteran was based in large part on the lies of my ex sister in law (who holds a bitter family grudge) & senior management weaponizing my racist detractors allowing them to vent their personal grievances & prejudicial proclivities against me to prop up their empty accusations. This was authorized, sanctioned & orchestrated by the facility director Mr. Phil Moschitta who has an open express personal animus against me. Any attempt to contact Mr. Michael Sabo, the VISN 3 director's office for help has been equally rebuffed & refused with his complicit condoning of the illegal conduct of his subordinate supervisors. In so doing this, the VA Northport senior management violated many laws, federal statutes & VA regulations that I've fully communicated to your office in detail on many occasions. On 5/28/2013, Dr. Limb (Long Term Care service chief) at the behest of Mr. Moschitta had me escorted off the campus grounds by the VA police placing me under de facto house arrest. I was humiliated & shamed being paraded around like a POW in front of my colleagues, friends & fellow veterans to satisfy Mr. Moschitta's grotesque vengeful retaliatory lust conjuring up images of dead Rangers being dragged through the streets of Mogadishu Somalia in 1993. Mr. Moschitta has denied my access to health care & impeded my ability to access my benefits that I'm entitled to by law despite having filed many complaints with elected congressional officials, Mr. Shinseki's office, the VA Northport patient advocate, etc. Mr. Moschitta has obstructed my ability to receive emergency medical care including but not limited to mental health counseling for my service connected PTSD. Mr. Moschitta continues to taunt, embarrass & humiliate me in his wicked attempts to provoke my PTSD by claiming in his congressional response letters to the above action that he & other senior management officials that engaged in this gross criminal misconduct were "concerned" about me when he ordered the VA police to illegally detain me without charges & without due process denying my access to health care & benefits that I'm entitled to by law. However, they NEVER took the proper steps to ensure & demonstrate their "concern." They violated the VA mental health protocol when they rushed to make a "clinical judgment" about me in the absence of a clinical evaluation/exam, however, Mr. Moschitta blames his decision to take this gross action against me on "a clinical decision" on behalf of Dr. Michael Marino (chair disturbed behavior committee). This is tantamount to a psychiatric exam vis a vis "fitness for duty" punishment which is a Prohibited Personnel Practice. Mr. Moschitta based his vicious actions solely on a presumption of disability rooted in lies with information illegally gleaned from my VA medical records. Mr. Moschitta clearly states this several times during his EEO ROI to the extent that he goes on the record to state that he had them access my charts (meaning medical records). However, Dr. Marino et al NEVER performed a medical/psychiatric evaluation. So Mr. Moschitta claims on the record in the EEO ROI that this team performed made a "clinical decision" which can only mean that by definition they based their discriminatory assumptions on a "psychiatric exam" based solely on false one sided testimonies & illegally accessing my medical records. Mr. Moschitta even extends this "clinical decision" blame game to the VA Northport police chief (Nick Squicciarrini) who ordered a subordinate cop to access my medical records on 5/24/13 & 8/2013. Dr. Marino et al NEVER assessed my risk of suicidal ideation (which is a mandatory requirement given that I am 220% service connected of which 70% is PTSD). By gross negligence as a supervisor & licensed medical professional, Dr. Limb et al endangered my mental, emotional & physical well-being in the absence of an evaluation under this duress. This blame should also extend to Dr. Michael Marino (psychologist, chair Workplace Violence/Disturbed Behavior Committee), Ms. Heidi Vandewinckel (social worker Employee Assistance Program), Mr. Nick Squicciarini (VA Northport police chief), Mr. William Marengo RN (patient advocate) & Ms. Fran Maida (patient

advocate) since I pleaded with them on multiple occasions to have a fee basis request approved for counseling since the severity of the VA police escort restriction that Mr. Moschitta imposed was so crippling that it exacerbates my service connected PTSD to the extent that I can't return to the VA Northport campus. The director is culpable since his responses to the multiple fee basis requests was an emphatic, "...tough shit..." preferring to humiliate me instead, parading me around like a circus freak show & to have me drive greater than 100 miles in New York city metro traffic to the other VA campuses located in VISN 3 (a commute that I cannot endure due to the nature of my service connected disabilities which VA Northport senior management is aware of since the patient advocate documented my complaints in full detail in the Patient Advocate Tracking System). Mr. Moschitta's logic is obviously flawed since he blames his decision on a "clinical decision labeling me a dangerous person" in the absence of any legal clinical evaluation. So if I'm deemed so "dangerous" that he levied this action against me, then how can Mr. Moschitta explain that I can freely go to any other VA facility within VISN 3 without the VA police escort restriction? Is my "danger to self & others" that he falsely alleges in the EEO ROI limited to the 11768 zip code of the VA Northport campus? Mr. Moschitta also granted a special accommodation to access my e-mail at the VA Bayshore NY satellite clinic without a restriction for 1 hour on 9/10/13 to access e-mails that the agency's OMI team requested in the OSC investigation DI 13-3661, so does this mean that I was not a "danger" during that 1 hour? This crazy rationale is so illogical that it proves my point that Mr. Moschitta has a personal animus against me that evinces himself & the agency's actions against me in the absence of any wrong doing, in the absence of a clinical exam & without due process! Mr. Moschitta did this in retaliation for an EEO complaint filed against his assistant Ms. Joanne Anderson RN & for the current OSC investigation. Mr. Sabo, Mr. Moschitta, Dr. Limb, Dr. Marino, Mr. Marengo RN, Ms. Anderson RN, Ms. Vandewinckel SW, Mr. Squicciarini & Ms. Maida NEVER did a suicidal risk assessment & they NEVER referred me to the crisis line should I need it. All the licensed professionals should be reported to their respective state licensing boards for misconduct, abuse, sanctions & disciplinary action. Do you expect 100% disabled veterans be denied access to their entitlements based solely on lies, hearsay & the venting of personal grievances? This is clearly disparate treatment. The director & the agency is fully aware that the restrictions so severely exacerbate my PTSD that I cannot return to the VA campus which interferes with my rights & abilities to access my benefits that I am entitled to by law. Desperate pleas to the patient advocate which was recorded in the Patient Advocate Tracking System (PATS) for fee basis health care was equally rebuffed with an emphatic "tough shit" by the director - I was given the option of either going to Northport with the restrictions or to any of the other facilities within VISN 3 without the restrictions (the director was fully aware that neither option was feasible - I cannot endure the greater than 100 mile round trip commute to the other facilities since my service connected disabilities prevent this arduous journey in NYC metro traffic, again preventing me from accessing my benefits). Their logic is also flawed since they labeled me a dangerous person based solely on hearsay & baseless complaints with a "clinical decision" rendered by the Workplace Violence Committee in the absence of any wrong doing & a clinical evaluation. So is my danger only limited to the 11768 zip code of the VA Northport campus? The restriction prevents me from accessing emergency treatment since it clearly states that I must contact the VA police 24 hours in advance & coordinate an escort with them. So if I am in any sort of emergency I cannot go to Northport since it would violate the terms of the restriction. Emergencies are right now without the luxury of 24 hour advance notification. By design the restrictions prevent me from accessing even emergency mental health

counseling. An ongoing OSC investigation into the wide spread illegal accessing of my VA medical records is proof positive that the agency adversely used this illegally obtained Protected Health Information against me. Many comments made about me regarded me "dangerous" based solely on my massive physical appearance & features, cultural gestures & mannerisms, my PTSD & knowledge of my Airborne & Special Forces background. This is clearly disparate treatment of how I was abused compared to other employees including convicted felons who were not disciplined for committing felony offenses on VA property. The director refuses to have my Workplace Violence complaints investigated. I filed workplace violence complaints against individuals that committed significant threats/actions against me leading up to Mr. Moschitta's AIB against me (the individuals are Ms. Cathy Fasano RN, Ms. Maryanne Tierney SW, Dr. Maureen Welsh psychologist, Mr. John Sperandeo SW, Ms. Melanie Brodsky SW, Mr. Matthew Bessel SW & Ms. Fran Ciorra SW). How come no action was taken against them when the director refused to have my workplace violence complaints investigated? Why did the director decide to dismiss my safety & well being in favor of his maniacal unilateral attempts to terminate me? The director's position has been clearly stated that his action taken against me was a "clinical decision on behalf of Dr. Marino." They can't just pick & choose which complaints to investigate. The director's clearly stated position in response to all of my complaints has been, "...AIB process was to protect all parties..." How does dismissing my complaints en masse protect me & my rights? The director also falsely alleges that he, "...had to keep moving me around because of all the problems I was causing..." Yet I was transferred to the Health Screening clinic in 2010 after sustaining wicked brutal abuse in Primary Care despite an exemplary performance as the Pain Specialist having implemented unprecedented improvements to care & health care operations. I excelled under the supervision of normal people like Marge Mitchell & Joe Ciulla having received three consecutive outstanding performance evals with three consecutive supplementary outstanding evals. Problems were again encountered when Mr. Moschitta moved his pet Joanne Anderson RN to oversee Community Relations to cover for her sham & failed Rural Health program. I was selected among others that interviewed & competed for the Long Term Care NP position in 8/2012 - Mr. Moschitta never moved me to that position as he so falsely alleges in the EEO ROI. Mr. Moschitta's timeline & authenticity is completely fraudulent. The director gloats & initially takes full credit for coordinating this AIB against me before soiling himself on the record, however, the AIB results had no findings to support his bogus claims or actions against me. It's riddled with lies & contradictions as expected. When reviewing Mr. Phil Moschitta's (facility director) lies, it's interesting to note that at first he plays the tough guy & takes full responsibility for the unilateral hostile action against me, however, he soils himself when confronted on disparate treatment re: comparing similarly situated instances. He then does a complete 180 & blames the Workplace Violence Committee for influencing his decision making process to the extent that he states that the decision to take this wicked action against me was a "clinical decision" based solely on the "clinical assessment" of the Workplace Violence Committee including Dr. Marino (chief psychology), Heidi Vandewinckel social worker (EAP rep) & Mr. Nick Squicciarini (VA police chief). He repeats this shared blaming several times citing his decisions were based on a "clinical assessment", however, NO assessment was ever performed on me, supporting my claims that this was a unilateral action in a complaint letter that I sent to many elected officials since the VA endangered my well being in the absence of a clinical/psych eval & the director ignoring my desperate pleas for fee basis counseling. This statement further supports my claims that the director ordered others to illegally access my VA medical records using that info adversely against me, hence, the ongoing Office

of the Special Counsel investigation into the privacy breaches. However, when under a FOIA request all documentation regarding same, the facility privacy officer responded that no such documents existed. My union president had a meeting with the director & HR re: the AIB results on Friday 9/27/13, "...It's to my understanding in conversations with Mr. Moschitta (VA Northport director), HR & others that the AIB where Mr. Fasano was the subject/witness resulted in no findings of any kind...As we have always contended our position is that the allegations were false & baseless & the AIB report were consistent with our position clearing Mr. Fasano of any wrong doing. Therefore we humbly ask for a return date to reinstate Mr. Fasano without incident immediately. Thank you in advance for your cooperation & support..." I am very upset & frustrated that the VA Northport senior management, administration & VA law enforcement continues to violate my privacy & has weaponized my PHI against me. In addition to repeat offenders, there are new culprits. I was interviewed by the agency's Office of the Medical Inspector team on 9/10/13 for approximately 1 hour. A copy of the access logs (SPAR) was provided to them. It seems as if they are not interested in how the illegally obtained medical information has been & continues to be adversely used against me - this fact is inextricably linked to the continued illegal accessing of my medical records (mostly at the behest of the facility director Mr. Phil Moschitta). I sincerely hope that your office has the moral fortitude to directly intervene & resolve this matter favorably for me.

e-mail:

From: Richard.Thomesen@va.gov
To: joesepe@msn.com
Date: Mon, 7 Oct 2013 08:43:59 -0400
Subject: FW: second request

From: Marino, Michael
Sent: Wednesday, October 02, 2013 10:08 AM
To: Thomesen, Richard; Duryea, Margaret; Schramm, Carl; Walters, Richard J
Cc: Vandewinckel, Heidi; Carrington, Cheryl L.; Squicciarini, Nicholas; Burns, Amanda M.
Subject: RE: second request

Rich, as you are fully aware of, the Workplace Violence review team has no authority to conduct investigations of WPV or other complaints. We act in an advisory capacity to those who do have the authority and responsibility to investigate WPV or other complaints. When the Workplace Violence Review Team receives a complaint, part of our process is to determine if it falls under the purview of the program or whether it falls to another organizational function/process to review to determine what if any action is appropriate. The Workplace Violence Review team has seen over time what we refer to as reciprocal complaints. A Reciprocal complaint is a complaint filed by one or more staff members towards another staff member after a complaint(s) has/have been filed against them. In these cases, we have viewed these as essentially one complaint, and that reciprocal complaint is investigated by the responsible supervisors as part of one investigation. We do not investigate the complaint or the reciprocal complaints but advise and consult with the supervisors charged by the chain of command to conduct the investigation. In the situation you described below, the complaints that came to the WPV Review team, including the complaints brought forward through NFFE, were viewed as clearly sequential in nature and part of the same matter of concern. The Director determined an Administrative Board not the supervisory chain of command was the proper method to review and investigate the complaints

and related matters. The Director only has the authority to determine if a Board is appointed and if so, then the supervisors are not charged with conducting the investigation rather the board has that authority. The Workplace Violence Review Team did not have an ongoing role after the Administrative Board was appointed for any of the complaints forwarded to the Board to determine any appropriate investigation procedures or concerns. I will also add here information concerning The WPV complaint filed by NFFE on September 30, 2013 on behalf of JF. The complaint alleges a list of identified VA employees have illegally accessed the complainant's medical records ("VA employees for illegally accessing my VA medical records..."). Since allegations of privacy violations are under the auspices of the facility privacy officer, this complaint was forwarded to Mr. Wintch to determine what if any facility action is required. Please contact Mr. Wintch for any information concerning this complaint or follow-up action if appropriate from the complaint. This is not a matter appropriate for an investigation by responsible supervisors to be tracked under the purview of the WPV Review team. At this time, the WPV Review team would only be involved in some advisory capacity if and only if this is requested at by the privacy officer and/or by the chain of command for review and investigation, if appropriate.

From: Thomesen, Richard

Sent: Tuesday, October 01, 2013 9:20 AM

To: Marino, Michael; Duryea, Margaret; Schramm, Carl; Walters, Richard J

Subject: RE: second request

Mike; that is wrong, they were filed separate and apart from the AIB, you have said that the VWC would investigate issues brought to the committee via the Unions, now your shirk your responsibility to investigate issues that were separate and apart from the AIB. Your taskforce is supposed to investigate any work place violence issues. NFFE will be force to file a grievance on this lack of following your own rules. Nowhere in the policy is it stated that an AIB will cover your responsibility's. Furthermore, if there are no findings in regards to Mr. Fasano, that doesn't mean that there was no work place violence committed against him. He was the focus of the AIB, it doesn't mean that he did anything but it does mean that you as a professional need to address the issues brought to your committee as you would anyone else. NFFE will be available to discuss this at a mutually agreeable time and place.

From: Marino, Michael

Sent: Monday, September 30, 2013 2:53 PM

To: Thomesen, Richard; Duryea, Margaret; Schramm, Carl; Walters, Richard J

Subject: RE: second request

Rich as I believe you know they were forwarded promptly to the Point of Contact for the Administrative Board appointed by the Director. They were not investigated under the purview of the WPV Review Team/Program rather the authority/investigation by the Board determined the appropriate investigatory action and procedures.

From: Thomesen, Richard

Sent: Monday, September 30, 2013 9:16 AM

To: Marino, Michael; Duryea, Margaret; Schramm, Carl; Walters, Richard J

Subject: second request

Mike this is the second request to fine out the results of the Work Place Violence complaints that I had submitted for Mr. Joe Fasano. A meeting is requested on this subject.

I was informed by Mr. Richard Thomesen (NFFE union president VA Northport NY) that Mr. Phil Moschitta (VA Northport director) has proposed a suspension in the absence of any wrong doing & without providing any written notice, terms, conditions or basis for the proposed hostile action against me as I was cleared of any findings by the AIB that the director maliciously used to justify his abuse, discrimination, retaliation & harassment. This may prevent me from renewing my RN & NP licenses in NY state. Your office is fully aware of the atrocious nefarious unilateral hostile personnel action that Mr. Moschitta levied against me as a 100% disabled veteran. Mr. Moschitta has prevented me from accessing the health care & benefits that I am entitled to by law for five months & has denied my access to mental health counseling, benefits, etc. I am very worried that this will negatively effect my re-credentialing & re-privileging (a process that all VA providers must go through every two years) - the suspension + being out of work on a paid non duty status may prevent my ability to get re-certified thus ending my VA employment along with stymieing my ability to renew my RN & NP licenses will result in me being unemployed with the VA & I will be unemployable anywhere else without a license as a disabled veteran. I will also be unable to renew my DEA registration number effectively making me further unemployable. This will raise my malpractice insurance premiums incurring further costs that I cannot afford. Mr. Moschitta continues his personal animus against me since he loathes all things veteran by reassigning me under Dr. Tank (whom I had an EEO case against that was settled) on Friday 10/25/13 to do C + P exams. This is another disaster in the making setting me up for failure. Please advocate on behalf of this 100% disabled veteran by sending a very strong & assertive message by accepting this OSC retaliation complaint exposing what Mr. Moschitta has done to a 100% disabled veteran. The VA Northport director continues to escalate his personal animus towards me with his increasing hostilities including a proposed suspension in the absence of any wrong doing - his express open animus regarding the OSC complaint as per prior correspondence evinces him & the agency in retaliation/ reprisals. I fear that this will otherwise discourage many others from coming forward with similar complaints of privacy breaches as a form of VA Prohibited Personnel Practices since the agency has so fiercely retaliated against me as a 100% disabled veteran (the logic being that if they can do it to me they can do it to anybody since being a 100% service connected disabled veteran is very rare). Despite the fact that I am getting paid, I have sustained substantial damage since Mr. Moschitta's restrictions interfere with my rights & abilities to access my VA benefits including but not limited to health care since they are well aware that the restrictions that he so savagely imposed severely exacerbate my PTSD. Also, by design, Mr. Moschitta's restrictions prevent me from accessing VA health care in an emergency since I am forced to coordinate a VA police escort 24 hours in advance; an impossibility during an emergency since emergencies by definition cannot be predicted 24 hours in advance. This CANNOT be legit since this maniac has been enabled to violate & humiliate me. The OSC should also be informed of all of the nefarious & terrible patient safety hazards that Mr. Moschitta has negligently condoned/ ignored during his reign of terror; a fact that I exposed internally, alas, he decided to retaliate against me when I brought these patient safety issues to his attention rather than correcting the situation. The restriction prevents me from accessing emergency treatment since it clearly states that I must contact the VA police 24 hours in advance & coordinate an escort with them. So if I am in any sort of emergency I cannot go to Northport since it would violate the terms of Mr. Moschitta's restrictions so by his design the restrictions prevent me from accessing even emergency mental health counseling. An ongoing OSC investigation (DI 13-3661) into the wide spread illegal accessing of my VA medical records is proof positive that the agency adversely used this

illegally obtained Protected Health Information against me. Many comments made about me regarded me "dangerous" based solely on my massive physical appearance & features, cultural gestures & mannerisms, my service connected PTSD & knowledge of my Airborne & Special Forces background. This is disparate treatment of how I was abused by Mr. Moschitta compared to other employees including convicted felons. The director refuses to have my Workplace Violence complaints investigated so how can Mr. Moschitta claim that his actions are, "...protect all parties involved..." - how is he protecting me & my rights; especially against the parties that I've filed workplace violence complaints against by dismissing my complaints en masse refusing to have them properly investigated? According to a high ranking confidential source, Mr. Thomas Sledge (illegally accessed my medical records in August 2013) who works in veteran registration & enrollments was directed by his supervisor Ms. Kristen Sievers (illegally accessed my medical records four times in August 2013) & the facility director (Mr. Phil Moschitta who has orchestrated & directed the unilateral hostile discriminatory retaliatory biased action against me based on illegally obtained info from my medical records) to remove me from the patient registration & eligibility profile in attempts to desperately wipe out any sort of evidence & electronic foot print of the illegal accessing of my medical records at the behest of Mr. Moschitta. The timing of this is ominous since Mr. Sledge carried out this action on 8/6/13 - the day prior to the agency's OMI team's initial site visit. The ramifications & implications are highly criminal & will obstruct my ability to access my healthcare including but not limited to emergency care should I need it in the event of a medical crisis. Mr. Sledge was ordered by the director's office to do so & when Mr. Sledge queried why he had to eliminate me from the system he was told, "...just do what you're told...he (Joe Fasano) doesn't work here any more...the director (Mr. Moschitta) wants him out of the system now...to prevent any more accessing of his (Joe Fasano) records...& to wipe out any trace of him (Joe Fasano)..." Mr. Thomas Sledge is the brother of Mr. Joseph Sledge who is the facility Public Affairs Officer working as the director's consigliere/ confidant. Tom Sledge was told that he was "...covered..." due to his consanguineous affiliations. The technical term for this action is to "inactivate" & "disenroll" me from the system as a veteran & as an employee - this was done by Mr. Phil Moschitta to retaliate against me for filing the OSC complaint since he has openly verbalized/ vented his disdain, personal animus & anger regarding my filing of EEO complaints & this OSC complaint - Mr. Moschitta thought that if he, "...got rid of Joe Fasano...this whole mess would disappear..." It appears the director's continued actions/ hostilities towards me evinces him & the agency's retaliation for filing an OSC complaint.

My veteran identification card (VIC) proves that I was enrolled in the VA (see attached scanned copy). Not only am I in Priority Group 1 as a 100% disabled veteran, I also qualify for Enhanced Eligibility based on the 100% rating and the fact that I am rated for greater than 6 service connected conditions places me in yet another special protected category of disabled veterans. Further proof that I was enrolled and eligible for VA benefits including but not limited to health care prior to the illegal disenrollment interfering with my rights to access my benefits with the illegal police escort restriction, illegal fee basis denials and illegal disenrollment making me ineligible for the full spectrum of benefits that I am entitled to.

Excerpt from Health Care Benefits Overview 2012 Handbook:

Frequently Asked Questions

Must I reapply every year, and will I receive an enrollment confirmation?

Depending on your priority group and the availability of funds for VA to provide health benefits to all enrollees, your enrollment will be automatically renewed without any action on your

part. Veterans, based on their financial status, who are exempted from paying medical care copays or who are eligible for a reduced inpatient copay are required to update their financial information on an annual basis or when their income changes, using VA Form 10-10EZ. ***Should there be any change to your enrollment status, you will be notified in writing.***

Can I request a Veterans Identification Card and/or an appointment before my enrollment is confirmed?

Yes. If you are applying in person at any VA medical center, you can have your picture taken for the Veterans Identification Card and/or request an appointment for medical care at the same time you apply for enrollment. Additionally, you can indicate on the VA Form 10-10EZ if you desire an appointment and when your application is processed at the medical center, an appointment will be scheduled for you. You will be notified in writing of the appointment and your eligibility for medical care. ***Once your enrollment has been verified the identification card will be mailed to you,*** usually in 5-7 days after your enrollment has been verified. ***For Veterans 50% or more disabled from service-connected conditions*** and Veterans requesting care for a service-connected disability, ***those appointments have a higher priority*** (see Enrollment Priority Groups on pages 19 - 20) and will be scheduled within 30 days of the desired date. Veterans may be seen at VA facilities for emergency care while pending verification.

If enrolled, must I use VA as my exclusive health care provider?

There is no requirement that VA become your exclusive provider of care. If you are a Veteran who is receiving care from both a VA provider and a private community provider, it is important for your health and safety that your care from both providers is coordinated, resulting in one treatment plan (co-managed care). Please be aware that our authority to pay for non-VA care is extremely limited (see pages 28 and 29). You may, however, elect to use your private health insurance benefits as a supplement for your VA health care benefits.

I am moving to another state.

How do I transfer my care to a new VA health care facility?

If you want to transfer your care from one VA health care facility to another, contact the Enrollment Office for assistance in transferring your records and establishing a new appointment. Director illegally forced option to seek care at other VA facilities that were way beyond the reasonable geographic proximity as previously communicated to your office.

How do I choose a preferred facility? How do I change my preferred facility?

When you enroll, you will be asked to choose a preferred VA facility. This will be the VA facility where you will receive your primary care. You may select any VA facility that is convenient for you. If the facility you choose cannot provide the health care that you need, VA will make other arrangements for your care, based on administrative eligibility and medical necessity. If you do not choose a preferred facility, VA will choose the facility that is closest to your home. You may change your preferred facility at any time. Simply discuss this with your primary care doctor. Your primary care doctor will coordinate your request with the Veterans Service Center at your local health care facility and make the change for you.

What income is counted for the Financial Assessment (Means Test) & is family size considered?

VA considers your previous calendar year's gross household income and net worth. This includes the earned and unearned income and net worth of your spouse and dependent(s). Earned income is usually wages you receive from working. Unearned income can be interest earned, dividends received, money from retirement funds, Social Security payments,

annuities or earnings from other assets. The number of persons in your family will be factored into the calculation to determine the applicable income threshold—both the VA national income threshold and the income threshold for your geographic region.

What is a geographic income threshold?

By law, VA is required to identify Veterans who are required to defray the cost of medical care. Those Veterans whose income falls between the VA means test limits and the VA national geographic income threshold for the Veteran's locale will have their inpatient medical care copays reduced by 80%.

As a combat Veteran, will I be required to provide financial information and be billed?

No. Combat Veterans are not required to provide their financial information to determine their enrollment priority. However, they are encouraged to complete a financial assessment to determine if they may be exempt from copays for care or medications unrelated to their combat service or to establish beneficiary travel eligibility.

Hearing aids and eyeglasses are listed as "limited" benefits. Under what circumstances do I qualify?

VA medical services include diagnostic audiology and diagnostic and preventive eye care services. VA will provide hearing aids and eyeglasses to Veteran's who receive increased pension based on the need for regular aid and attendance or being permanently housebound, receive compensation for a service-connected disability, are a former POW, were awarded a Purple Heart, currently enrolled in a Vocational Rehabilitation program, are about to be admitted to a VA Blind Rehabilitation Program, you have a eye or hearing impairment that resulted from the existence of another condition for which you are currently receiving VA care, or which resulted from treatment of the medical condition, or your vision or hearing are so severely impaired that aids are necessary to permit active participation in your own medical treatment. Otherwise, hearing aids and eyeglasses are provided only in special circumstances, and not for normally occurring hearing or vision loss. For additional information, contact the prosthetic representative of your local VA health care facility.

Am I eligible for dental care?

Dental benefits are provided by the Department of Veterans Affairs (VA) according to law. In some instances, VA is authorized to provide extensive dental care, while in other cases treatment may be limited. The Chart below describes dental eligibility criteria and contains information to assist Veterans in understanding their eligibility for VA dental care. The eligibility for outpatient dental care is not the same as for most other VA medical benefits and is categorized into classes. For instance, if you are eligible for VA dental care under Class I, IIC, or IV you are eligible for any necessary dental care to maintain or restore oral health and masticatory function, including repeat care. Other classes have time and/or service limitations.

If you:	You are eligible for:	Through:
Have a service-connected compensable dental disability or	Any needed dental care.	Class I

condition.		
Are a former prisoner of war.	Any needed dental care.	Class IIC
Have service-connected disabilities rated 100% disabling, or are unemployable and paid at the 100% rate due to service-connected conditions.	Any needed dental care. <i>[Please note: Veterans paid at the 100% rate based on a temporary rating, such as extended hospitalization for a service-connected disability, convalescence or pre-stabilization are not eligible for comprehensive outpatient dental services based on this temporary rating]</i>	

Veterans Identification Card:

VA provides eligible Veterans a Veterans Identification Card (VIC) for use at VA health care facilities. This card provides quick access to VA health benefits. *VA recommends all enrolled Veterans obtain a card.* Veterans may have their photo taken at their local VA health care facility. *Once the Veteran's enrollment has been verified, the card will be mailed to the Veteran's mailing address, usually within 5 to 7 days.* Veterans may call toll-free 1-877-222-VETS (8387) to check on the status of their card. In the event the card is lost or destroyed, a replacement card may be requested by contacting the VA where the picture was taken.

NOTE: VICs cannot be used as a credit or an insurance card and it does not authorize or pay for care at non-VA facilities.

The VIC does not contain any sensitive, identifying information such as the Veteran's Social Security number or date of birth on the face of the card. However, that information is coded into the magnetic stripe and barcode. For that reason, VA recommends that Veterans safeguard their VIC as they would a credit card.

What is a VA service-connected rating, and how do I establish one?

A service-connected rating is an official ruling by a Veterans Benefits Administration Regional Office that your

illness or condition is directly related to your active military service. VA Regional Offices are also responsible for

administering educational benefits, vocational rehabilitation and other benefit programs, including home loans.

VA Health Care Enrollment Priority Groups:

Upon receipt of a completed application, the Veteran's eligibility will be verified. Based on his/her specific eligibility status, he/she will be assigned to one of the following priority groups.

The priority groups range from 1 through 8 with *Priority Group 1 being the highest priority* and Priority Group 8 the lowest.

Priority Group 1: Veterans with service-connected disabilities 50% or more disabling.

Attachments/ References:

*Item #58 from enclosed Excel file titled FeeBasisOrientationChecklist provides hyperlinks to additional training and references regarding other VA data bases and platforms where my privacy was violated as per prior correspondence including but not limited to Veteran Information System (VIS), Hospital Inquiry (HINQ), VistA, etc.

*The attached Veterans Health Guide and Health Care Benefits Overview Pdf files provide more information on my rights, benefits and entitlements that I am guaranteed by law that were removed, disrupted and intefered with by Mr. Moschitta's illegal police escort restriction, illegal fee basis denial, illegal disenrollment, illegal privacy breaches, illegal monitoring, etc. enumerated in prior correspondence as part of the pending OSC Disclosure Unit and OSC CEU Unit investigations.

*The attached VA Northport campus map is enclosed so that you get a real sense of the size, scale and scope of the diabolical nature of management's voracious attack on me via the massive privacy breaches and other enumerated disclosure violations directed by the facility director Mr. Phil Moschitta. As per prior e-mail correspondence, the VA Northport is not just located in one building rather it is a massive complex greater than 500 acres with most of the buildings encompassing a geographic foot print of 1 mile in circumference. In the very near future I will plot and track the location of the privacy breaches on the map to cluster the concentration density showing the massive scale of the criminal activity since the enormous campus and 1800+ employees in hundreds of offices, nooks, crannies and cubicles are scattered across the large expanse that can only be coordinated by the director's office located in building #10 and senior management. Not just a mere coincidence or random act, rather a coordinated criminal attack on me.

The Privacy Responsibilities of Federal Employees

Privacy is the ability to control the collection, use, and dissemination of personal information. The definition of privacy involves the following key ideas:

keeping a person's Personally Identifiable Information (PII) private by assuring that it is used by only those persons with a need to know **controlling personal events** that might interfere with your ability to keep information private **preventing unauthorized intrusion** into personal information.

As federal employees, who might be in a position to collect, use, or disseminate personal information, your responsibility with regard to privacy includes respecting the privacy of an individual's personal information following procedures designed to maintain that privacy observing federal privacy laws ensuring the Fair Information Principles (FIPs) are followed.

Protection of privacy is the appropriate use of personal information, given the circumstances. "**Given the circumstances**" means the appropriate use of personal information as defined by the law, which primarily refers to the Privacy Act, public sensitivity, and context.

Personal information is any information that relates to an individual and can be used to identify that individual. **Personally Identifiable Information (PII)** is defined as any information in a system or online collection that directly or indirectly identifies an individual whether the individual is a U.S. citizen, legal permanent resident, or a visitor to the U.S. PII might include an individual's:

- name
- address
- e-mail address
- telephone number
- social security number
- photograph
- biometric information
- National Identification Number
- vehicle registration ID number
- driver's license number
- fingerprints

Not all "personal" information is considered PII however. Information that is common, or information that is a matter of public record, is not generally considered personally identifiable information. This includes information such as:

- first or last name (if common)
- country, state, or city of residence
- age, especially if non-specific
- gender or race
- names of schools attended
- workplace
- grades
- salary or job position
- criminal record

"Protection" of personal information means controlling or evaluating who has access to personal information, who can **manipulate, change** and **disseminate** personal information, and evaluating the sensitivity of the information, to the best of your ability.

Privacy, in relation to personal information, is the ability to control the collection, use, and dissemination of personal information. As a federal employee you have a responsibility to protect the privacy of all personal information to which you are privy, to the best of your ability. This involves using personal information appropriately, given the circumstances.

Course: Privacy Awareness (Update Available)

Topic: What Is Privacy?

Privacy of Personal Information Legislation

The privacy of personal information is built on three primary statutory pillars, which are implemented and amplified by the Office of Management and Budget (OMB) and agency policy directives.

The Privacy Act

This act governs how federal agencies gather, maintain, and disseminate personal information. **Fair Information Practices (FIPs)** have long governed the collection, use, maintenance, and dissemination of personal information. The act essentially implements these FIP guidelines, but specifically applies to records kept about individual U.S. citizens and legal permanent residents in a **system of records**. A **System of Record** is any information that can be retrieved using a unique personal identifier. FIP principles include the following:

notice – Individuals should be made aware and should be given notice of an entity's information practices before any personal information is collected from them.

choice – Individuals should be given options as to how any personal information collected from them may be used, and they must be given an opportunity to consent.

access – The public should have the ability to access data about themselves and to contest the accuracy and completeness of that data.

security – An individual's data should be accurate and secure. Security involves measures that protect against loss, unauthorized access, destruction, use, or disclosure of data.

redress – Individuals have a statutory right to address violations of privacy regulations.

Personally Identifiable Information (PII) is any piece of information that can potentially be used to uniquely identify, contact, or locate a single person. When an individual can be identified through personal information collected, for whatever purpose, privacy protection actions should be enforced. This means that all personal information must be respected and protected.

The Privacy Act also allows individuals to access personal information about themselves subject to exemptions and conditions of disclosure. All agencies must publish a Privacy Act Statement (PAS) for how PII is used within the agency, and how they specifically comply with the Privacy Act's requirements.

The Freedom of Information Act (FOIA)

The FOIA provides the right for anyone to request access to federal agency records and information. The nine exemptions from disclosure are classified national defense and foreign relations information internal agency personnel rules and practices information that is prohibited from disclosure by another federal law trade secrets and commercial or financial information obtained from a person that is privileged or confidential inter-agency or intra-agency memoranda or letters that are protected by legal privileges personnel, medical, financial, and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy certain types of information compiled for law enforcement purposes records that are contained in or related to examination, operating, or condition reports prepared by, on behalf of, or for the use of any agency responsible for the regulation or supervision of financial institutions geological and geophysical information and data, including maps, concerning wells.

The three exclusions from disclosure are as follows:

(c)(1) Exclusion – Subject of a criminal investigation or proceeding is unaware of the existence of records concerning the pending investigation or proceeding and disclosure of such records would interfere with the investigation or proceeding.

(c)(2) Exclusion – Informant records maintained by a criminal law enforcement agency and the individual's status as an informant is not known.

(c)(3) Exclusion – Existence of FBI foreign intelligence, counterintelligence, or international terrorism records are classified fact.

The E-Government Act of 2002

This act's privacy provision, as well as OMB guidance, requires each federal agency to conduct Privacy Impact Assessments and to post web site privacy policies in both statement and machine-readable form. Section 208 of the act requires that OMB issue guidance to agencies on implementing the act's privacy provisions. Other OMB Guidance and Policy Memos direct agencies to examine their procedures for ensuring the privacy of personal information in federal records and to designate a senior official to assume primary responsibility for privacy policy. The Section 208 Privacy Provisions require all government agencies to conduct a PIA ensure the review of the PIA by the Chief Information Officer, or an equivalent official if practicable, after completion of the review under clause (ii) above, make the PIA publicly available through the agency's web site, publication in the Federal Register, or other means.

Penalties

The penalties for regulatory non-compliance vary:

Under the Privacy Act, individuals may file suit, with a maximum of actual damages and \$1,000, plus attorney fees and reasonable litigation costs. Unlawful, willful disclosure of personal information by an employee or agent is a misdemeanor and may result in a fine of not more than \$5,000.

Under the FOIA, individuals may file suit against an agency, which may need to cover reasonable attorney fees and other litigation costs.

Under the E-Government Act of 2002, unlawful, willful disclosure of personal information by an employee or agent may result in a Class E felony conviction and imprisonment of not more than five years or a fine of not more than \$250,000 or both.

Beyond the statutory penalties, there are other consequences for not protecting the personal information entrusted to you. Consequences for both you and the Department could include: loss of employment, reduced mission effectiveness, and loss of public trust.

Personal information privacy is built on three statutory pillars. The **Privacy Act** governs how agencies in the executive branch of the federal government collect, maintain, and disseminate personal information. The **Freedom of Information Act (FOIA)** provides the right for anyone to request access to federal agency records and information. The **E-Government Act of 2002** governs the use of electronic and Internet-based information technology by federal agencies. OMB and agency policy directives implement and amplify these statutes. The **penalties for non-compliance** with the three statutes vary. Beyond the statutory penalties, other consequences could include loss of employment, reduced mission effectiveness, and loss of public trust.

Course: Privacy Awareness (Update Available)

Topic: Statutory Requirements

Unintentional Violations of Privacy

Most statutory and policy privacy violations are unintentional.

Common errors

Three of the most common information-handling errors include:
inadvertently creating a system of record
unauthorized information sharing

browsing or using personal information

Common work practices that cause risk

Some work practices can also pose risks to the privacy of the information you handle on a daily basis. You can take these precautions to reduce the risk of violating privacy:

Be cautious when giving out personal information on the phone. Make sure that the person you are speaking to has the need to know and is authorized to have the information requested.

Secure paperwork that includes PII. Lock it in a desk drawer or filing cabinet.

Log off from your computer when away from your desk. Make sure you are maintaining the privacy of any PII included in e-mail or left in open documents on your desktop.

Always be prepared to receive sensitive or personal information by standing watch over a fax machine while the information is being transmitted.

Even innocent actions such as leaving your computer on with a confidential document displayed, dropping a piece of paper containing personal information on the floor or in your car, or repeating verbally conveyed personal information on a cell phone can constitute violation of an individual's privacy.

The need to know

"Need to know" is a determination made by an authorized holder of information when a recipient requires access to specific information in order to perform or assist in a lawful and authorized governmental function. To protect the privacy of personal information, you need to:

prevent unauthorized disclosure

prevent unauthorized access

prevent unauthorized use

Provide personal information only to those who have a "need to know," and use personal information **only** for official purposes. Most importantly, only give access to personal information if you have the specific authority to do so.

Most statutory and policy privacy violations are unintentional. Inadvertently creating a system of record, unauthorized information sharing, and browsing or using personal information are three of the most common information handling errors. You should follow work practices that ensure the privacy of the information you handle on a daily basis. The "need to know" is determined by an authorized holder of information. To protect the privacy of personal information, you should prevent its unauthorized disclosure, access, or use. Personal information should only be given to those who have a "need to know," and only for official purposes.

Course: Privacy Awareness (Update Available)

Topic: Unintentional Violations

Releasing Information under PA and the FOIA

Privacy Impact Assessment (PIA)

PIAs are required by the E-Government Act of 2002 and detailed requirements are specified in OMB guidance. A PIA can be one of the most important instruments in establishing trust between the federal government's operations and the public. A PIA is an analysis of how personally identifiable information is collected, stored, protected, shared, and managed.

The PIA requirement is triggered by both the collection and use of personal information and the technology used to maintain it. A PIA should be conducted both during the development and prior to the deployment of any new technology used to collect or manage personal information that could be linked to an individual.

System of Records Notice (SORN)

Any changes to a system of records may require a SORN. A SORN is essentially a description of an organization's information management practices. Its purpose is to educate the public, promote transparency, and ensure accountability of government. The typical notice tells the individual:

what data is collected

how the data is used

to whom the data is disclosed

how to exercise any choices that may exist with respect to such use and disclosures

whether the individual can access or update the information

Releasing information under PA and the FOIA

Both the Privacy Act (PA) and the Freedom of Information Act (FOIA) have provisions for releasing information to individuals and to the public. There are specific laws that mandate the release of this information. All requests received must be in writing and are considered formal. Contact your respective FOIA/Privacy Offices whenever a request is received, before making any release determinations. Also, if you receive a FOIA request, forward it immediately to the FOIA office, as all information you release can only be done when specifically requested by your FOIA office.

A Privacy Impact Assessment (PIA) is an analysis of how personally identifiable information is collected, stored, protected, shared, and managed. The E-Government Act of 2002 requires that PIAs be done whenever personal information is collected or used. A System of Records Notice (SORN) is a description of an organization's information management practices and may be required when any changes to a system of records is made. You should only ever release information to individuals or the public in accordance with the relevant provisions of the PA and the FOIA, and after you have received a formal written request and have contacted your respective FOIA/ Privacy Offices.

Course: Privacy Awareness (Update Available)

Topic: Guidelines for Releasing Information

Collecting and Filing Personal Information

As a federal employee who might be in a position to collect, use, or disseminate personal information, your responsibility with regard to privacy includes respecting the privacy of an individual's personal information, following procedures designed to maintain that privacy, observing federal privacy laws, and ensuring the Fair Information Principles (FIPs) are followed. Protection of privacy is the appropriate use of personal information given the circumstances.

"Given the circumstances" means the appropriate use of personal information as defined by law, public sensitivity, and context. The privacy of personal information is built on three primary statutory pillars, which are implemented and amplified by the Office of Management and Budget (OMB) and agency policy directives:

The **Privacy Act** governs how agencies in the executive branch of federal government gather, maintain, and disseminate personal information.

The **Freedom of Information Act (FOIA)** stipulates that an agency must provide access to identifiable documents within its possession unless one of nine exemptions or three exclusions applies. The exact language of the exemptions can be found in the FOIA.

The **E-Government Act of 2002** promotes and guides federal agencies' use of electronic and Internet-based information technology. The privacy provision of the E-Government Act (Section 208), as well as OMB guidance, requires each federal agency to conduct privacy impact assessments and to post web site privacy policies in both statement and machine-readable form. To protect the privacy of personal information, keep in mind the following guidelines to prevent unauthorized disclosure, prevent unauthorized access, and prevent unauthorized use. Provide personal information only to those who have a "**need to know**," and use personal information **only** for official purposes. Most importantly, only give access to personal information if you have the specific authority to do so. Remember that any change in a records management system that requires the collection, storage, analysis, and possible redistribution of information that can be tracked to specific individuals requires a Privacy Impact Assessment (PIA) and/or a System of Records Notice (SORN). When in doubt, contact your Privacy Office or CIO Office.

When soliciting personal information directly from an individual, ensure they are provided a Privacy Act Statement (PAS) that advises them of four things:

authority – What authorizes collection of this information? Refer to the Privacy Act systems notice that applies and ensure that when soliciting the social security number, you cite E.O. 9397. In any case, you may not require the social security number if the systems notice does not authorize collection.

purpose – Specify why the information is being requested. The "purpose" is listed in the systems notice.

routine uses – Identify who will routinely have access to this information and for what purpose.

voluntary or mandatory – In most cases the request for such information is voluntary, unless a specific law or statute requires the information. Normally, you can state that the information requested is voluntary, and follow that with a statement that says what the failure to provide such information may result in.

Do not collect personal information without determining that you have an authorized need for the information. Do not file personal information in such a way that it can be retrieved by an individual's name, social security number, or other personal identifier, unless you have identified a Privacy Act System of Records Notice (SORN) that permits such collection.

Being a federal employee, you have access to a lot of personal information that must be protected in accordance with the law. Being familiar with the federal regulatory requirements and your own agency's policies and guidelines related to privacy will help ensure that you comply.

Course: Privacy Awareness (Update Available)

Topic: Key Points

Privacy Awareness TMS NFED 1310106

Privacy Awareness (Update Available)

Glossary

F

FIPS

Fair Information Practices (FIPs) have long governed the use of personal information and provide the basis for many recent legislative reforms regarding personal information collected, managed, and used in current management and information systems. The fundamental principles

include: Notice/Awareness, Choice/Consent, Access/Participation, Integrity/Security, Enforcement/Redress.

P

PAS

Privacy Act Statements (PASs) must notify users of the authority for and purpose and use of the collection of information subject to the Privacy Act, whether providing the information is mandatory or voluntary, and the effects of not providing all or any part of the requested information.

PIA

Privacy Impact Assessment (PIA) is an analysis of how personally identifiable information is collected, stored, protected, shared, and managed. "Personally identifiable information" is defined by the federal Office of Management and Budget as "Information which can be used to distinguish or trace an individual's identity, such as their name, social security number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.." Privacy Act protections apply whether the individual is a U.S. citizen, legal permanent resident, or a visitor to the U.S. In some cases, personal information, such as a body scan, may be captured only for a short period of time. This is still considered a collection, however, and a PIA would need to be conducted during the development and prior to the deployment of the new technology. Section 208 of the E-Government Act of 2002 requires all Federal government agencies to conduct PIAs for all new or substantially changed technology that collects, maintains, or disseminates personally identifiable information.

PII

Personally Identifiable Information (PII) is the information from which an individual can be identified or singled out. When an individual can be identified through personal information collected, for whatever purpose, privacy protection actions should be enforced. This means that this personal information must be respected and protected.

S

SOR

A system of record (SOR) is an information storage system or information technology, which stores and serves as a source of retrievable data, including personal information about individuals.

SORN

System of Records Notice (SORN) is essentially a description of an organization's information management practices. Any change to a system of record may require a SORN. The typical notice describes what data is collected, how it is used, to whom it is disclosed, how to exercise any choices that may exist with respect to such use and disclosures, and whether an individual can access or update the information.

Privacy Awarenesss (Update Available)

SkillBriefs

[The Privacy Responsibilities of Federal Employees](#)

Learn about privacy definitions and responsibilities.

[Privacy of Personal Information Legislation](#)

Discover the three primary statutory pillars.

[Unintentional Violations of Privacy](#)

Discover common errors that can lead to privacy violations.

Releasing Information under PA and the FOIA

Discover the guidelines for releasing information.

Collecting and Filing Personal Information

Learn about collecting and filing personal information.

References

Web Sites

Office of Management and Budget – Privacy Guidance

<http://www.whitehouse.gov/omb/privacy/>

It seems that I'm uncovering additional laws, rules and regulations that were violated by the VA on an almost daily basis. This is highly disturbing and I sincerely hope that it is fully and thoroughly investigated since the criminal activity was not just limited to the privacy breaches + all the other complaints to the OSC Disclosure and CEU units.

FEDERAL TRADE COMMISSION RED FLAG RULES

FTC issued regulations on 11/7/2007 (the Red Flag Rules)

<http://www.ftc.gov/os/fedreg/2007/november/071109redflags.pdf>

FTC identity theft resource <http://www.ftc.gov/bcp/edu/microsites/idtheft/>

<http://www.ftc.gov/bcp/edu/pubs/business/idtheft/bus23.pdf>

<http://www.ftc.gov/bcp/edu/pubs/articles/art11.shtm>

The VA violated these FTC Red Flag Rules which are inextricably linked to the massive ongoing privacy breaches against me which dove tails neatly into the identity theft complaint that I've recently added to OSC file # 14-0558. The enclosed transcript is a reference provided in the VA Talent Management System (TMS) Red Flag Rules (General Staff Education)

NFED 11781. What's truly nefarious and diabolical regarding the massive privacy breaches on all data platforms (electronic and hard copy) and identity theft is that it was ALL internal to the agency at the direction of senior management; mainly Mr. Phil Moschitta (facility director). The PII, SPI, PHI and identity of myself and my family have been illegally accessed, breached and adversely used against me as an employee, veteran and a patient that will have negative repercussions for years to come further amplifying the repeated victimization at the hands of the VA. Mr. Steven Wintch (facility privacy officer) and Ms. Joanne Anderson (director's assistant) are spewing forth inaccurate bogus information sessions to employees discouraging them from filing privacy complaints and even have strongly hinted at weaponizing this process unfairly targeting employees that have appropriately accessed medical records creating an environment/ climate/ culture of fear and confusion that will impede/ obstruct the rights of employees, veterans and patients with their implied agency retaliation further compounding the privacy breaches and identity theft issues by displacing the blame/ enforcement/ focus on the victims and innocent staff instead of conducting proper legal investigations and enforcement with senior management where the blame truly lies with. The VA has violated every single known law, rule and regulation associated with privacy and identity theft with associated criminal activities that they have failed to properly enforce, monitor and mitigate the crimes

committed against me by the agency as this continues without any signs of waning. The VA's corrective panacea to deal with their corruption and crimes is to flood the masses with education (mostly misinformation as described) and more reviews is a failed strategy that just doesn't work. None of the mitigation and recovery measures required by the FTC and other privacy/ identity governing bodies/ agencies has been implemented by the VA. The VA fails to implement same effectively since the true criminals in these instances are the VA senior management that are not being held accountable/ responsible for the crimes that they promulgate, perpetuate, foster, encourage and commit. It's the proverbial "fox guarding the hen house" analogy requiring external oversight, enforcement, monitoring and governance.

Identity Theft at VA

Enclosed please find additional considerations including Identity Theft for OSC case # DI-14-0558 since it is inextricably linked to the massive privacy breaches against me by the VA.

Enclosed please find a scanned letter received from the VA regarding the privacy violations and an Identity Theft claim against the VA. Also attached is a special accommodation request that was sent out by my union to VA senior management.

Identity Theft

Identity Theft and Assumption Deterrence Act of 1998 (ITADA): this act makes identity theft a federal crime. Criminals who “unlawfully possess a means of identification of another person or to aid and abet any unlawful activity” are subject to federal and state consequences and penalties. The VA employees including but not limited to senior management and law enforcement who illegally accessed my VA medical records and other VA data platforms were in violation of the ITADA act of 1998 since in their commission of their privacy crimes, they are criminals who unlawfully possessed a means of identification of me since my Personally Identifiable Information (PII), Sensitive Personal Information (SPI) and Protected Health Information (PHI) was compromised and adversely used against me.

The Fair and Accurate Credit Transactions Act of 2003 (FACTA) definition of identity theft was adopted by the VA “Fraud committed using the identifying information of another person.

Selected Laws and Programs specific to VA:

Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009: this act was violated by any and all of the VA employees involved in illegally accessing my PHI, PII and SPI as your office is aware since I've already conveyed my concerns that these and other individuals transmitted this illegally obtained information via unsecured electronic communications such as standard Outlook e-mail which is an unsecure unencrypted electronic communications tool, unsecured faxes, etc. This law addresses the privacy and security concerns associated with the electronic transmission of health information. The HITECH act requires HIPAA covered entities that experience a breach effecting more than 500 residents of a State or jurisdiction to notify the affected individuals and provide notice to prominent media outlets serving the State or jurisdiction.

Veterans Benefit, Health Care and Information Technology Act of 2006 requires the VA to implement organization-wide security standards of practice to protect VA's sensitive personal information and VA information systems. This was also repeatedly violated as per above + all other privacy breaches and disclosure violations enumerated to the OSC.

VHA Handbook 6500 establishes the foundation for the VA comprehensive information security program and its practices which lays out how to protect the confidentiality, integrity and availability of information created, processed, stored, aggregated and transmitted by VA's information systems and business processes. This was also repeatedly violated as per above + all other privacy breaches and disclosure violations enumerated to the OSC.

VA Directive 6502 was violated as your office is aware when Dr. Mandar Tank demanded that I provide a detailed graphic humiliating letter from my wife's OB/GYN as an illegal pretext to granting leave. This directive is a department-wide program policy for the protection of privacy of Veterans, their dependents and beneficiaries, as well as the privacy of all employees and contractors of the VA and other individuals for whom personal records are created and maintained in accordance with Federal law.

NONE of the existing VA systems, processes, controls, policies, procedures, regulations, etc. protected my privacy AND my PII, SPI and PHI and the privacy, PII, SPI and PHI of my wife and daughter violating applicable laws governing privacy and identity theft.

RECOVERY

I will need to also file a complaint with the Federal Trade Commission, local police department, fraud alert with all three major credit bureaus and the Internal Revenue Service incurring additional undue hardships, time constraints and financial burdens because the VA has consistently victimized me over several years as an employee, a veteran and a patient failing to take any action to cease and desist from this criminal activity and retaliating against me as an employee, veteran and a patient when I did alert the VA of same. Please consider this additional damage to accept this complaint in its entirety for an OSC investigation as part of OSC case # DI-14-0558.

References:

Federal Policies

Electronic Code of Federal Regulations, (January 25, 2013). *Title 45: Public Welfare Subpart E—F Identifiable Health Information*. Retrieved from: <http://www.ecfr.gov/cgi-bin/index?c=ecfr&SID=66243c05cf1dcfc80eb8b4f3ad8f9740&rgn=div5&view=text&node=45:1.0.1.3.78.5>

Federal Trade Commission, (September 30, 1996). *Fair Debt Collection Practices Act*. Retrieved from: <http://www.ftc.gov/os/statutes/fdcpa/fdepact.shtml>

Federal Trade Commission, (October 30, 1998). *Identity Theft and Assumption Deterrence Act*. Retrieved from: <http://www.ftc.gov/os/statutes/itada/itadact.htm>

Federal Trade Commission, (January 7, 2002). *Fair Credit Reporting Act (FCR)*. Retrieved from: <http://www.ftc.gov/os/statutes/fcra.pdf>

Federal Trade Commission, (4, December 2003). *FAIR AND ACCURATE CREDIT TRANSACTIONS*. Retrieved from: <http://www.gpo.gov/fdsys/pkg/PLAW-108publ159/pdf/PLAW-108publ159.pdf>

Federal Trade Commission, (December 16, 2003). *Controlling the Assault of Non-Solicited Pornography and Marketing Act of 2003 (CAN-SPAM Act of 2003)*. Retrieved from: <http://www.ftc.gov/os/caselist/0723>

U.S. Department of Veterans Affairs, (December 22, 2006). *Veterans Benefits, Health Care, and Information Technology Act of 2006*. Retrieved from: <http://www.va.gov/ogc/d>

VA Directives

NOTE: The links in this section must be accessed from inside the VA Network.

Department of Veterans Affairs VA Handbook 0730/4, (March 31, 2013). *SECURITY AND LAW ENFORCEMENT*. Retrieved from: http://vaww1.va.gov/vapubs/viewPublication.asp?Pub_ID=700&FType=2

Department of Veterans Affairs VA Handbook 6500, (September 20, 2012). *RISK MANAGEMENT FRAMEWORK FOR VA INFORMATION SYSTEMS – TIER 3: VA INFORMATION SECURITY PROGRAM*. Retrieved from: http://vaww1.va.gov/vapubs/viewPublication.asp?Pub_ID=638&FType=2

Department of Veterans Affairs VA Handbook 6500.2, (January 6, 2012). *MANAGEMENT OF DATA BREACHES INVOLVING SENSITIVE PERSONAL INFORMATION (SPI)*. Retrieved from: http://www1.va.gov/vapubs/viewPublication.asp?Pub_ID=608&FType=2

Department of Veterans Affairs VA Handbook 6502, (May 5, 2008). *VA ENTERPRISE PRIVACY PROGRAM*. Retrieved from: http://vaww1.va.gov/vapubs/viewPublication.asp?Pub_ID=404&FType=2

Other

Federal Trade Commission, (February 26, 2013). *FTC Releases Top 10 Complaint Categories for 2012*. Retrieved from: <http://www.ftc.gov/opa/2013/02/sentinel1top.shtm>

Office of Information Security Portal, (No Date). *Employee Toolkit: 10 Ways to Prevent Identity Theft*. Retrieved from: https://vaww.portal2.va.gov/sites/infosecurity/rmir/ID%20Theft/RMIR_Factsheet_To_olkit.pdf

Office of Information Security Portal, (No Date). *ISO-PO-Locator*. Retrieved from: <https://vaww.infoprotection.va.gov/ISO-PO-Locator/default.aspx>

Office of Information Security Portal, (No Date). *OIS Communications; Defend Veterans' Identities*. Retrieved from: <https://vaww.portal2.va.gov/sites/infosecurity/iprm/id%20theft.aspx>

Office of Information Security Portal, (No Date). *Risk Management & Incident Response, Incident Resolution Announcement*. Retrieved from: <https://vaww.portal2.va.gov/sites/infosecurity/rmir/Incident%20Response.aspx>

Service Delivery and Engineering, (No Date). *Continuous Readiness in Information Security Program (CRISP)*. Retrieved from: <https://vaww.sde.portal.va.gov/oitauditprep/SitePages/Home.aspx>

VA Learning University Talent Management System, (May 3, 2011). *10176 VA Privacy and Information Security Awareness and Rules of Behavior*. Retrieved from: <https://www.tms.va.gov/learning/user/login.jsp>

Veteran Population, (January 12, 2010). *National Center for Veterans Analysis and Statistics*. Retrieved from: http://www.va.gov/vetdata/Veteran_Population.asp

NFFE is very concerned regarding Mr. Fasano's work conditions; especially in light of the severe pervasive systematic abuse, harassment and discrimination that he has suffered by VA senior management combined with the massive illegal ongoing privacy breaches of Mr. Fasano's medical records as a 100% disabled veteran. NFFE requests a meeting to resolve the following outstanding issues related to above:

1. **REASONABLE ACCOMMODATION REQUEST based on Mr. Fasano's disabilities in accordance with the Americans with Disabilities Act:**
 - a. **Mr. Fasano must be assigned an office whereby he can fully control the lighting. As you are fully aware, the fluorescent lighting exacerbates his disabilities (migraine headaches) – to date no such exceptions have been honored and/ or granted to accommodate same despite multiple requests by NFFE.**
 - b. **Mr. Fasano must be assigned an office whereby his safety, well- being and security is protected in light of the above mentioned illegal privacy breaches**

and failure of senior management to properly process and investigate his Workplace Violence Reports of Contact which can be very startling and frightening exacerbating his PTSD.

- c. Mr. Fasano must be assigned an office with minimal to no disruptions, intrusions and/ or interruptions which can be very startling and frightening exacerbating his PTSD.
- d. Mr. Fasano must be assigned an office where his personal space and privacy is respected and honored allowing Mr. Fasano to speak in a manner, tone and volume that suits his comfort level with an assigned zone of privacy which can be very startling and frightening exacerbating his PTSD, migraine headaches and hearing loss.
- e. Mr. Fasano requires a relaxed start and departure time since on certain days his walk to and from the parking lot can be extended due to painful service connected orthopaedic conditions.
- f. Mr. Fasano requires Authorized Absence to attend to medical appointments off campus since the agency has repeatedly failed to protect his privacy, safety and well-being. Mr. Fasano is a 100% disabled veteran, however, Mr. Fasano's ability to exercise his full veteran's benefits including but not limited to attending medical appointments at the medical center on station have been impeded due to the above management directed hostilities placing an undue and unnecessary hardship on Mr. Fasano requiring him to seek private medical care both at his personal expense and time. Other similarly situated employees are able to do this as part of their duty days, however, such is not the case for Mr. Fasano due to the above mentioned agency failures to him as an employee and a 100% disabled veteran.
- g. Mr. Fasano requires a supervisor that does not scream, yell, threaten, curse, intimidate or otherwise engage in any behaviors to purposely exacerbate his disabilities which can be very startling and frightening exacerbating his PTSD.
- h. Mr. Fasano requires some sort of safe guard and guarantee of his safety and well-being against Mr. Phil Moschitta since Mr. Fasano is very frightened of the director in light of all of the abuse, hostilities, victimization and harassment that was directed at Mr. Fasano by Mr. Moschitta which can be very startling and frightening exacerbating his PTSD.
- i. Mr. Fasano requires some sort of safe guard and guarantee of his safety and well-being against Ms. Cathy Fasano RN since Mr. Fasano is very frightened of her in light of all of the abuse, hostilities, victimization and harassment that was directed at Mr. Fasano by Ms. Fasano in her false police report and false statements that she filed against him which can be very startling and frightening exacerbating his PTSD.
- j. NFFE demands that all of Mr. Fasano's WPV ROC's be fully investigated that were filed in calendar year 2013. These were all dismissed without due process by the director which can be very startling and frightening exacerbating his PTSD.

Summary Suspension

SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

Actions taken by Mr. Phil Moschitta (director), Ms. Maria Favale (associate director), Mr. William Sainbert (chief human resources) and senior management = a Summary Suspension of Clinical Privileges since they illegally Reassigned me to a new position in the absence of any wrong doing, in the absence of any AIB findings ultimately leading up to a Reappointment that is stuck in neutral due to above (see below chart as a reference/ guide). None of the below listed bases were ever invoked to take this Major Adverse Action against me further constituting a Prohibited Personnel Practice (PPP) in violation of the listed VHA Handbooks and laws governing Title 38 employees in addition to all other Disclosure violations communicated to the OSC office regarding OSC case # DI-14-0558 of the Disclosure Unit and compelling info for OSC case # MA-14-0162 for a PPP of the Complaints Examining Unit. I've been repeatedly denied any due process rights regarding the Major Adverse Actions taken against me including but not limited to fairly to provide me advanced written notice of the terms, conditions and bases for the actions denying my appeals rights; especially in the absence of any wrong doing. Due process in one arena does not necessarily satisfy due process for another since I was continually denied any due process in ALL agency actions against me reported to your office including but not limited to the Reassignment and Reappointment with Reduction/ Revocation of Privileges. Due process that's not provided in combination with a personnel action must be provided separately. That particular due process (illegal AIB) is not the same as a Fair Hearing as defined by the Medical Staff By-Laws allowing full participation in the entire hearing including but not limited to calling witnesses, asking witnesses questions, etc. The AIB does not supplant for blanket due process nor does it suffice for a Fair Hearing, Disciplinary Appeals Board, etc. All Licensed Independent Providers (LIP's) are entitled to a "Fair Hearing and Appeal" due process in accordance with VHA Handbooks 1100.17 and 1100.19. That Revocation and/ or Reduction in privileges MUST be sustained through a Fair Hearing or an Appeals Process otherwise it CANNOT be acknowledged in the absence of due process which I was NEVER afforded. Furthermore the evidence type (Substantial v. Preponderance) to take any agency actions must be determined only during the due process proceedings such as a Fair Hearing. Since I continue to be denied all rights including but not limited due process I am denied the right to the Evidentiary Process as part of that denial of due process rights as a full time permanent non-probationary Title 38 employee with privileges. Also the Clinical Executive Board (CEB) and the Executive Committee Medical Staff (ECMS) did not make any recommendations for the reduction, suspension or revocation of any privileges as evidenced by the Chief of Staff's Report of Contact and e-mail communications with Human Resources (of which your office has copies). This non-renewal and/ or denial of clinical privileges is considered an Adverse Action since it's equivalent to a revocation or reduction in privileges constituting yet another PPP. This can lead to a reduction in my clinical status as an NP reduced to an RN with a reduction in pay.

References:

Provide medical staff professionals and individuals with credentialing and privileging involvement or program oversight responsibility and information on summary suspension of privileges, Professional Conduct or Competence (PCC), Privileging actions and reporting to the National Practitioner Data Bank (NPDB) and Reporting to State Licensing Board (SLB).

38 USC 7422 Professional conduct or competence (PCC) defined *Triggers right to a
Disciplinary Appeals Board
as direct patient care or clinical competence for T38 Adverse Actions

38 USC 7462

38 USC 7463

VHA Handbook So substantially failed to meet generally accepted *Triggers the process to
possibly report to

1100.18 standards of clinical practice as to raise reasonable the SLB
concern for the safety of patients

VHA Handbook Substandard care, professional incompetence & *Triggers a right to a
fair hearing & appeals

1100.19 misconduct process should
privileges be reduced or

revoked for this reason

VHA Handbook Concern that failure to take such action may *Triggers summary
suspension of

1100.19 result in imminent danger to health of any privileges
Individual

1100.17

Flow charts and sample letters:

http://vaww.va.gov/ohrm/EmployeeRelations/other_t38_issues.htm

Talent Management System course Licensed Independent Practitioner Credentialer's Boot Camp
Credentialing Separation Class # VA 19589

Reporting and Responding to State Licensing Boards

Provide medical staff professionals and individuals with credentialing and privileging involvement or program oversight responsibility with the basic, fundamental knowledge and resources to assist in reporting and responding to state licensing boards to meet Agency and regulatory standard; avoid potential negligent credentialing; and above all, ensure qualified, competent providers are delivering safe, quality patient care to veterans.

VA responsibility to State Licensing Boards (SLB's) includes: protecting the public and veteran patients, notify SLB's for concerns about a professional's clinical practice or behavior, etc. The licensed professionals involved in the agency's massive privacy breach against me should be reported to their respective SLB's for criminal conduct and professional misconduct.

VHA Handbook 1100.18 on SLB Reporting, 38 CFR Part 47, RIN 2900-A178, Reporting Health Care Professionals to SLB's.

Talent Management System course Licensed Independent Practitioner Credentialer's Boot Camp
Credentialing SLB Class # VA 19590

This provides further information re: OSC case # DI-14-0558 and quite possibly compelling info for OSC case # MA-14-0162.

Additional OSC Disclosure violations:

1. VIOLATIONS OF 38 USC § 5705 - CONFIDENTIALITY OF MEDICAL QUALITY-ASSURANCE RECORDS:

The illegal privacy breaches of my VA medical records were inextricably linked to all of the violations reported to the OSC Disclosure and Complaints Examining Units forming the basis for a potential new investigation(s) including but not limited to illegal police escort restriction, illegal disenrollment, illegal fee basis denials, illegal Administrative Investigation Board (AIB), illegal refusal to comply with Freedom of Information Act (FOIA) requests, etc. since mostly non-clinical senior management officials, VA law enforcement and Business Office staff illegally accessed my Protected Health Information (PHI) as part of this overall ongoing illegal agency activity against me at the behest of Mr. Phil Moschitta (VA Northport director). Further privacy violations in addition to the illegal accessing of my VA medical records (electronic and hard copy) and other data platforms includes violations of 38 U.S.C. 5705 - Confidentiality of Medical-Quality Assurance Records since Barbara Inskip RN from the Performance Improvement (PI)/Quality Assurance (QA) department illegally accessed my VA medical records 1 day prior to my AIB interrogation ordeal. This illegally obtained PHI was adversely used against me by Mr. Moschitta (director) and Dr. Michael Marino (Chief Psychology) and Mr. Nick Squicciarini (VA Northport Police Chief) of the Workplace Violence (WPV)/Disturbed Behavior Committee (DBC) to form the basis of all the illegal Disclosure and CEU/ PPP violations setting the stage for the AIB. The AIB used this illegally obtained PHI to mock, taunt, humiliate, bully and ridicule me during 2 days of 9 hours of grueling interrogation. The links connecting all the dots in this systematic weaponizing of this PHI against me is proven by the director's own EEO ROI testimony, the AIB transcripts and all other evidence that has been hitherto submitted to your office that was obtained at my access level in light of the FOIA non-compliance by the agency. The AIB not only adversely used this against me but they also failed to properly secure the chain of custody including but not limited to 5705 documents which were revealed to the AIB. All AIB questions had phrases of embedded guilt with presumptions of guilt with overlying hostile accusatory overtones placing my disabilities on trial beyond the scope of the AIB charge. All questions were prefaced with lengthy preambles of guilt scolding me as a bully tactic to force a submissive capitulation by Mr. Paul Haberman RN AIB chair. As the AIB chair Mr. Haberman RN had a seething preconceived predetermined biased prejudicial vitriol of guilt against me based on the illegally obtained PHI and 5705 documents illegally gleaned from my VA medical records, military records illegally gleaned from other VA data platforms/bases and my confidential classified military experiences. In so doing Mr. Haberman RN failed key tenants of an AIB chair with his self-righteous zeal against me with his predisposed theories mainly: 1. he didn't try to disprove his own initial theories based on his own racist prejudicial proclivities as evidenced by his own statements clearly evident in the AIB transcripts and 2. he threw away evidence that did not support his own theory by refusing to interview supportive witnesses for me and was rephrasing witness testimonies in a manner that was not consistent with their intent in order to support his preconceived prejudicial guilt theory of me as per witnesses Police Officer Bill Kosteas, AFGE union steward Mr. Timothy McLaughlin, NFFE union president Mr. Richard Thomesen NP, Ms. Ellyn Milia RN, Dr. Sabahat Mahmood, etc. The AIB chair is tasked with finding the truth as it *is*; **NOT** as he sees it. This is clearly stated in the VA's own AIB training videos located in the VA Talent Management System (TMS) AIB course # VA 7083. Mr. Haberman RN failed to obtain medical clearance for

patients interviewed that had highly suspect cognitive/psychiatric capacities. Conflicts of interest with the AIB and convening authority (director) were not mitigated - evidence exists in the Chief of Staff (COS) Dr. Ed Mack Report of Contact (ROC) and e-mail correspondence with Human Resources (HR) manager Ms. Cheryl Carrington regarding my proposed suspension (of which your office has copies). The COS did not agree with the director and had serious misgivings since the director as the convening authority/deciding official had an already predetermined punishment/ major adverse action planned prior to the COS as the proposing official had recommended not to take any actions since he NEVER agreed with the premise of the entire AIB fiasco and subsequent debacle. Further conflicts of interest: Mr. Steven Wintch (privacy officer) as an AIB member was involved with the massive privacy breaches and failure on his part for years to do anything about it was retaliatory since I'd alerted him repeatedly and Mr. Wintch also illegally accessed my VA medical records (of which your office has copies of the e-mails and access logs with his name on it), Ms. Barbara Albanese RN (Workplace Development Program Manager Director's Office) as an AIB member is the director's personal friend involved with prior investigations of serious safety issues/ violations that I had reported to the director's office regarding the VA Northport nursing homes (of which your office has e-mail correspondence) and Mr. Paul Haberman RN as the AIB chair had a personal bias against me as evidenced by his statements in the AIB transcripts (of which your office has copies). This is all tantamount to a vindictive agency retaliation against me since the director clearly stated in his EEO ROI that he personally hand-picked the AIB (of which your office has copies). The OSC is compelled to also investigate who accessed my VA hard copy medical records including my C-file since there should be hard copy access logs unlike the computerized access logs (Sensitive Patient Access Report [SPAR]) for the electronic data bases and who illegally accessed my military/Department of Defense (DOD) records. Mr. Wintch continually refuses to release this information despite multiple FOIA requests for same; especially since this information was also adversely used against me by the AIB, WPV/ DBC and senior management against me along with the other PHI contained in the electronic data bases including but not limited to the Computerized Patient Record System (CPRS), VistA, VIS (VBA, SHARE), HINQ, etc. The AIB jumped to early conclusions based on a presumption of guilt, they did not disprove their own biased theories and they didn't question the evidence in writing their biased report. The same VA regional counsel attorney Ms. Kathleen Tulloch that was used as the agency attorney for the AIB represented a major conflict of interest since she was the same agency attorney involved in representing the agency in one of my EEO (Equal Employment Opportunity) cases I had filed to go to trial before the Equal Employment Opportunity Commission (EEOC) in federal court. Ms. Tulloch should've recused herself instead of attempting to "get rid of the case" by either firing me or discrediting my EEO case. This guidance is according to Aaron Lee National VA AIB Training Facilitator.

References: <http://vaww1.va.gov/ohrm//EmployeeRelations/AIB/AIBhome.htm>, VHA Handbook 0700

38 USC § 5705 - CONFIDENTIALITY OF MEDICAL QUALITY-ASSURANCE RECORDS:

Current through Pub. L. **113-36**. (See **Public Laws for the current Congress**.)

(a) Records and documents created by the Department as part of a medical quality-assurance program (other than reports submitted pursuant to section 7311(g) ⁽¹⁾ of this title) are confidential and privileged and may not be disclosed to any person or entity except as provided in subsection (b) of this section.

(b)

(1) Subject to paragraph (2) of this subsection, a record or document described in subsection (a) of this section shall, upon request, be disclosed as follows:

(A) To a Federal agency or private organization, if such record or document is needed by such agency or organization to perform licensing or accreditation functions related to Department health-care facilities or to perform monitoring, required by statute, of Department health-care facilities.

(B) To a Federal executive agency or provider of health-care services, if such record or document is required by such agency or provider for participation by the Department in a health-care program with such agency or provider.

(C) To a criminal or civil law enforcement governmental agency or instrumentality charged under applicable law with the protection of the public health or safety, if a qualified representative of such agency or instrumentality makes a written request that such record or document be provided for a purpose authorized by law.

(D) To health-care personnel, to the extent necessary to meet a medical emergency affecting the health or safety of any individual.

(2) The name of and other identifying information regarding any individual patient or employee of the Department, or any other individual associated with the Department for purposes of a medical quality-assurance program, contained in a record or document described in subsection (a) of this section shall be deleted from any record or document before any disclosure made under this subsection if disclosure of such name and identifying information would constitute a clearly unwarranted invasion of personal privacy.

(3) No person or entity to whom a record or document has been disclosed under this subsection shall make further disclosure of such record or document except for a purpose provided in this subsection.

(4) Nothing in this section shall be construed as authority to withhold any record or document from a committee of either House of Congress or any joint committee of Congress, if such record or document pertains to any matter within the jurisdiction of such committee or joint committee.

(5) Nothing in this section shall be construed as limiting the use of records and documents described in subsection (a) of this section within the Department (including contractors and consultants of the Department).

(6) Nothing in this section shall be construed as authorizing or requiring withholding from any person or entity the disclosure of statistical information regarding Department health-care programs (including such information as aggregate morbidity and mortality rates associated with specific activities at individual Department health-care facilities) that does not implicitly or explicitly identify individual patients or employees of the Department, or individuals who participated in the conduct of a medical quality-assurance review.

(c) For the purpose of this section, the term "medical quality-assurance program" means—

(1) with respect to any activity carried out before October 7, 1980, a Department systematic health-care review activity carried out by or for the Department for the purpose of improving the quality of medical care or improving the utilization of health-care resources in Department health-care facilities; and

(2) with respect to any activity carried out on or after October 7, 1980, a Department systematic health-care review activity designated by the Secretary to be carried out by or for the Department for either such purpose.

(d)

(1) The Secretary shall prescribe regulations to carry out this section. In prescribing such regulations, the Secretary shall specify those activities carried out before October 7, 1980, which the Secretary determines meet the definition of medical quality-assurance program in subsection (c)(1) of this section and those activities which the Secretary has designated under subsection (c)(2) of this section. The Secretary shall, to the extent appropriate, incorporate into such regulations the provisions of the administrative guidelines and procedures governing such programs in existence on October 7, 1980.

(2) An activity may not be considered as having been designated as a medical quality-assurance program for the purposes of subsection (c)(2) of this section unless the designation has been specified in such regulations.

(e) Any person who, knowing that a document or record is a document or record described in subsection (a) of this section, willfully discloses such record or document except as provided for in subsection (b) of this section shall be fined not more than \$5,000 in the case of a first offense and not more than \$20,000 in the case of a subsequent offense.

2. CREDENTIALING AND PRIVILEGING VIOLATIONS, REASSIGNMENT VIOLATIONS AND REAPPOINTMENT VIOLATIONS:

Mr. Moschitta (director) must provide a basis, rationale, terms and conditions for the illegal reassignment (Major Adverse Action) in the absence of any wrong doing which ultimately negatively effects my illegal reappointment in failing/ refusing to do so; especially since my former supervisor Dr. Youghee Limb (Service Chief Extended Care) clearly stated in her EEO ROI that she, "...had no issues with him (Joe Fasano) as a Nurse Practitioner..." (of which your

office has a copy). This intentional delay and woeful disregard for law, rule and regulation is a form of retaliatory harassment. Mr. Moschitta insists to appoint Ms. April Esposito as a **NON-CLINICAL** supervisor. Having a non clinical supervisor without a clinical service chief renders me incapable of working as a Nurse Practitioner (NP) at the VA negatively impacting the following: my Credentialing and Privileging (C + P) to new illegal reassignment and illegal reappointment which is a Major Adverse Action, my professional Registered Nurse (RN) and NP licensures and certification(s), etc. Despite many pleas by my union (see attached scanned e-mail correspondence), Mr. Moschitta, VA regional counsel and senior management remain obstinate in their stubborn refusal to comply with law, rule and regulations governing above rendering their decisions illegal in violation of the VA's own regulations, policies, procedures and Medical By-laws and statutory plenary laws governing NP practice. This is also a violation of The Joint Commission mandates. Mr. Moschitta, Ms. Maria Favale (Associate Director) and Mr. William Sainbert (Human Resources Chief) have weaponized this process to harass and retaliate against me by intentionally disrupting, delaying and negatively impacting my NP practice with potential adverse effects as previously outlined regardless of my reassignment to the Business Office. The Chief of Staff (COS) office and the C + P office cannot and will not certify, verify, ratify nor release the reappointment due to the following: the reassignment was a Major Adverse Action violating VHA Handbook 5021 and the NFFE Master Agreement, the C + P office cannot/ will not rescind my prior Collaborative Practice Agreement, there still is no new Collaborative Practice Agreement regarding my reappointment, the SF 50 and 52 forms were incorrect listing me as a Physicians Assistant (PA) v. NP, I've been assigned a non-clinical supervisor lacking the required legal credentials and authority, my Scope of Practice and Position Description/ Functional Statement have NOT been re-written, defined nor reassigned, etc. Also at issue is the illegal Prohibitive Personnel Practice (PPP)/ Disclosure issues enumerated to your office which are enmeshed and inextricably linked to this action including but not limited to illegal premise forming the basis for the illegal AIB being illegally placed on a non-duty status and the illegal police escort restrictions caused a greater than 30 day unresolved practice gap, however, despite being cleared by two AIB's (one internal, one external without due process nor representation also illegal) and multiple FOIA requests, the agency still refuses to release the AIB report in order to resolve same with the C + P office. This may in fact show up as a negative finding on the National Practitioner Data Bank (NPDB) query and enrollment in the Continuous Query Update, my State Licensing Board (SLB) New York State (NYS) since I am licensed through NYS and NOT the VA and I am certified via a private certifying body the American Academy of Nurse Practitioners (AANP) as an NP and NOT through the VA. The Service Chief is the responsible party for *recommending* privileges NOT the director, HR, COS, Business Office, etc. I am not assigned to a clinical service line further complicating this process. However, the director is the individual who grants privileges, revokes privileges, reduces privileges, suspends privileges or takes actions against privileges, therefore this clearly evinces the director and the agency in their retaliatory harassment and tangible employee actions negatively effecting same privileges. My reassignment and reappointment have NOT been ratified/certified by the Clinical Executive Board (CEB)/ Medical Executive Committee (MEC) because of same. The delineation of clinical privileges must be provider specific, setting-resource/ support staff-specific and facility specific. Also, a Focused Professional Practice Evaluation (FPPE) must be performed with each and every new reassignment/ reappointment - an impossibility with a non-clinical supervisor.

3. ADDITIONAL PRIVACY BREACH VIOLATIONS:

a. Further privacy breach violations include unauthorized repeated access to my VA7710Q records for Credentialing and Priveleging purposes by Ms. Joanne Anderson (director's AA). This Health Care Provider Credentialing and Priveleging Records VA is covered by the Privacy Act of 1974 since it includes sensitive information such as but not limited to: individually identifiable info, address, biometric data, education and training info, licensure, registration and certification info, citizenship, honors, awards, appointment info, mental and physical status (Declaration of Health form), evaluation of clinical and/or technical skills, etc. There are only 23 routine uses (RU's) permissable. All disclosures (internal and external) require a Release of Information (ROI) signature approval from the employee.

b. Dr. Mandar Tank (Service Chief PACT VA Northport) and my former supervisor, violated my wife's and daughter's Protected Health Information (PHI) further constituting additional HIPAA and Privacy Act violations by forcing me to provide a very detailed graphic humiliating letter from my wife's OB/ GYN private physician regarding her high risk pregnancy status requiring a C-section as a pre-tense/ pre-text and unnecessary hardship to approving my (paternity) leave requests, however, three other male physicians in the same department under his supervision during that same calendar year had their (paternity) leave requests automatically granted without any extemporaneous documentation. The VA failed to identify how they would properly/legally process, maintain and secure that letter and how it would be destroyed. It **MUST** be destroyed in accordance with VHA Handbook 6500 regulations as a logged **WITNESSED DISPOSAL**. The letter was maintained in an open public unsecured file that all were able to easily access in April 2010, however, it remains unknown if and how that letter was maintained, transferred, logged or even destroyed. The requested leave was illegally processed as a Family Medical Leave Act (FMLA) despite my refusal to sign or complete that paper work. I also had accrued significant benefit time so that I didn't need to use FMLA. I applied for and was eligible for the VA's Family Friendly Leave Act (FFLA), alas, the agency illegally processed it as an FMLA. The agency still refuses to correct this violation.

References:

VHA Handbook 1100.19 Credentialing and Priveleging, Talent Management System (TMS) training webinar "LIP Get the Scoop/LIP Policy Review" course # VA19596, Title 38 U.S.C. for Title 38 employees, Records Control System for VHA (RCS) 10-1, Credentialing and Priveleging 10-Q1, 77VA10Q System of Records for Credentialing and Priveleging, VHACRED&PRIV@va.gov, VHA Handbook 6500, Privacy Act of 1974, HIPAA Act of 1996, VHA Handbook 0700, VHA Handbook 5021, NFFE Master Agreement, VHA Handbooks 1605, 1605.1, 1605.2 and 1605.03.

Enclosed please find an Excel spreadsheet tracking the illegal privacy breaches with the corresponding geographical cross reference to the attached VA Northport NY campus map. The overwhelming majority of illegal privacy breaches were committed by folks assigned to the Business Office and the Director's Office. The Business Office reports directly to the Director's Office co-located in Building #10. This is only a partial listing since at my access level I am not able to obtain all of the titles, office/ location/ service/ department, etc. on many of the remaining

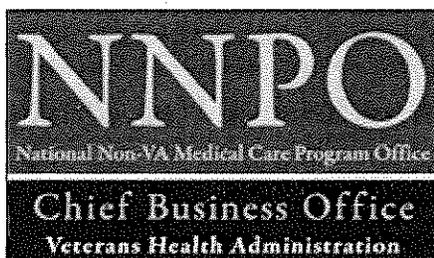
staff involved in the illegal privacy breaches, however, with the info that I do have it appears that the overwhelming majority of the hits are concentrated in the Business Office and Director's Office located in Buildings #10 and #200, then Building #12, then Building #6, then Building #11 and Building #9. Buildings # 10, 9, 6, 11 and 12 are NON-CLINICAL serving a purely administrative function, therefore they had no right to access my medical records. The Business Office oversees Fee Basis Office, Compliance Office, Privacy Office, Eligibility and Enrollment Office, etc. across Buildings #10, #200 and #9 along with the Performance Improvement Office are task organized under the Director's Office. Simply put, this was an illegal effort combined with the other Disclosure issues that can only have been coordinated by the director against me. Your office has all copies of the access logs (SPAR). The breakdown is as follows:

Building 200 -> 30/48 staff
Building 10 -> 11/48 staff
Building 12 -> 2/48 staff
Building 9 -> 1/48 staff
Building 11 -> 1/48 staff
Building 6 -> 2/48 staff

Business Office 25/48 staff
Director's Office 1/48 staff
Chief of Staff Office 3/48 staff
Nursing Service 6/48 staff
OI & T Office 2/48 staff
Social Work Dept 3/48 staff
Police Dept 1/48 staff
Performance Improvement Dept 1/48 staff
Orthopaedics Dept 1/48 staff
Radiology Service 1/48 staff
Pharmacology Dept 1/48 staff
PM & R Service 1/48 staff
Community Relations Dept 1/48 staff

I've also included my Veterans Identification Card (VIC) which clearly shows that I was a registered, enrolled and eligible service connected disabled veteran prior to the illegal disenrollment and other illegal activities constituting a Disclosure and/or CEU PPP issue for further/additional investigation.

Enclosed please find Fee Basis policy, procedures, laws and regulations to shed light on how severe and pervasive the criminal conduct is at the VA towards me.



Policy & Procedures - Law & Regulations

Listed by category are the three main Fee Basis Purchased Care United States Codes (U.S.C.) followed by their applicable Code of Federal Regulations (CFR).

- 38 U.S.C. 1703 Contracts for hospital care and medical services in non-Department facilities

38 CFR 17.52 Hospital care and medical services in non-VA facilities

38 CFR 17.53 Limitations on use of public or private hospitals

38 CFR 17.54 Necessity for prior authorization

38 CFR 17.55 Payment for authorized public or private hospital care

38 CFR 17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care

- 38 U.S.C. 1728 Reimbursement of certain medical expenses

38 CFR 17.120 Payment or reimbursement of the expenses of hospital care and other medical services not previously authorized

38 CFR 17.121 Limitations on payment or reimbursement of the costs of emergency hospital care and medical services not previously authorized

38 CFR 17.122 Payment or reimbursement of the expenses of repairs to prosthetic appliances and similar devices furnished without prior authorization

38 CFR 17.123 Claimants

38 CFR 17.124 Preparation of claims

38 CFR 17.125 Where to file claims

38 CFR 17.126 Timely filing

38 CFR 17.127 Date of filing claims

38 CFR 17.128 Allowable rates and fees

38 CFR 17.129 Retroactive payments prohibited

38 CFR 17.130 Payment for treatment dependent upon preference prohibited

38 CFR 17.131 Payment of abandoned claims prohibited

- 38 U.S.C. 1725 Reimbursement for emergency treatment
38 CFR 17.1000 Payment or reimbursement for emergency services for nonservice-connected conditions in non-VA facilities

38 CFR 17.1001 Definitions

38 CFR 17.1002 Substantive conditions for payment or reimbursement

38 CFR 17.1003 Emergency transportation

38 CFR 17.1004 Filing claims

38 CFR 17.1005 Payment limitations

38 CFR 17.1006 Decisionmakers

38 CFR 17.1007 Independent right of recovery

38 CFR 17.1008 Balance billing prohibited

Other Non-VA Care Related Laws & Regulations:

- 38 U.S.C. Part III Chapter 31 Training and Rehabilitation for Veterans with Service-Connected Disabilities
- 38 U.S.C. 8153 Sharing of health care resources
- 38 U.S.C. 8111 Sharing of Department of Veterans Affairs and Department of Defense health care resources
- 38 CFR 17.36 Enrollment - provision of hospital and outpatient care to veterans
- 38 CFR 17.37 Enrollment not required - provision of hospital and outpatient care to veterans
- 38 CFR 17.38 Medical benefits package
- 38 CFR 21 Vocational Rehabilitation and Education

[NNPO Home »](#)

- About
- Administration and Contracts
- Fee Facts Archive

- Field PD Samples
- History of Fee
- NNPO Newsletters and News Alerts
- National Non-VA Care Program Conference Call
- Medicare Pricing Implementation



- Law & Regulations
- Handbooks & Directives
- Procedure Guides
- Notices
- Memorandums
- Fact Sheets
- Program Information
- Tools



- Field Advisory Team
- Site Visit Requests



- Audits
- Indian/Tribal Agreements
- State Homes
- Dialysis

Program Integrity

Patient-Centered Community Care (PC3)

Clinical Advisory Group

VA OIT Bulletins

FBCS Archive

FBCS Stoplight

FBCS Enhancements

FBCS Optimization

Enclosed please find VA enrollment and eligibility policy, procedures, laws and regulations to shed light on how severe and pervasive the criminal conduct is at the VA towards me.

Enrollment

Public Law 104-262, The Veterans' Health Care Eligibility Reform Act of 1996, required the Veterans Health Administration (VHA) to establish a patient enrollment system by October 1, 1998. In order to satisfy this congressional mandate, software was engineered with incremental releases on the Veterans Health Information Systems and Technology Architecture VistA and Health Eligibility Center (HEC) systems.

Featured Initiative

Administrative Data Quality Council

Guidance for providing VA Health Care

Frequently Asked Questions (FAQs)

Administrative Data Quality Council

Administrative data is key within the Veterans Health Administration (VHA) for managing health care. Administrative data is defined as Identity, Demographic, Eligibility, Enrollment and Insurance data related to beneficiaries. Complete and accurate administrative information facilitates the business processes that drive essential functions within VHA, including enabling veterans to receive their prescriptions, the distribution of scheduling letters and/or other important correspondence, accurate determination of eligibility for care, complete and accurate billing, and access to complete medical record information. Incomplete or inaccurate information also affects Identity Management, which substantiates unique identification of beneficiaries in the provision of healthcare and is essential in avoiding patient safety issues and enabling identification of beneficiaries throughout the enterprise.

The Administrative Data Quality Council (ADQC) facilitates the formalization and implementation of a cohesive plan to improve data quality areas such as billing, eligibility, addresses, and identity management across systems throughout the enterprise.

Guidance for providing VA Health Care

The VHA Chief Business Office (CBO) maintains a collection of publications and other resources which provide a very helpful overview of VA healthcare enrollment and benefits available for our veterans. These documents should be shared with facility personnel and veterans and their families. Enrollment coordinators and healthcare benefit advisors can visit the CBO Eligibility and Enrollment Library to obtain copies of this documentation for local distribution.

CBO Eligibility and Enrollment Library

Enrollment Training Initiatives

Enrollment Training Home

10-10EZ

Combat Veteran

DFAS Pay Management

Enrollment Subpriorities

Enrollment System Redesign

Enrollment Update

Enrollment VistA Changes

HINQ

OEF/OIF

Preventing Catastrophic Edits to Patient Identity

Register Once Messaging

Veterans Identification Card

Veterans Information Solution

Archived Training Initiatives

Proves different access levels to my PHI by the Chief Business Office, Compliance Office, Performance Improvement Department and Fee Basis Office staff involved in privacy breaches against me.

Security: e-Mail Concerns

Introduction: E-mail is not a secure mode of communication. This is especially important to remember when dealing with individually identifiable personal or medical information.

Objective: When you complete this lesson, you will be able to better protect individually identifiable health information when using e-mail.

The Health Insurance Portability and Accountability Act (HIPAA) imposes severe penalties for the disclosure of protected health information. It is the responsibility of each VA staff member to secure such information.

- Do not send electronic mail (e-mail) containing individually identifiable personal or medical information on a veteran. If it is necessary to transmit such information via e-mail, the sender must encrypt the message so that only the intended recipient will be able to access it.

- Do not send faxes containing protected health information unless the receiving fax machine is in a protected location. A protected location is defined as a location that does not allow access to unauthorized individuals or to the general public

Security: Public Key Infrastructure (PKI)

Introduction: Public Key Infrastructure (PKI) maintains ensures the Confidentiality of health information.

Objective: Upon completion of this lesson, users will be familiar with the basic uses and requirements of PKI.

Public Key Infrastructure (PKI) is a system of digital certificates and other registration authorities that verify and authenticate the validity of each party involved in an internet transaction. In health care, PKI is an encryption and decryption of protected health information used to ensure Health Insurance Portability and Accountability Act (HIPAA) standards in order to prevent violations of information confidentiality. PKI uniquely identifies business partners and associates to ensure that the sender and recipient are who they represent themselves to be. A digital key, or signature, identifies and certifies that all parties involved in a transaction are who they claim to be.

If a transaction requires the electronic transmission of individually identifiable health information, the sender must encrypt the data during the transfer, and a system of records must exist for audit purposes.

Users can digitally sign and/or encrypt email messages through Microsoft Outlook, which uses certificates to support the digital signature and/or encryption. The digital signature enables recipients to verify the identity of the sender and provides the recipients assurance that the message remains unaltered during transmission. A digital signature does not affect the contents of the message nor does it ensure that someone other than the intended recipient can read the message. Encryption is the only way to ensure that only the intended recipient receives and reads the message.

For more information about PKI, contact the Information Security Officer (ISO) at your facility.

Summary: This completes the lesson on PKI. In this lesson, the basic requirements and uses of PKI were reviewed.

Routing Claims: Electronic Data Interchange (EDI)

Security: Routing Claims Electronic Data Interchange (EDI)

Introduction: Electronic claims reside on the Fee Payment Processing System (FPPS). The individual learner's duties determine the level of access to this system.

Objective: Upon completion of this lesson, learners will know the various levels of access to the FPPS.

Electronic claims are transmitted to and reside on the Fee Payment Processing System (FPPS). The National Fee Program Office in Denver grants access to this system upon requests from employees' supervisors. When Denver approves the request, employees will receive notification and access instructions via Microsoft Outlook. Typically, Fee Clerks add this website to the listing of Internet Favorites.

Use of EDI for the processing of Fee Basis claims ensures VA compliance with Health Insurance Portability and Accountability Act (HIPAA) transaction requirements. Position-specific responsibilities determine the employee's level of access. There are five access levels assignable to employees:

Level of Access	Access	Explanation
Fee Mail Clerk	Process Claim Menu	Limited to the printing of claims
Fiscal User	Out of System Claim Menu	Limited to submitting payment information for payments made outside the VistA Fee Program
Fee Clerk	All menus	Access to all menus, though there will be some limitations within each menu
Fee Supervisor	All menus	Access to all menus within his or her own facility
Veterans Integrated System Network (VISN) Administrator	All menus	Access to all menus for VISN facilities and some VISN to VISN access

My veteran identification card (VIC) proves that I was enrolled in the VA (see attached scanned copy). Not only am I in Priority Group I as a 100% disabled veteran, I also qualify for Enhanced Eligibility based on the 100% rating and the fact that I am rated for greater than 6 service conditions places me in yet another special protected category of disabled veterans. Further proof that I was enrolled and eligible for VA benefits including but not limited to health care prior to the illegal disenrollment.

This is more evidence that evinces Mr. Moschitta (facility director) and the agency in the massive disclosure violations against me including but not limited to the following:

DISCLOSURE VIOLATIONS:

***Illegal fee basis denials**

***Illegal privacy breaches**

***Illegal disenrollment**

Separation of Duties (SOD)/ Continuous Readiness Information Security Program (CRISP) training is part of the Chief Business Office (CBO) training module:

SOD: the assigning to different individuals the responsibilities of authorizing transactions, recording transactions and maintaining custody of assets. Designed to decrease opportunities for one person to perpetrate and conceal errors of fraud, waste and abuse (FWA) and decrease the risk of errors. This process further proves the CBO's involvement in the illegal privacy breaches (of various platforms) in connection with the illegal disenrollment and illegal fee basis denials.

SOD responsibilities: duties of employees with system access will be properly and *controlled* so that no employee violates his or her system privileges needed to perform their duties. *Failure to properly monitor computer access levels compromises SOD results in fraudulent or improper payments or leaves VA funds vulnerable to loss or theft.* This proves that the CBO was involved in all aspects of the privacy breaches with their access to all data platforms and System of Records (SOR) in connection with the illegal privacy breaches, illegal fee basis denials and illegal disenrollment. This process involves all CBO staff by design since in the performance of their duties they would've been inextricably involved in all aspects of the illegal privacy breaches and illegal disenrollment yet they failed to report this crime. In failing to do so (whether by commission or omission) they violated law, regulation or rule being accomplices to this agency crime.

VA Policy References:

http://vaww.cfo.med.va.gov/173/Alerts_13/005_2013_fee_cert_busi_rules.pdf

<http://vhahacnonva.vha.med.va.gov/docs/DeputyCBOMemoVistASecurityControlsSeparationofDuties.pdf>

Deputy CBO memorandum – VistA Security Controls – SOD

CBO Fact Sheet – VistA Fee – IFCAP SOD

Manual M-1 Operations Part I Medical Administration Activities

The Information Security Officer (ISO) Linda McGinty and Compliance Officer (CO) Pat Helgesen were both involved by failing to properly oversee and directly involved by being part of the illegal process to disenroll me, illegal privacy breaches and illegal fee basis denials.

References: Business Rules Related to VistA Fee Application Software Access and SOD Control, Volume 2013; Issue 05; Oct 12, 2012.

It is interesting and disturbing to note that most of the senior management and administration officials from various departments (Performance Improvement, Director's Office, Compliance Office, Fee Basis Office, Chief of Staff office, Fiscal Office, Business Office, Billing Office, Coding Office, Travel Beneficiary Office, Human Resources, Chief of Staff office, etc.) involved in the illegal privacy breaches, illegal fee basis denials, illegal police escort restriction and illegal disenrollment are all co-located in building #10 on the VA Northport campus. To place this in the proper perspective, the VA Northport is NOT just located within one building rather the 1,800+ member workforce is scattered across the 500 acre campus in hundreds of offices over a myriad of buildings making this massive crime that much more ominous given the enormous geographical foot print of the facility (in fact one lap around the main complexes of buildings is equivalent to one mile) so this was clearly a coordinated systematic effort emanating from the director's office with the following individuals + many others in the Business Office, Fee Basis Office, Non-VA Care Coordination (NVCC) office, Compensation and Pension (C and P) office, Compliance office, Performance Improvement department, etc. illegally accessed my VA CPRS medical records, therefore by design they would've illegally accessed all other data platforms constituting further privacy breaches: Pat Helgesen (Compliance Officer), Steven Wintch (Privacy Officer), Linda McGinty (Information Security Officer), Nancy Mirone (Chief Business Office), April Esposito (Assistant Chief Business Office and my new supervisor), Marie Irwin (Fee Basis specialist supervisor), Omaid Wilson (Fee Basis clerk), Thomas Sledge (Eligibility and Enrollment staff), Kristin Sievers (Chief Eligibility and Enrollment office), Nyny Romero (C and P staff), Maribel Haddock, Sharran Chambers-Murphy (Business Office clerk), etc.

Aberrancies must be reviewed and recorded with a Causation/ Corrective Action Plan(s) (CCAP) to address deviancies. This was not done in my case. These worksheets must be sent to the VISN (3) leadership for review, then certified and signed by the VISN (3) director (Michael Sabo) to be sent to VA Central Office (VACO) Compliance and Business Integrity (CBI) office. Mr. Sabo is ultimately guilty since he was fully aware of all the illegal issues directly since I contacted his office several times (being rebuffed each time) and by being informed via Eric Shinseki's (VA Secretary) office, elected officials, OSC, NFFE union, etc. with my many complaints to them eventually being processed and filtered down the VISN (3) chain of command (COC).

Facility Compliance Officers: must follow procedures outlined below as related to the CFO Alert Volume 2013, Issue 05 – VISTA FEE APPLICATION SOFTWARE ACCESS AND SEPARATION OF DUTIES CONTROL – this would've been required by Pat Helgesen (CO) regarding illegal privacy breaches on all platforms and databases, illegal fee basis denials and illegal disenrollment:

*Validate results from CBO/ISO with the CBI Validation Template

***ALL results must be reported via CIRTS incident record by using a CIRTS subject category called Privacy, Security and HIPAA Issues; CRISP Fee**

*ALL findings need to be recorded in the local Compliance Committee minutes

This was never done for me on above Disclosure violations of law, rule, regulation. Ultimately, the local failures, criminal activities and violations of rule, law and regulations hold the VISN (3) leadership culpable.

Additional databases and platforms where my medical information, Protected Health Information (PHI), personal information, etc. was compromised and illegally shared and transmitted is Outlook e-mail since it's NOT considered a secure means of (electronic) communications. Any messages containing ANY sort of sensitive information MUST be encrypted, however, this is rarely done since the VA is very sloppy with its shoddy command and control over its System of Records (SOR) either by deliberate commission or omission. Simply put, any information regarding me that was shared, transmitted, forwarded, saved, stored, deleted, downloaded, printed, etc. by ANY VA employee(s) including but not limited to senior management, administration, police, clinicians, clerks, etc. MUST be either encrypted using PKI software application and/or handled on the Vista e-mail system. I am not privy at my access level to the veritable plethora of the above that was discussed about me during this entire process and the time before, during and since, however, ALL FOIA requests for same was repeatedly refused, rebuffed, denied and/or ignored by the facility privacy officer Mr. Steven Wintch.

More Violations: Justification and Delegation of Authority Tool:

Mr. Phil Moschitta (VA Northport director) violated 48 CFR 801.670-3 and 48 CFR 813-307 Delegation of Authority when he refused Fee Basis requests for care via the patient advocate (which was well documented by Mr. William Marengo RN in the Patient Advocate Tracking System of which you have a copy). The Fee Basis requests, acceptance or denials can only be processed by the Chief of Staff (COS) Dr. Ed Mack who has the sole authority. This must be documented by the COS in a Department of Veteran's Affairs template with the subject line: Delegation of Clinical Approving Authorities (see above CFR's) with the key word being "Clinical"; NOT the director who has neither the legal clinical authority nor credentials to make any sort of "clinical" decisions. The Business Office, Non-VA Care, Fee Basis or Comp and Pension offices at the VA Northport should NOT have accessed my VA medical records (Computerized Patient Records System [CPRS]) since Mr. Moschitta completely circumvented the above Fee Basis processes denying my rights to due process. The five claim types under this program are Pre-Authorization (1703), Un-Authorized (1728), Mill Bill (1725), Civil (1750) and Contract Sharing. By illegally disenrolling me Mr. Moschitta interfered with my rights to eligibility and enrollment jeopardizing my health, safety and well-being. CPRS is a GUI (Graphic User Interface) based Electronic Medical Record (EMR) system representing only one aspect of the entire VA System of Records (SOR) hence it is NOT the only way in which privacy breaches/ violations can and did occur with me. Other data bases, SOR's, EMR's, and hard copy records that were illegally accessed include but are not limited to: Veteran Information System

(VIS a.k.a. VBA, SHARE), Hospital Inquiry (HINQ), C-file (for Comp and Pension info), VISTA (which is a Command User Interface [CUI] based system with multiple screens and menus representing a veritable treasure trove of data) such as the Service Record Screen in OERR, etc. The folks in the above named offices would've undoubtedly accessed all of the named SOR's since many of them were involved in the massive privacy violations in the OSC investigation DI 13-3661. The illegally obtained information was adversely used against me to form the basis for the illegal unilateral hostile personnel action that was extended to me as a veteran/ patient with the illegal police escort restriction and the denial of fee basis care. I am now treated like some sort of social leper akin to an ex-con on a work-release program - a minimum of two people engage me at all times with at least one being from management. Mr. Steven Wintch privacy officer as you are well aware has refused and failed to investigate the privacy breaches and continues to refuse to comply with Freedom on Information Act (FOIA) requests for pertinent information; he refuses to release the access logs to this additional SOR despite multiple FOIA requests. He also refuses to provide information on disclosures of my Protected Health Information (PHI) representing yet another disclosure violation. Mr. Wintch refuses to provide/ release under FOIA prior e-mails with him, the Privacy Office, the Information Security Office, HR, etc. since most of these were purged/ deleted during my agency-induced absence from the VA (a form of evidence tampering) - this data is impossible for me to retrieve at my access level. Most of my new co-workers including April Esposito my new supervisor were involved in the illegal accessing of my VA medical records, PHI and privacy breaches. My reassignment requires extensive computer based training reviewing many laws, regulations, etc. which was enlightening offering new insight into the further extent of the massive privacy breaches that haven't stopped at the CPRS medical records. This must be investigated along with how the laws and regs were broken and adversely used against me. I am placed in a conference room being closely monitored on all sides by the same people that illegally accessed my medical records, PHI, etc. It's very humiliating and further alienates me by reinforcing the stigmata of being disabled and having Post Traumatic Stress Disorder (PTSD) - the associate director Ms. Maria Favale clearly stated this in a meeting on 11/13/2013 when she flippantly mocked with a karate chop motioning of her hand towards me that I, "...was on a paid vacation lounging around the house..." and "...that you need to be closely watched...monitored...to make sure you're doing what you're supposed to be doing..." Nothing can be further from the truth. You are well aware of how this awful ongoing experience has exacerbated my disabilities including but not limited to PTSD and severe migraine headaches with increased nightmares, depression, anxiety, insomnia, etc. This desecrates the memories of all of my fallen comrades and brothers in arms. The sad part is that I actually like having nightmares because for a short while I am reunited with my brethren, however, I wake up depressed and angry to the reality that they are dead. I have to sleep on the couch since my fitful sleep is very disruptive to my wife. It's hard enough that I have a baseline detached aloofness from my family as part of my service connected PTSD; like I'm just going through the motions - but I'm not really there. Now the same federal agency that is required by law to provide all of my benefits as a 100% disabled veteran is involved in a massive targeted systematic privacy breach adversely using that illegally obtained info against me in their illegal attempts to terminate my employment at the direction of Mr. Moschitta. The extent of this ongoing illegal activity will not be known unless OSC accepts an additional disclosure and/ or PPP complaint for investigation to reveal the breadth and scope of the agency involvement. I am the only Joseph Fasano employed by the VA so it's clear that I was targeted since there are many

Joseph Fasano veterans but I am the ONLY 100% disabled Joseph Anthony Fasano veteran employee.

To that extent as I understand these issues are categorized by OSC as the following:

DISCLOSURE ISSUES:

*Illegal police escort restriction

*Illegal Fee Basis Care denials

*Disparate treatment/ interpretation/ application of Workplace Violence/ Disturbed Behavior Committee policy and procedure re: no threat level therefore false pretenses forming basis for illegal AIB

*AIB discrimination (see 65 pages of AIB transcripts) - my disabilities were placed on trial and the AIB members including Mr. Paul Haberman RN (AIB chair), Mr. Steven Wintch (privacy officer) and Ms. Barbara Albanese RN made fun of my disabilities by taunting, mocking, humiliating and jeering at me in a disrespectful aggressive tone (it felt more like water boarding than an interview). Mr. Haberman also made fun of my sometimes Limited English Proficiency when I revert back to my native tongue (Italian) grasping for certain phraseology and descriptives which are easier for me to articulate in Italian than English (there are several instances of this during the AIB testimony, however I would need to send you the entire 225 pgs of transcripts). When I sheepishly stated that as a child I was placed in English remedial classes being plucked out of the classroom due to my English deficiencies, Mr. Haberman laughed at me stating, "...well it sounds like you had tart cart syndrome,...riding the short bus like a retard..."

*Whistle Blower retaliation - conflict of interest that Mr. Wintch was an AIB member (according to NFFE and AFGE union reps, he was targeting me in a zealous manner during the AIB interviews of their Bargaining Unit Employee (BUE) witnesses - he was rephrasing and placing words in their mouths contrary to their testimonials and intent - he especially targeted those with Limited English Proficiency preying upon their difficulties to fully express complex issues). AIB refused to interview supportive witnesses. This is whistle blower retaliation for exposing and complaining about the privacy issues with me.

*AIB refusal to provide a special accommodation based on disabilities - the two days of nine hours of grueling testimony in a public heavily trafficked location embedded in the HR department with a cop present was frightful, intimidating and humiliating - the location should've been off campus in a neutral location since the police escort restriction severely exacerbates my PTSD

*New privacy breaches since the privacy violations extend far beyond the medical records

*The AIB external review is double jeopardy without due process since I was cleared with no findings at the local level and I was informed by my union president that the external review confirmed no findings

*Agency FOIA refusals and non compliance

*Whistle blower retaliation: VA regional counsel is pitching a fit that I've contacted and notified my elected officials of the ongoing issues that I'm suffering as a 100% disabled veteran, patient and employee. They are falsely impugning me by saying that I am being emotionally disruptive when I am as quiet as a mouse focused on conducting the required computer based training for my reassignment (which can be easily proven by the IT department). My former supervisor Dr. Younghee Limb is spreading false rumors that I am intimidating and threatening my new co-workers when all I do is sit in isolation in front of a computer all day.

*Disclosure violations: the illegal disenrollment from Eligibility and Enrollment by Thomas Sledge, Kristen Sievers, et al during 8/2013.

PPP COMPLAINTS EXAMINING UNIT ISSUES:

*OSC CEU is still conducting an analysis for acceptance of whistle blower retaliation and the reassignment for investigation as a PPP.

References: in my case the VA Northport would've failed this Justification and Delegation of Authority Tool (JDA) compliance audit for Mr. Moschitta unilaterally denying my Fee Basis requests as documented by the patient advocate in the Patient Advocate Tracking System (PATS). The attachments have embedded training courses with hyperlinks to the laws, regulations, policies, procedures and memos for veteran health care including but not limited to fee basis care. The references serve as a guideline to show the repeated violations in my case re: denial of due process, denial of fee basis care and ongoing privacy breaches.

Pre-Authorized Fee Care highlighted by the Department of Veterans Affairs Office of Inspector General (OIG) and Management Quality Assurance Service (MQAS) as an area of risk.

Guided by regulations:

VHA Handbook 1601F.01, General Fee Policies and Guidelines

48 CFR SS 801.670-3 – Medical, dental and ancillary services

Deputy Under Secretary for Health for Operations and Management Memo, 11/23/09

Title 38 USC 1703, Chapter 17 – Hospital, Nursing Home, Domiciliary and Medical Care

VHA Handbook 1907.01 “Health Info Management and Health Records” paragraph 6 section S

JDA Audit Tool:

I. Column B: Was Justification Documented?

Goal: 100% Yes for compliance

Acceptable justification:

1. VA facility does not provide the services
2. Veteran cannot safely travel to VA due to medical reason
3. Veteran cannot travel to VA due to geographical inaccessibility

4. VA cannot timely provide the required service

5. Other

II. Was procedure specified?

Goal: 100% yes for compliance

III. Column D: Is the care approved/denied in the consult

Goal: 100% of responses are Approved/ Denied and signed

If the request was approved or denied, is the approval/denial specifically documented in the referral consult?

IV. Column E: Was the approval/denial performed by:

1. Chief of Staff, or

2. Chief MAS (or Chief Health Administration Service, Business Office Manager i.e. the person delegated by the facility director to perform medical administration functions)?

Answer choices: Yes or No (Presence of approval or denial by the correct official would result in a "yes" answer. Decisions made by another official would result in a "no.

Goal: 100% Yes for compliance

V. Column F: Is there an established Delegation of Authority Memo in existence?

Goal: 100% Yes for compliance if someone other than the COS or Chief MAS/equivalent made the decision

VI. Column G: if NOT approved/denied by COS or Chief MAS/equivalent was the approver named in a Delegation of Authority Memo?

Goal: 100% Yes for compliance for cases when someone other than the COS or Chief MAS/equivalent made the decision to approve/deny treatment

New Bill: VA Must Provide for Veterans Seeking Outside Mental Health Services

Mr. Moschitta violated this legislation when he refused fee basis request for PTSD counseling - he was fully aware of my disability and that the illegal police escort restriction exacerbated severely my PTSD.

http://www.usmedicine.com/articles/new-bill-va-must-provide-for-veterans-seeking-outside-mental-health-services.html#.Uo9Ze_De85A.email

<http://www.usmedicine.com/articles/new-bill-va-must-provide-for-veterans-seeking-outside-mental-health-services.html#.Uo9ZeDe85A.email>

Non-VA Medical Care Eligibility Criteria

Introduction

Non-VA Medical Care eligibility is covered under four statutes:

38 U.S.C. § 1703 - Obtaining non-VA inpatient and outpatient medical services on a preauthorized basis by contract or individual authorization.

38 U.S.C. § 1728 - Reimbursement for emergency treatment furnished to service-connected Veterans meeting required criteria in a non-VA health care facility (HCF) without prior authorization.

38 U.S.C. § 1725 - Reimbursement for emergency treatment of non-service connected conditions in a non-VA HCF without prior authorization.

Definition

Clinical Access Criteria – Non-VA Medical Care statutes authorize the use of non-VA medical care when VA or other Federal HCFs are feasibly unavailable. This means that VA or other Federal HCFs with which VA has an agreement to furnish inpatient or emergency care for Veterans, could not provide the care due to:

VA is not capable of furnishing economical care, or

VA is geographically inaccessible to the Veteran, or

VA cannot provide the necessary care or service, or

When the prudent layperson standard applies.

Individual Eligibility Criteria – The administrative determination regarding Veteran eligibility is based on individual eligibility criteria, such as treatment of service-connected conditions or referral from a VA HCF for an emergency condition the VA cannot treat.

Prudent Layperson Standard – The prudent layperson standard applies to a medical condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health.

This standard would be met if there was an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine would reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Note: Prudent layperson standard is based on the symptoms the Veteran presents with to the emergency room and not the actual clinical diagnosis when determining if the episode of care is an emergency. A clinician should make the determination for the prudent layperson standard.

Eligibility Criteria for Authorization of Emergency Treatment 38 U.S.C. § 1703

Eligibility under 38 U.S.C. § 1703 may be authorized for both outpatient and inpatient care as indicated in the table below. Additionally, this information may be found on the NNPO Intranet contained in VHA DIRECTIVE 1601.

Eligibility Criteria for Emergency Treatment of SC Conditions 38 U.S.C. § 1728

How to Validate Veteran's Eligibility Status

Use the interfaces listed below are available to validate the Veteran's eligibility:

VistA Fee Inquiry

KLF Menu, "Search for User Activity in Past 24 Months", for national activity: Find User

(Check CPRS VistAWeb/Remote Data

HINQ (Hospital Inquiry)

VIS (Veteran Information Solution)

ESR

Contact the HEC

Additional References

Additional guidance for non-VA medical care authorities, are available in the following Title 38 Code of Federal Regulations (CFRs).

38 U.S.C. § 1703:

38 CFR § 17.53 Limitations on use of public or private hospitals

38 CFR § 17.54 necessity for prior authorization

38 CFR § 17.55 Payment for authorized public or private hospital care

38 CFR § 17.56 Payment for non-VA physician and other health care

38 U.S.C. § 1728:

38 CFR § 17.120 Payment or reimbursement of the expenses of hospital care and other medical services not previously authorized

38 CFR § 17.121 Limitations on payment or reimbursement of the costs of emergency hospital care and medical services not previously authorized

38 CFR § 17.122 Payment or reimbursement of the expenses of repairs to prosthetic appliances and similar devices furnished without prior authorization

38 CFR § 17.123 Claimants

38 CFR § 17.124 Preparation of Claims

38 CFR § 17.125 Where to file claims

38 CFR § 17.126 Timely filing

38 CFR § 17.127 Date of filing claims

38 CFR § 17.128 Allowable rates and fees

38 CFR § 17.129 Retroactive payment prohibited

38 CFR § 17.130 Payment for treatment dependent upon preference prohibited

38 CFR § 17.131 Payment of abandoned claims prohibited

38 U.S.C. § 1725:

38 CFR § 17.1000 Payment or reimbursement for emergency services for non-service-connected conditions in non-VA facilities

38 CFR § 17.1001 Definitions

38 CFR § 17.1002 Substantive conditions for payment or reimbursement

38 CFR § 17.1003 Emergency Transportation

38 CFR § 17.1004 Filing claims

38 CFR § 17.1005 Payment limitations

38 CFR § 17.1006 Decision makers

38 CFR § 17.1007 Independent right of recovery

38 CFR § 17.1008 Balance billing prohibited

Eligibility Determination VHA HANDBOOK 1601A.02:

ELIGIBILITY DETERMINATION

1. **REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook updates Department of Veterans Affairs (VA) information on determining eligibility for VA health care benefits.

3. DEFINITIONS

f. **Compensable Service-Connected (SC) Disability.** A compensable SC disability is a VA-rated SC disability for which monetary compensation is authorized for payment. *NOTE: Military retirees, who were discharged for a disability incurred or aggravated in the line of duty, are eligible for care for 1 year after discharge; after the first year of care, enrollment is required.*

j. **Enrollment.** Enrollment is the acceptance of an eligible Veteran into the VA Health Care System and assignment to an enrollment priority group.

t. **Service-Connected (SC) Veteran.** A SC Veteran is one who has an illness or injury incurred in, or aggravated by military service as adjudicated by the Veterans Benefits Administration (VBA).

v. **Veteran.** In general, a Veteran is a person who:

(1) Served in the active military, naval, or air service; and

(2) Was discharged or released from service under conditions "other than dishonorable."

NOTE: For more information on the definition of Veteran and for other service that may qualify an individual for Veteran status, see: 38 CFR § 3.1, §3.6, and §3.7.

4. SCOPE. This handbook provides details on:

- a. Tentative eligibility for VA care;
- b. Basic eligibility requirements for VA care;
- d. Eligibility for specific categories;

5. TENTATIVE ELIGIBILITY FOR VA CARE

Medical services (excluding outpatient dental care) may be provided to a Veteran when an application is received for which eligibility is likely to be granted, but which requires adjudication of service connection or another eligibility determination, which cannot be immediately established. Tentative eligibility is only made:

- a. If the applicant needs hospital care or other medical services in emergency circumstances, or
- b. For persons recently discharged from service, if the application was filed within 6 months after honorable discharge from an active duty period, which was at least 6 months long.

***NOTE:** For more information on tentative eligibility see 38 CFR § 17.34.*

6. BASIC ELIGIBILITY REQUIREMENTS FOR VA CARE

***NOTE:** For more information on eligibility determinations, see *VHA Procedure Guide (PG) 1601A.02 (for internal VHA use only)*.*

a. Enrollment as a Condition of Eligibility

- (1) To be eligible for VA health care benefits, most Veterans must be enrolled with VA.
- (2) Among those who are exempt from the enrollment requirement are:
 - (a) Veterans requiring care for SC condition;
 - (b) Veterans rated 50 percent or greater SC for any condition; and
 - (c) Veterans who are retired, discharged, or released from active military service for disability incurred in, or aggravated by, a line of duty. These Veterans:
 - 1. Are not required to enroll to receive hospital care or outpatient medical services for that disability the first 12 months following separation from active military service; however,

2. Must enroll to be eligible for health care benefits after the first 12 months following separation from active military service.

NOTE: For more information on the categories of Veterans who are exempt from the enrollment requirement, see US CODE: Title 38,101. Definitions

b. Criteria for Basic Eligibility Services under VA's Medical Benefits Package

(1) To qualify for health care benefits Veterans must have:

(a) Other than a dishonorable character of discharge, as described in subparagraph 6c, and

(b) Served a period of active duty as outlined in subparagraph 6d.

NOTE: See 38 U.S.C. § 5303A for further information on minimum active-duty service requirements.

(2) Veterans who are disabled from disease or injury incurred or aggravated in the line of duty, while serving on active duty, are eligible for medical care in the same manner as any other Veterans who served on active duty.

(3) Veterans who are disabled from disease or injury incurred or aggravated in the line of duty while serving on inactive duty (as for training) and are rated SC for disability(ies) are eligible for medical care in the same manner as any other Veterans who served on active duty.

(4) A variety of groups who provided military-related service to the U.S. are also eligible for VA health care benefits. *NOTE: For more information on eligibility for specific categories, see paragraph 8.*

c. Character of Discharge Requirements

(1) Generally, when a Veteran is discharged or released from active duty, the respective military service department issues a discharge document that characterizes the nature of the Veteran's military service. The military department's characterization of discharge, as reflected on the service member's DD Form 214, Certificate of Release or Discharge from Active Duty, is used by VA as a tool in evaluating basic eligibility for VA health care benefits. To qualify for VA benefits, military service must be "under conditions other than dishonorable." see 38 U.S.C. § 101(2); and 38 CFR § 3.12. An "honorable" or "under honorable conditions" discharge is binding on VA for purposes of character of discharge (see 38 CFR § 3.12(a)). Accordingly, Veterans who receive an "honorable" discharge or an "under honorable conditions" discharge (also termed a general discharge) are generally eligible for VA health care benefits. *NOTE: An exception to this rule applies where such a Veteran is barred from benefits based on application of the very limited circumstances described in 38 U.S.C. § 5303.*

7. OUTPATIENT DENTAL TREATMENT

In accordance with 38 U.S.C. § 1712, and 38 CFR §§17.160-17.163, VA health care facilities must provide outpatient dental services and treatment to eligible Veterans. a. **Classes of Dental Eligibility**. Outpatient dental benefits must be furnished to Veterans in accordance with the provisions of existing legislation and regulations promulgated by the Secretary of Veterans Affairs. Those specified as eligible for dental examinations and treatment on an outpatient basis are defined, and their entitlements described in 38 CFR § 17.160 et seq. More specifically, further vital references for the administration of the dental outpatient program are contained in 38 CFR §§ 17.161-17.166. The following definitions of classifications of eligible dental outpatients are not complete as to entitlements and restrictions; the actual statutes and the VA regulations from which they are derived must be referenced in order to properly administer the program.

(6) **Class IV**. Those Veterans whose SC disabilities have been rated at 100 percent, or who are receiving the 100 percent rating by reason of individual unemployability, are eligible for any needed dental care. A total disability which is defined as "temporary" does not entitle a beneficiary to dental care.

9. ELIGIBILITY FOR SPECIFIC CATEGORIES

f. Military Sexual Trauma

(1) Title 38 U.S.C. §1720D authorizes VA to furnish both male and female Veterans counseling services and medical care needed to treat psychological trauma resulting from sexual trauma, which a VHA mental health professional has determined occurred while the veteran was serving on active duty or active duty for training.

(2) Sexual trauma includes:

(a) Sexual harassment as defined in 38 U.S.C. §1720D(d);

(b) Sexual assault;

(c) Rape; and

(d) Other batteries of a sexual nature.

Privacy Breach Info: Health Information Management and Health Records:

VHA HANDBOOK 1907.01

HEALTH INFORMATION MANAGEMENT HANDBOOK

1. PURPOSE

This Veterans Health Administration (VHA) Handbook is issued to provide basic health information procedures for managing the patient health record. Procedures have been revised to delineate new and additional specificity for health record documentation requirements, management of the health record, and management of health information.

2. BACKGROUND

- a. VHA, by Federal policy, must maintain complete, accurate, timely, clinically-pertinent, and readily-accessible patient records which contain sufficient recorded information to serve as a basis to plan patient care, support diagnoses, warrant treatment, measure outcomes, support education and research, facilitate VHA performance improvement processes and legal requirements.
- b. The most current standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) must be followed, unless specifically otherwise stated.
- c. The record must be standardized with regard to content, creation, maintenance, management, processing, and expected quality measures. Electronic capture and storage of patient health information must be implemented to enhance access to patient data by health care practitioners and other authorized users. Electronically stored and/or printed patient information is subject to the same medical and legal requirements as handwritten information in the health record.

3. AUTHORITY

Title 38 United States Code (U.S.C.) 7304(a) is the statutory authority for the Under Secretary for Health to promulgate regulations concerning the custody, use, and preservation VHA of records and papers.

4. DEFINITIONS

The following terms are defined, as used in this Handbook:

- a. **Active Record.** An active record is the health record of a patient who is currently receiving VHA authorized care.
- l. **Business Rules.** Business rules authorize specific users, or groups of users, to perform specified actions on documents in particular statuses (e.g., a practitioner who is also the expected signer of the note may edit an Unsigned Progress Note). *NOTE: Sites can modify or add to these rules to meet their own local needs.*
- m. **Clinical Applications Coordinator (CAC).** The CAC is a person at a hospital or clinic assigned to coordinate the installation, maintenance, and upgrading of CPRS and other Veterans Integrated and Systems Technology Architecture (VistA) software programs for the end users.
- r. **Compliance.** Compliance is an oversight process, supported by appropriate organizational conditions (culture, regulations, policies, procedures, controls, etc.), which, over time, are most

likely to ensure that employee actions and character are consistent with VHA core values. As an oversight process, compliance is used by all levels of the organization to identify high-risk areas, and to see that appropriate corrective actions are taken.

s. **Computerized Patient Record System (CPRS)**. CPRS is the primary patient record system that stores information in VistA, or other automated systems using electronic storage. CPRS supports entry of notes and orders, rules-based order checking, and results reporting. Also integrated into CPRS is VistA imaging which permits display of radiological images, Electrocardiograph (ECG) tracings, imaging from other sources, and document scanning.

t. **Confidential**. Confidential is the status accorded to data or information indicating that it is protected for some reason, and therefore it needs to be guarded against theft, disclosure, or improper use, or both, and must be disseminated only to authorized individuals or organizations with a need to know. Patient health records are sensitive due to the requirements of confidentiality as they contain restrictive information about the individual. Per the Security Rule, confidentiality is the property that data or information is not made available or disclosed to unauthorized persons or processes.

y. **Crises, Warnings, Allergies and/ or Adverse Reactions, and Directives (CWAD)**. CWAD are displayed on the Cover Sheet of a patient's computerized record, and can be edited, displayed in greater detail, or added to (see subpar. 4jjj, Patient Postings).

gg. **Encounter**. An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating, and/or treating the patient's condition (adapted from American Society for Testing and Materials (ASTM), 1999, p. 2).

jj. **Facility**. Facility includes a hospital, medical center, nursing home, domiciliary, outpatient clinic, and/or CBOC (satellite clinic), unless otherwise specified.

kk. **Fee Basis Record**. A fee basis record is a record of treatment by non-VA health care providers authorized and paid for by VA.

mm. **Health Information Administrator or Manager**. A Health Information Administrator or Manager is the professional title of practitioners, usually certified by the American Health Information Management Association (AHIMA), with recognized health information management credentials, who have primary responsibility for the management of the health record and health information program, computer-based or otherwise. *NOTE: Henceforth the Health Information Manager is referred to as a health information professional.*

nn. **Health Record**. A health record includes the electronic medical record and the paper record, combined, and is also known as the legal health record. A health record can be comprised of two divisions, which are the:

(1) **Health Record**. This is the documentation of all types of health care services provided to an individual, in any aspect of health care delivery. It includes individually identifiable data, in any

medium, collected and directly used in and/or for documenting health care. The term includes records of care in any health-related setting used by health care professionals while providing patient care services, to review patient data or document their own observations, actions, or instructions. The health record includes all handwritten and computerized components of the documentation.

(2) **Administrative Record.** This is an official record pertaining to the administrative aspects involved in the care of a patient, including demographics, eligibility, billing, correspondence, and other business-related aspects.

oo. **Health Record Review.** Health record review is the process of measuring, assessing and improving the quality of health record documentation; i.e., the degree to which health record documentation is accurate, complete, and performed in a timely manner. This process is carried out with the cooperation of relevant departments or services. The function includes the oversight of the development of document titles, computerized templates, overprinted forms, order sets, boilerplates, and note titles for standardization in the health record.

pp. **Health Summary.** Health summary is the compilation of components of patient information extracted from other VistA applications.

qq. **Inactive Record.** An inactive record is the record of a patient who has not received VHA authorized health care in a 3-year period.

uu. **Legal Health Record.** The legal health record is the documentation of the health care services provided to an individual in any aspect of health care delivery by a health care provider organization. The legal health record is individually-identifiable data, in any medium, collected and directly used in and/or documenting health care or health status.

xx. **Master Patient Index.** VHA's Master Patient Index (MPI) is the enterprise-wide database that uniquely identifies all active patients who have been admitted, treated, or registered in any VHA facility, and assigns a unique identifier to the patient. The database contains patient-identifying information and correlates a patient's identity across the enterprise, including all VistA systems and external systems, such as the Federal Health Information Exchange (FHIE) at any VHA facility since 1996. **NOTE:** *At some point in the future, the database may also incorporate persons other than patients, including employees and providers and may be used throughout VA to uniquely identify persons.*

yy. **Medical Record.** See subparagraph 4nn, "Health Record."

zz. **Medical Staff Member.** Medical staff members are physicians and dentists, or other licensed individuals, permitted by the health care facility's By-laws to provide patient care services independently, i.e., without supervision or direction.

bbb. **Need to Know.** Need to know is access to health information by authorized clinical or administrative users based on the user's role and a specific reason the information is needed to perform the user's job function.

ggg. **Outpatient.** An outpatient is a recipient of medical services who is not admitted to a bed.

hhh. **Patient.** A patient is the recipient of VHA-authorized care. Veterans admitted to nursing home care units may also be referred to as "residents". For the purposes of this document, "patient" will include reference to nursing home residents.

iii. **Patient Care Encounter (PCE).** PCE is a data repository that captures clinical data resulting from ambulatory care patient encounters.

jjj. **Patient Postings.** Patient postings are a component of CPRS that includes messages about patients; it is an expanded version of CWAD.

kkk. **Patient Record.** See subparagraph 4nn, Health Record.

lll. **Patient Treatment File (PTF).** PTF is an Automatic Data Processing (ADP) system for inputting, maintaining, and presenting personal, demographic, and clinical data related to care and treatment episodes of individuals who are patients or members:

(1) In VA hospitals, domiciliaries, nursing care units, and restoration centers, or **VHA HANDBOOK 1907.01 August 25, 2006 8**

(2) Are provided care or treatment under VA auspices in a non-VA hospital or non-VA nursing home.

mmm. **Perpetual Medical Record (PMR).** PMR are specific documents on specific patients from inpatient episodes of care that were maintained at the facility after retirement of the health record. Documents originally included: the autopsy, if appropriate; discharge summaries; pathology reports; operation reports; and the most recent VA Form 10-10, Application for Medical Benefits. Health records are no longer perpetuated. *NOTE: On August 17, 1992, the National Archives and Records Administration granted approval to discontinue the creation of PMR.*

nnn. **Person Class.** Person class is a profession and/or occupation code defined by Medicare that is assigned to individual providers. It reflects training, licensure, and scope of practice for that individual. Person Class associations are part of the minimum data set reported to the NPCD.

ppp. **Practitioner**

(1) **Licensed Practitioner.** A Licensed Practitioner is an individual at any level of professional specialization who requires a public license and/or certification to practice the delivery of care to patients. A practitioner can also be a provider.

(2) **Licensed Independent Practitioner.** A Licensed Independent Practitioner is an individual permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the individual's license and consistent with individually-granted clinical privileges.

(3) **Non-licensed Practitioner.** A non-licensed Practitioner is an individual without a public license or certification who is supervised by a licensed and/or certified individual in delivery of care to patients. Physician residents may be licensed or non-licensed practitioners, but must be supervised by a supervising practitioner when functioning as part of an accredited residency training program.

(4) **Supervising Practitioner.** Supervising practitioner refers to licensed, independent physicians, dentists, podiatrists, and optometrists, regardless of the type of appointment, who have been credentialed and privileged at VA medical centers in accordance with applicable requirements.

(5) **VA Special Fellow.** The term VA Special Fellow refers to a VA-based physician or dentist trainee who has enrolled in a VA Special Fellowship Program for additional training, primarily in research. Physicians in VA Special Fellowships have completed an ACGME- accredited core residency (medicine, surgery, psychiatry, etc.) and may also have completed an accredited subspecialty fellowship. They are board-eligible or board-certified, and consequently, are licensed independent practitioners. Dentists in VA Special Fellowships have completed a Commission on Dental Accreditation (CDA)-accredited residency and are licensed independent practitioners. All VA Special Fellows must be credentialed and privileged in the discipline(s) of their completed (specialty or subspecialty-training) programs. VA Special Fellows may function as supervising practitioners for other trainees, and billing may occur in their name.

qqq. **Provider.** A provider is a business entity that furnishes health care to a consumer; it includes a professionally-licensed practitioner who is authorized to operate within a health care facility.

ttt. **Referral.** Referral is a request to evaluate and assume the responsibility for care.

uuu. **Resident.** The term 'resident' refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties, e.g., internal medicine, surgery, psychiatry, radiology, nuclear medicine, etc.), dentistry, podiatry, or optometry, and who participates in patient care under the direction of supervising practitioners. **NOTE:** *The term "resident" includes individuals in their first year of training often referred to as "interns" and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as "fellows" by some sponsoring institutions.*

zzz. **Information Security.** Information security is protecting information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide:

- (1) **Integrity**, which means guarding against improper information modification or destruction, and includes ensuring information non-repudiation and authenticity;
- (2) **Confidentiality**, which means preserving authorized restrictions on access and disclosure, including means for protecting personal privacy and proprietary information; and
- (3) **Availability**, which means ensuring timely and reliable access to, and use of, information

ffff. **User Class.** User Classes (e.g., attending physician, dentist, optometrist, podiatrist, resident physician, provider, medical record technician, nurse, Chief, Health Information Management Service (HIMS)) and sub-classes are defined in the VistA User Class File (8930). Responsibilities and privileges (for accessing, entering, signing, co-signing, editing, deleting, etc.) are defined through this file.

gggg. **Veterans Equitable Resource Allocation (VERA).** VERA is a patient classification system developed by VHA and used to allocate funds based on classification.

hhhh. **View Alerts.** See subparagraph 4ddd, Notifications.

iiii. **Veterans Health Information Systems and Technology Architecture (VistA).** Software applications previously known as the Decentralized Hospital Computer Program (DHCP). **August 25, 2006 VHA HANDBOOK 1907.01 11**

jjjj. **VA Sensitive Information.** VA sensitive information is all VA data, on any storage media, or in any form or format, which requires protection from inadvertent or deliberate disclosure, alteration, or destruction of the information. The term includes information whose improper use or disclosure could adversely affect the ability of an agency to accomplish its mission, proprietary information, records about individuals requiring protection under various confidentiality provisions, such as the Privacy Act, the Health Insurance Portability and Accountability Act Privacy Rule, and information that can be withheld under the Freedom of Information Act. Examples of VA sensitive information include: individually-identifiable medical, benefits, and personal information; financial, budgetary, research, quality assurance, confidential commercial, critical infrastructure, investigatory, and law enforcement information; information that is confidential and privileged in litigation, such as: information protected by the deliberative process privilege, attorney work-product privilege, and the attorney-client privilege; and other information, which, if released could result in violation of law, harm, or unfairness to any individual or group; or could adversely affect the national interest, or the conduct of Federal programs.

5. PRIVACY, CONFIDENTIALITY, AND INFORMATION SECURITY

a. Authority

(1) The privacy and security of patient information stored in any media must be protected in accordance with, but not limited to, the Privacy Act of 1974, Freedom of Information Act, Federal Information Security Management Act, Office of Management and Budget (OMB) Circulars A-123 and A-130, VHA Directive 6210, Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title 45 Code of Federal Regulations (CFR) Parts 160 and 164, VHA Handbook 1605.1 and JCAHO standards.

(2) In accordance with the Privacy Act and VHA Directive 6210, Automated Information Systems (AIS) Security, local safeguards must be established concerning patient record security and confidentiality.

b. Confidentiality

(1) All staff with access to patient information in the performance of their duties are informed of responsibilities in maintaining the confidentiality of patient information. ***NOTE:** Emphasis needs to be placed on the annual VHA Privacy Policy training requirement, as well as other applicable privacy awareness education.*

(2) Patient records are confidential regardless of medium. The privacy of patient information must be preserved and the information will not be accessible to, or discussed with, unauthorized persons.

(3) Every employee with access to patient records in any medium is responsible for the proper handling of the patient records. Each employee is accountable for safeguarding patient confidentiality and privacy, and failure to do so may result in disciplinary or other adverse action up to, and including, termination.

c. Access

(1) Access to health care information is controlled to ensure integrity, to minimize the risk of compromising confidentiality, and to increase reliability.

(2) Access to health records and health record file areas is limited to authorized personnel. Only authorized personnel are allowed to print extractions from the electronic record or to make copies from the paper chart.

(3) Active records must be readily accessible to authorized clinical staff.

d. Security

(1) Security measures for authorizing access to the patient's health record must be delineated in local policy.

- (2) Only the Chief, HIMS, or designee, can approve the physical removal of original health records from the treating facility.
- (3) Health records in file areas and other areas where health records are temporarily stored (clinic or treatment areas, record review areas, quality assurance areas, release of information, etc.) must be locked when responsible personnel are not present to ensure the security of the area and to ensure records are not accessible to unauthorized individuals.
- (4) Precautions must be taken by staff to ensure that patient records on computer screens cannot be seen by individuals who do not have a legitimate need-to-know.
- (5) All patient-identifiable waste paper, or discarded materials, from any department must be shredded or disposed of in accordance with approved disposal policies and procedures. Locked containers or shredders must be provided in employee work areas for disposal of sensitive patient information.
- (6) A disaster plan for protecting and recovering health records damaged or destroyed by fire, flood, or by other means must be in place in accordance with VHA Directive 6210. The disaster plan must include provisions for recovering health care records on different types of storage media. The plan needs to emphasize that the goal is to prevent damage first, and then focus on recovery if records are damaged or destroyed.

e. Provider to Provider E-mail Communication

- (1) Electronic mail and information messaging applications and systems can only be used for authorized government purposes and must contain only non-sensitive information unless the data, and are protected with a VA-approved encryption mechanism.
- (2) For Outlook/Exchange mail, the Office of Cyber and Information Security (OCIS) issues Public Key Infrastructure (PKI) certificates to encrypt communications between a sender and receiver. *NOTE: Personnel must follow the national PKI policies and procedures issued by 005.* Requests for PKI certificates are to be directed to the local ISO, who typically serves as the Local Registration Authority (LRA) for VAPKI deployment.

f. Employee Health Records

- (1) The health records of employees are under the management of human resources and are maintained in a separate location from veteran health records. If documented electronically in CPRS, they may be secured utilizing appropriate business rules and note titles to limit access to identified personnel; all employee health records in CPRS must be designated as sensitive.
- (2) The records of employees who receive care as a veteran are under the auspices of Health Information Management (HIM) and are maintained with other veteran records. These records may be sequestered in a special location if directed by local policy. The electronic

documentation of these records must be secured by identifying them as “sensitive” records in CPRS.

NOTE: See VHA Handbook 1605.1, Privacy and Release of Information, for more information.

h. **Compliance.** There must be periodic review, or audit, of access to patient records to ensure compliance with record privacy and confidentiality standards.

6. GENERAL GUIDELINES

a. **Responsibility.** Administrative management of health records is the responsibility of HIM. Clinical management of health records is ultimately the responsibility of the Chief of Staff, or designee, with each clinician and professional service contributing to the content of the patient record.

b. HIM Professional

(1) Health information professionals serve as a resource to the facility and are active in the facility’s decision-making activities related to health information systems, health record content, authentication of record entries, correction of documentation errors, documentation approaches, information system backup, and disaster recovery. Health information professionals play an active role along with administration and the clinical staff in the development of future strategies for initiatives based on the organization’s health information. The health information professional may serve as the Privacy Officer.

(2) Health information professionals at the facility level are responsible for planning, managing, advising, and directing the health information program in accordance with applicable Federal laws, facility By-law, VHA policy, JCAHO standards, the Rehabilitation Accreditation Commission (CARF) formerly known as the Commission on the Accreditation of Rehabilitation Facilities, and other regulatory and accrediting agencies. Health information professionals at the facility level are responsible for creating and monitoring systems to ensure accurate, timely, and complete health records, in accordance with VHA policy and JCAHO health information protocols. The health information professional is involved in all decisions, both technical and administrative, that impact, define and/or control access to patient health records.

c. **Health Record Creation.** A separate, unique health record is created and maintained for every individual assessed or treated by VHA, as well as those receiving community or ancillary care at VHA expense. It is not required to print and file paper documents from electronic media for active records.

d. **Types of Patients.** Patient records must be maintained on the following:

(8) Veterans undergoing Compensation and Pension (C&P) or Persian Gulf examinations.

(9) The individual placed in pre-bed care, on ambulatory care and/or outpatient status or on fee-basis status.

e. **Health Record and/ or Health Information Availability.** During the transition from paper health record systems to full implementation of CPRS, there must be a local policy and process that describes how the facility assembles all relevant health information when a patient is admitted to inpatient or nursing home care, seen for a prescheduled or unscheduled ambulatory care visit, or presents for emergency services. In addition, there must be processes in place that ensure health information is available during scheduled and non-scheduled downtime of the computer systems. Health records must contain original signed documents, or electronically-authenticated documents.

f. **Ownership.** The health record and the health information within the health record are property of VA, as specified in 44 U.S.C. § 3301.

h. **Patient Identification.** The patient name, SSN, and date of birth are used to identify the patient. In the event the identity of a patient is unknown and the moniker of John Doe is assigned, a pseudo SSN and the date of birth (DOB) of 1/1/1900 will be used. The patient is then treated as a non-veteran, humanitarian emergency. *NOTE: If a patient is admitted under an incorrect name, once the name correction is made in VistA, all electronic documentation must be linked to the correct patient (see subpar. 7g) including health information in packages other than TIU and CPRS (i.e., laboratory, radiology). Any paper health information must also be corrected to reflect the correctly identified patient.*

j. **Retention, Disposition, and Transfer**

(1) **Policy.** The retention policy applies equally to both paper and electronic records. VHA health record retention policy is 75 years after the last episode of care. Retention policies and guidelines are detailed in VHA Records Control Schedule (RCS) 10-1. Disposal procedures are set forth in 44 U.S.C. Chapter 33.

(2) **Facility Storage.** Records must be stored at the treating VHA facility for 3 years following last patient activity. Paper records may be retired to the VA Records Center and Vault (VA RC&V).

(3) **Retirement of Records**

(a) Permission may be obtained from the VA RC&V to retire records earlier due to storage space. As of April 1, 2002, new accessions are sent to:

VA Records Center

11693 Lime Kiln Drive

Neosho, Missouri 64850

***NOTE:** Printing of electronic and digitized (scanned) records at the time of retirement is not necessary if it can be ensured that the computerized system retention period is consistent with current health record retention requirements, and if there is a quality control process in place to ensure that: electronic and digitized records can be efficiently identified for authorized use; the images are retrievable and legible; and that the integrity of digitized records is maintained.*

(b) Electronic and digitized (scanned) records may not be purged.

(4) **Previous Inpatient and Outpatient Records.** Previous inpatient and outpatient records existing at the facility must be made available upon specific request for treatment purposes. When there is evidence that a record exists at another VA facility, or the VA RC&V, the record must be ordered upon specific request.

(6) **Electronic Viewing.** For most cases where a patient is treated or seen at another VHA facility, the Patient Data Exchange (PDX), Network Health Exchange (NHE) or Remote Data View (RDV), VistA web, or Register Once software must be used to expedite the transfer of needed health information between facilities; however, scanned documents are not yet viewable through these technologies. Facilities must use the PDX encryption feature when transmitting data to other VHA facilities. If additional information is required, it may be copied and sent via overnight mail or fax machine when absolutely necessary.

(8) **External Source Documents.** Only those external source documents that are authenticated may be maintained as part of the patient's VHA permanent health record at the practitioner's written request. Practitioners must indicate which documents need to be retained and limit this to pertinent, present, and/or continued care. A summary progress note written by an appropriate clinician after a review of the external source documents may be used in lieu of filing and/or scanning any external source documents.

(a) Any documents or information filed, maintained, or scanned into a patient's health record, including external source documents, are deemed to be part of the patient's VA health records. These records are subject to all applicable Federal regulations concerning maintenance and disclosure including the Privacy Act of 1974 (5 U.S.C. 552a) and VA confidentiality statutes. Once a document is filed, absent Federal law or regulation to the contrary, it becomes a VA record subject to protection and release under Federal law.

m. **Authentication.** Authentication demonstrates that the entry has not been altered. Authentication includes the time, date, signature or initials, and the professional designation of the practitioner (credentials).

(1) Standardized and current electronic signature blocks for all authorized users based on the person class taxonomy file must be maintained at each facility. This ensures non-repudiation and

that appropriate billing occurs. Authentication functionality must include the identity and credential and/ or professional discipline of author, the date signed, and the time signed, if required. If the title block is used, it needs to accurately reflect the functional position of the user as defined by the service. As employees enter, leave, or transfer to a different position, the person class file and the title block must be edited to appropriately reflect job status. Monitors to ensure person class files are correct must be established at each facility.

(2) In those facilities still in transition to CPRS, a method of identifying the author must be established; e.g., stamps with the printed name and professional designation of the clinician, or a requirement of the clinician to print the clinician's name to ensure legibility. Any initialed entries must be substantiated by at least one entry with the signature of the individual made during the episode of care.

(3) All entries must be recorded and authenticated immediately after the care event or the observation has taken place to ensure that the proper documentation is available. This ensures quality patient care.

(4) Electronic signatures cannot be utilized for Schedule II drug prescriptions for outpatient prescriptions according to the CFR pursuant to Drug Enforcement Agency (DEA) regulations. *NOTE: At the time the DEA permits such electronic authentication, it will be permitted in VHA health records. Electronic signatures can be utilized for Schedule II drug prescriptions for inpatient prescriptions.*

n. **Authorized Entries**

(1) Policies, procedures and ASU rules must be established at each facility to ensure only authorized individuals document in the health record and that the author(s) and any required cosigner(s) are identified. ASU rules must be in concert with facility By-laws and facility policy.

(2) Only those individuals authorized by facility policy are allowed to make entries into the health record.

(3) The practitioner who treats a patient is responsible for documenting and authenticating the care provided. Where multiple practitioners treat during the same encounter, additional signers are strongly encouraged (for example, multidisciplinary notes in rehabilitation and psychiatry). Addenda may also be used to facilitate the documentation of multidisciplinary care.

(4) All clinical staff authorized to document in a health record must record in CPRS, except for those instances where technology is not available for electronic entry.

(5) The respective clinical staff, as defined by their scope of practice, must document every episode of clinical care.

(6) Health record entries must be completed, processed promptly, signed and/or cosigned as necessary, and transmitted, filed, and/or uploaded to ensure the information is available for

patient care. Health care practitioners are responsible for completing their respective notes within prescribed timelines for patients under their care (see par. 8).

o. Sensitive Records

(1) Some specific record types are deemed sensitive and may be maintained under direct supervision of the health information professional, or be flagged as “Sensitive” in VistA, or other facility computerized record repositories. These include, but are not limited to:

(2) VA veteran employee patient records;

(3) Regularly scheduled veteran volunteers;

(4) Individuals engaged in the presentation of claims before VA, including representatives of veterans’ organizations, or cooperating public or private agencies, or Administrative Tort Claims; and

(5) Records involved in Administrative Tort Claim activities.

q. Master Patient Index (MPI)

(1) A local MPI is maintained on each local VistA system that is a subset of the National MPI. The role of the MPI is to assign a unique identifier to active patients; this unique identifier is used across the system to link patient data. Historically, each site has maintained an MPI within their local VistA system, designated by site. ***NOTE:** Prior to implementation of VistA in 1984, facilities had manual MPI card systems.*

(2) Active patients are enumerated at the MPI nationally as information is entered into VistA at local sites. Accuracy of patient demographic data is essential. Patient name, SSN, and DOB are key elements used to uniquely identify patients. Inaccurate entry can mean that a new Integration Control Number (ICN) is generated, when, in reality, the patient already has an existing ICN.

s. Fee Basis

(1) Patient record notations concerning medical fee-basis care must be filed in the ambulatory and/ or outpatient care portion of the health record.

(2) The requesting physician must document in the health record a justification for using fee status in lieu of providing staff treatment. Justification for extending short-term, fee-basis services must also be documented in the health record.

(3) Decisions to continue the use of fee basis must be documented in the health record by the reviewing physician.

(4) Copies of reports submitted by physicians and other reports (laboratory, X-ray, etc.) must be filed or scanned in the health record. **NOTE:** *Electronic or scanned entry is preferred over paper records.*

(5) Claims for travel expenses must be filed in the administrative portion of the record.

(6) Paid fee claims are retained in the VistA Fee software package, therefore, a paper copy does not need to be filed in the administrative record.

(7) Fee-basis dental records must be filed in the health record. **NOTE:** *Documentation requirements for fee-basis dental records are contained in the provisions of M-1, Part I, Chapter 18, Outpatient Care-Fee.*

7. ELECTRONIC HEALTH RECORD

a. **General.** CPRS is considered Electronic Protected Health Information (EPHI); as such, the HIPAA Security Rule requires covered entities that it creates, receives, maintains or transmits.

(1) CPRS is the primary electronic health record where patient information is documented. Because it is a computerized system, the software is constantly being updated and improved. **NOTE:** *Documentation on paper media is being phased out.* Although electronic functionality provides many enhancements for active patient documentation, it presents significant areas of risk. Particular emphasis and attention, therefore, needs to be placed on the policies, procedures, and guidelines governing the use of the electronic health record.

(2) As technology allows, all patient care documentation must be stored in VistA and entered by direct data entry, through CPRS, TIU, VistA Imaging (or other VistA interfaces that facilitate dictation, transcription, uploading, voice recognition, document scanning), and other emerging technologies deemed appropriate by VHA.

(3) In CPRS, the following terms apply:

(a) **Date of Note.** The date (and time) by which the clinician references the document. For Progress Notes, this will likely be the date of the provider's encounter with the patient. For documents that have been dictated and transcribed (e.g., discharge summaries), it corresponds to the dictation date of the record. In all cases, this is the date by which the document is referenced and sorted.

(b) **Date of Entry.** The date and time at which a document was originally entered into the database.

(c) **Date of Signature.** The date and time at which the document was signed by the author.

(d) **Visit Date.** The date of the provider's encounter with the patient to which an

outpatient progress note is linked.

(e) Admission Date. The date of the admission to the hospital for which a note is written and linked.

g. Health Record Alterations and Modification

(1) Electronic progress notes, operative reports, and discharge summaries are occasionally entered in the TIU and the CPRS software packages by practitioners for the wrong patients or sometimes the information within the document(s) may be incorrect or erroneous. A local procedure must be established for correcting erroneous patient information entered electronically or on paper. When an alteration of a health record includes an image, the image must also be altered in the same manner to be congruent with the change in the note. It is the responsibility of the HIM professional to ensure there is a process in place to correct erroneous health information.

(2) There are four types of health record changes:

(a) Administrative Update. An administrative update is current information entered in place of existing data, i.e., an address change or other registration data, etc. Data meant to be updated frequently is considered to be transient (by nature, bound to change). Most transient data is obtained through requests to update VA files. Changes to demographic data, which is information used to identify an individual such as name, address, gender, age, and other information specifically linked to a specific person, are generally considered to be administrative in nature and may be initiated by the veteran.

(b) Administrative Correction

1. An administrative correction is remedial action by administrative personnel with the authority to correct health information previously captured by, or in, error. Administrative corrections include factual and transient data entered in error or inadvertently omitted. Administrative corrections are not initiated by the veteran.

2. Examples of items that can be handled in this manner include, but are not limited to: incorrect date, association and/or linking data to wrong patient, association and/or linking data to wrong clinician or facility, and other designated clinical data items impacting the integrity of a patient's record.

3. Any retraction or rescission of entry must be initiated by the author or originating discipline. Laboratory, radiology, and pharmacy are examples of disciplines that may initiate retractions or rescissions within their own packages.

g. Employee Orientation. The HIM professional participates in, or contributes to, orientation of all new staff expected to have contact with, or access to, health records. **NOTE:** *The HIM professional and the Clinical Application Coordinator(s) need to work collaboratively with*

respect to the set-up, maintenance, access, and use of the CPRS system. Orientation and/or education must include, but is not limited to, the following:

(1) Confidentiality of health records (including VHA disciplinary actions for violations of confidentiality) and the proper procedures for releasing information.

j. Release of Information

(1) **HIM Professional.** HIM Professional is responsible for:

(a) Both safeguarding and disclosing, as appropriate, health information according to applicable VA standards:

1. The Privacy Act of 1974;
2. HIPAA;
3. Freedom of Information Act (FOIA);
4. Title 38 U.S.C. Section 5701, which protects veterans' names and addresses;
5. Title 38 U.S.C. Section 5705, which protects VA records and documents created by a VA medical center's medical quality assurance program activities; and

(b) Developing policies, processes, and procedures, designed to protect the privacy of patient health information and the confidentiality of health records maintained by VHA; this includes monitors that both safeguard and appropriately disclose protected health information. These policies and procedures must:

1. Address appropriate methods of disclosure.
2. Define those circumstances that require patient authorization prior to disclosure of patient data and health care information, and when disclosure of patient health care information may be made without the patient's consent.
3. Differentiate between mandatory disclosure (for example reporting of elder abuse) and permissive disclosure (for example access by health care staff).
4. Identify the circumstances that require inclusion of a re-disclosure notice with the release of patient-identifiable data and health care information.
5. Define circumstances when the transmission of patient-identifiable data and health care information can be appropriately forwarded by facsimile machine.

6. Identify those communicable diseases and other public health threats that require reporting to an appropriate government agency, and the mechanism by which the reporting is accomplished.

7. Address the discriminating level of confidentiality provided to health care information pertaining to behavioral health, substance abuse treatment, HIV, AIDS, abortion, and adoption.

8. Establish policies and procedures to allow the patient to review, amend, and/or correct the patient's health record.

9. Establish policies and procedures to make administrative updates and corrections to the patient health record.

10. Establish agreements for any HIM home-based employees that state that the employees are under the same requirements as regular employees for protecting confidentiality of all patient-identifiable data and health care information to which they have access.

11. Ensure that contracts for outside services state that the companies providing the services are responsible for maintaining the confidentiality of all patient-identifiable data and health care information to which they have access.

12. Ensure that the confidentiality policies and procedures are part of new HIM employee orientation and are reviewed with the employee on an ongoing basis as part of each employee's continuing education.

(c) Developing, conducting, and evaluating the impact of education and training programs for the facility and/or for specific programs that encompass confidentiality and disclosure of patient-identifiable data and health care information.

(2) **Release of Information Unit.** Release of Information is organized and managed as a comprehensive, centralized unit that:

(a) Meets the requirements of FOIA, HIPAA, 38 U.S.C. Section 7332, and 38 CFR 1.460-1.499.

(b) Applies the appropriate, detailed provisions of VHA regulations.

(c) Honors the patient's right to consent to authorize disclosure.

(d) Ensures each request for patient data and health care information has a valid authorization prior to disclosure.

(e) Coordinates disclosures of protected health information (PHI) from intra-organizational units; ensures disclosures are handled by staff who possess knowledge of applicable VHA laws and regulations and who have had training in the legal ramifications of subpoenas and court orders.

(f) Applies routine administrative processes to all requests, records all disclosures, and accounts for any exceptions to routine processing.

(g) Safeguards the process through the application of quality controls.

NOTE: Portions of paragraph 9 are adapted from the 1998 AHIMA Health Information Management Practice Standards: Tools for Assessing Your Organization.

10. MANAGEMENT OF THE PAPER HEALTH RECORD

a. **Medical Record File Activity.** The management of the paper file activity affects the professional and administrative aspects of health care. Two important elements in the management of patient records are the maintenance of folders and file areas, and the service rendered by responsible personnel. Proper and adequate procedures must be established to maintain an efficient and effective patient record file service. Because of the wide variation in physical locations, space allocations and resources for patient record filing administrative procedures may vary. Local policies and guidelines need to be established and followed for the following:

(1) Promptness in manual and electronic filing of record documents.

(2) Consistent availability of patient records when needed and prompt delivery to the requester or user.

(3) Adequate control, requisition, and follow-up of records, including the security of files and limited access to files and file systems.

NOTE: Centralization of records and 24-hour access for paper records is encouraged. Where 24-hour coverage of an HIM professional is not available, a secure method for location of VHA
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needed records is in place. The filing system must be organized by SSN in terminal digit. Over time, full implementation of CPRS reduces the number of hours the file area must be open since CPRS ensures 24-hour 7-day a week availability of patient information.

(4) Overflow paper records storage areas must comply with the same standards established for access and security of records.

c. Record Charge Out System

(1) The principal rule for the file area is that no record is removed from file area to a qualified user without being charged out. The rule applies to all personnel and is strictly enforced.

(2) Local policy must be established and published regarding the length of time a record may be kept out of file. To the extent practicable, records sent to clinics must be returned before the close of business each day, so that if emergencies occur, the health care team has access to needed information.

(3) Records not returned to the file room must be maintained in an area that is accessible to authorized persons, but secure from unauthorized access.

(4) Record charge out or Record Tracking must be accomplished by the VistA Record Tracking Package. *NOTE: Local policies and procedures must be established and published for use of the system.*

d. File Area Rules And Procedures

(1) Patient record folders must be filed as promptly as possible, or at least once a day.

(3) Documents pertaining to active outpatients receive priority processing.

(4) Documents must be fastened in the established filing sequence in the correct section of the respective patient and administrative folders.

(5) An appropriate mechanism must be initiated locally to ensure record availability for those patients who have multiple clinic appointments on the same day.

(6) Only authorized agency personnel with a need to see records, or perform maintenance work, or housekeeping will be allowed access to the file room.

(7) Proper use of filing equipment must be emphasized. Files are not to be jammed so tightly or records inserted so haphazardly that the top edge and right margin of the folder are not flush within the numerical guides.

(8) The supervisor of the file area is responsible for maintaining folders and storage equipment in a neat and orderly manner. Damaged and torn folders must be promptly repaired or replaced. Care must be exercised to ensure that significant markings on the old folders are carried forward to the new ones.

(9) Records being processed must remain on desktops, or in specified marked files, so they can be available at any time to authorized personnel.

11. PAPER HEALTH RECORD MAINTANENCE

a. General

(1) When indicated, a VA Form 10-1079, Emergency Medical Identification Label, is used to identify multiple medical problems experienced by a patient and/or special medical program into which a patient has been entered (see M-2, Pt. I, Ch. 17). **NOTE:** *Attempted suicide is no longer to be documented on this label, but must be documented on the Problem List and in the progress notes.*

(2) A label must be affixed to the front of the inpatient chart holder to denote any allergies or clinical warnings. Upon release from inpatient care, the label must be reviewed and verified for accuracy, then removed from the chart holder and affixed to the front of the health record folder in the block titled "WARNING," if a label is not already present. If one is present, any needed updates must be made.

(3) When a new volume of the patient's health record is created, a new label must be affixed to the new volume. The HIM professional, or designee, is responsible for recording and validating the medical problem(s) and/or program(s) on the newly created labels of the patient records volumes. **NOTE:** *Patient confidentiality must be considered when documenting on this label.*

(4) VA Form 10-2198, Priority Service-Connected Veteran Label, must be affixed to the right side of the exterior cover of the health record of veterans who have a service-connected disability. The label must be affixed in a manner that will not obscure the printing on the form or other notations on the record.

12. REFERENCES

a. NIST Special Publication 800-66, An Introductory Resource Guide for Implementing the Health Insurance Portability and Accountability Act (HIPPA) Security Rule, Appendix A.

b. Title 5 U.S.C. 551a. **VHA HANDBOOK 1907.01 August 25, 2006 72**

- b. Title 44 U.S.C.33.
- c. Title 44 U.S.C. 3542.
- d. Title 5 CFR 2635.
- e. Title 45 CFR 160 and 164.
- f. HIPAA of 1996.
- g. VA Directive 5021.
- h. RCS 10-1.

VHA HANDBOOK 1601A.04 Fee Basis Purchased Care Appeals:

Policy & Procedures - Handbooks & Directives

Fee Basis Purchased Care Appeals

Benefits Overview

**August 31, 2009 VHA HANDBOOK 1601A.04 1 HEALTH CARE BENEFITS
OVERVIEW**

1. PURPOSE

This Veterans Health Administration (VHA) Handbook provides information on the health care benefits available to enrolled Veterans and other beneficiaries.

2. AUTHORITY

a. The authority for this Handbook resides in Title 38 United States Code (U.S.C.), Chapter 17 and Title 38 Code of Federal Regulations (CFR), Part 17, which governs eligibility for health care benefits.

b. In implementing 38 U.S.C 1705, the Department of Veterans Affairs (VA) established the Medical Benefits Package (see 38 CFR§17.38) to provide a standard set of health benefits to all enrolled Veterans. This package emphasizes “basic care and preventive care” and offers a full range of outpatient and inpatient services.

3. DEFINITIONS

b. **Enrollment.** Enrollment is the process established for managing categories of Veterans for whom VA will provide services in accordance with Enrollment Provision of Hospital and Outpatient Care to Veterans (38 CFR §17.36).

c. **Medical Need.** Medical need is a treatment, procedure, supply, or service considered medically necessary when, in the judgment of an appropriate clinical care provider, and in accordance with generally-accepted standards of clinical practice, the treatment, procedure, supply, or service:

(1) Promotes health by:

(a) Enhancing quality of life or daily functional level,

(b) Identifying a predisposition for development of a condition or early onset of disease, which can be partly or totally improved by monitoring or early diagnosis and treatment, and

(c) Preventing development of future disease.

(2) Preserves health by:

(a) Maintaining the current quality of life or daily functional level;

(b) Preventing progression of disease;

(c) Curing disease; and

(d) Extending life span.

(3) Restores health by restoring the quality of life or the daily functional level that has been lost due to illness or injury.

NOTE: For further information see 38 CFR §17.38.

4. SCOPE

This VHA Handbook provides:

a. An overview of the VA Medical Benefits Package, including information on:

(1) Services provided under the VA Medical Benefits Package;

(2) Availability of care;

(3) Centers of Excellence;

(4) Eligibility for care; and

(5) Preventive care services.

b. Information on services covered under special authorities;

c. Information on excluded services and benefits; and

d. Information on the appeals process.

5. OVERVIEW OF THE VA MEDICAL BENEFITS PACKAGE

a. Services Included in the VA Medical Benefits Package

(1) VA's Medical Benefits Package, as specified in 38 CFR §17.38, outlines those benefits that are included in the medical benefits package.

(2) The medical benefits package emphasizes preventive and basic care and offers a full range of outpatient and inpatient services, including routine medical and surgical services for Veterans enrolled in the health care system. **August 31, 2009 VHA HANDBOOK 1601A.04 3**

(3) There are limitations to services related to sensori-neural aids, such as: eyeglasses, contact lenses, hearing aids, as specified in 38 CFR § 17.149.

b. **Availability of Care.** The VA Medical Benefits Package is generally available to all enrolled Veterans regardless of the Veteran's priority group. The Veteran's preferred facility is responsible for establishing policy and procedures for coordination of services not available locally or at another VA health care facility within the Veterans Integrated Service Network (VISN).

d. **Eligibility for Care.** To be enrolled in the VA Health Care System, the Veteran must be eligible to receive VA benefits. The Veteran, at a minimum, must meet the following requirements:

(1) The definition of a Veteran in accordance with 38 U.S.C. §101(2);

(2) The definition of active duty in accordance with 38 U.S.C. §101(21); and

(3) The definition of minimum length of active-duty service in accordance with 38 U.S.C. §5303A, exceptions as outlined in 38 U.S.C. § 5303A.

NOTE: For more information on eligibility, see VHA Handbook 1601A.02 (to be published) and for more information on enrollment, see VHA Handbook 1601A.03.

e. **Preventive Care Services.** The VA Medical Benefits Package preventive care services include:

- (1) Periodic medical exams;
- (2) Health education, including nutrition education;
- (3) Maintenance of drug-use profiles, drug monitoring, and drug use education;
- (4) Mental health and substance abuse preventive services;
- (5) Immunization against infectious disease;
- (6) Prevention of musculoskeletal deformity or other gradually-developing disabilities of a metabolic or degenerative nature;
- (7) Genetic counseling concerning inheritance of genetically-determined disease;
- (8) Routine vision testing and eye-care services; and **VHA HANDBOOK 1601A.04 August 31, 2009 4**
- (9) Periodic re-examination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

f. **Services Covered Under Special Authorities.** Even if not enrolled in the VA health care system, a Veteran may be eligible for certain VA care and services not included in the “medical benefits package” if authorized by statute. Veterans must qualify for these services on a case-by-case basis (See App. A).

38 CFR 17.38 Medical benefits package

§17.38 Medical benefits package.

(a) Subject to paragraphs (b) and (c) of this section, the following hospital, outpatient, and extended care services constitute the “medical benefits package” (basic care and preventive care):

(1) Basic care.

(i) Outpatient medical, surgical, and mental healthcare, including care for substance abuse.

- (ii) Inpatient hospital, medical, surgical, and mental healthcare, including care for substance abuse.
- (iii) Prescription drugs, including over-the-counter drugs and medical and surgical supplies available under the VA national formulary system.
- (iv) Emergency care in VA facilities; and emergency care in non-VA facilities in accordance with sharing contracts or if authorized by §§17.52(a)(3), 17.53, 17.54, 17.120-132.
- (v) Bereavement counseling as authorized in §17.98.
- (vi) Comprehensive rehabilitative services other than vocational services provided under 38 U.S.C. chapter 31.
- (vii) Consultation, professional counseling, marriage and family counseling, training, and mental health services for the members of the immediate family or legal guardian of the veteran or the individual in whose household the veteran certifies an intention to live, as necessary and appropriate, in connection with the veteran's treatment as authorized under 38 CFR 71.50.
- (viii) Durable medical equipment and prosthetic and orthotic devices, including eyeglasses and hearing aids as authorized under §17.149.
- (ix) Home health services authorized under 38 U.S.C. 1717 and 1720C.
- (x) Reconstructive (plastic) surgery required as a result of disease or trauma, but not including cosmetic surgery that is not medically necessary.
- (xi)(A) Hospice care, palliative care, and institutional respite care; and
(B) Noninstitutional extended care services, including but not limited to noninstitutional geriatric evaluation, noninstitutional adult day health care, and noninstitutional respite care.
- (xii) Payment of beneficiary travel as authorized under 38 CFR part 70.
- (xiii) Pregnancy and delivery services, to the extent authorized by law.
- (xiv) Newborn care, post delivery, for a newborn child for the date of birth plus seven calendar days after the birth of the child when the birth mother is a woman veteran enrolled in VA health care and receiving maternity care furnished by VA or under authorization from VA and the child is delivered either in a VA facility, or in another facility pursuant to a VA authorization for maternity care at VA expense.
- (xv) Completion of forms (e.g., Family Medical Leave forms, life insurance applications, Department of Education forms for loan repayment exemptions based on disability, non-VA

disability program forms) by healthcare professionals based on an examination or knowledge of the veteran's condition, but not including the completion of forms for examinations if a third party customarily will pay health care practitioners for the examination but will not pay VA.

(2) Preventive care, as defined in 38 U.S.C. 1701(9), which includes:

(i) Periodic medical exams.

(ii) Health education, including nutrition education.

(iii) Maintenance of drug-use profiles, drug monitoring, and drug use education.

(iv) Mental health and substance abuse preventive services.

(v) Immunizations against infectious disease.

(vi) Prevention of musculoskeletal deformity or other gradually developing disabilities of a metabolic or degenerative nature.

(vii) Genetic counseling concerning inheritance of genetically determined diseases.

(viii) Routine vision testing and eye-care services.

(ix) Periodic reexamination of members of high-risk groups for selected diseases and for functional decline of sensory organs, and the services to treat these diseases and functional declines.

(b) *Provision of the "medical benefits package"*. Care referred to in the "medical benefits package" will be provided to individuals only if it is determined by appropriate healthcare professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.

(1) *Promote health*. Care is deemed to promote health if the care will enhance the quality of life or daily functional level of the veteran, identify a predisposition for development of a condition or early onset of disease which can be partly or totally ameliorated by monitoring or early diagnosis and treatment, and prevent future disease.

(2) *Preserve health*. Care is deemed to preserve health if the care will maintain the current quality of life or daily functional level of the veteran, prevent the progression of disease, cure disease, or extend life span.

(3) *Restoring health*. Care is deemed to restore health if the care will restore the quality of life or daily functional level that has been lost due to illness or injury.

(c) In addition to the care specifically excluded from the “medical benefits package” under paragraphs (a) and (b) of this section, the “medical benefits package” does not include the following:

(1) Abortions and abortion counseling.

(2) In vitro fertilization.

(3) Drugs, biologicals, and medical devices not approved by the Food and Drug Administration unless the treating medical facility is conducting formal clinical trials under an Investigational Device Exemption (IDE) or an Investigational New Drug (IND) application, or the drugs, biologicals, or medical devices are prescribed under a compassionate use exemption.

(4) Gender alterations.

(5) Hospital and outpatient care for a veteran who is either a patient or inmate in an institution of another government agency if that agency has a duty to give the care or services. This exclusion does not apply to veterans who are released from incarceration in a prison or jail into a temporary housing program (such as a community residential re-entry center or halfway house).

(6) Membership in spas and health clubs.

(Authority 38 U.S.C. 101, 501, 1701, 1705, 1710, 1710A, 1721, 1722, 1782, 1786)

[64 FR 54217, Oct. 6, 1999, as amended at 67 FR 35039, May 17, 2002; 73 FR 36798, June 30, 2008; 75 FR 54030, Sept. 3, 2010; 76 FR 11339, Mar. 2, 2011; 76 FR 26172, May 5, 2011; 76 FR 78571, Dec. 19, 2011]

I am 100% SC: 38 CFR 17.37 Enrollment not required - provision of hospital and outpatient care to veterans

ENROLLMENT PROVISIONS AND MEDICAL BENEFITS PACKAGE

§ 17.36 Enrollment—provision of hospital and outpatient care to veterans.

(a) *Enrollment requirement for veterans.*

(1) Except as otherwise provided in § 17.37, a veteran must be enrolled in the VA healthcare system as a condition for receiving the ‘medical benefits package’ set forth in § 17.38.

NOTE TO PARAGRAPH (a)(1): A veteran may apply to be enrolled at any time. (See

§ 17.36(d)(1).)

(2) Except as provided in paragraph

(a)(3) of this section, a veteran enrolled under this section and who, if required by law to do so, has agreed to make any applicable copayment is eligible for VA hospital and outpatient care as provided in the “medical benefits package” set forth in § 17.38.

NOTE TO PARAGRAPH (a)(2): A veteran’s enrollment status will be recognized throughout the United States.

(3) A veteran enrolled based on having a disorder associated with exposure to a toxic substance or radiation, for a disorder associated with service in the Southwest Asia theater of operations during the Gulf War, or any illness associated with service in combat in a war after the Gulf War or during a period of hostility after November 11, 1998, as provided in 38 U.S.C. 1710(e), is eligible for VA care provided in the “medical benefits package” set forth in

§ 17.38 for the disorder.

(b) *Categories of veterans eligible to be enrolled.*

The Secretary will determine which categories of veterans are eligible to be enrolled based on the following order of priority:

(1) Veterans with a singular or combined rating of 50 percent or greater based on one or more service-connected disabilities or unemployability.

(2) Veterans with a singular or combined rating of 30 percent or 40 percent based on one or more service-connected

disabilities.

(3) Veterans who are former prisoners of war; veterans awarded the Purple Heart; veterans with a singular or combined rating of 10 percent or 20 percent based on one or more service-connected disabilities; veterans who were discharged or released from active military service for a disability incurred or aggravated in the line of duty; veterans who receive disability compensation under 38 U.S.C. 1151; veterans whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that such veterans’ continuing eligibility for that care is provided for in the judgment or settlement described in 38 U.S.C. 1151;

(d) *Enrollment and disenrollment process—(1) Application for enrollment.*

A veteran may apply to be enrolled in the VA healthcare system at any time. A veteran who wishes to be enrolled must apply by submitting a VA Form 10–10EZ to a VA medical facility or via an Online submission at <https://www.1010ez.med.va.gov/sec/vha/1010ez/>.

(2) Action on application.

Upon receipt of a completed VA Form 10-10EZ, a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will accept a veteran as an enrollee upon determining that the veteran is in a priority category eligible to be enrolled as set forth in

§ 17.36(c)(2). Upon determining that a veteran is not in a priority category eligible to be enrolled, the VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, will inform the applicant that the applicant is ineligible to be enrolled.

(3) Placement in enrollment categories.

(i) Veterans will be placed in priority categories whether or not veterans in that category are eligible to be enrolled.

(ii) A veteran will be placed in the highest priority category or categories for which the veteran qualifies.

(iii) A veteran may be placed in only one priority category,

(v) Veterans will be disenrolled, and reenrolled, in the order of the priority categories listed with veterans in priority category 1 being the last to be disenrolled and the first to be reenrolled. Similarly, within priority categories 7 and 8, veterans will be disenrolled, and reenrolled, in the order of the priority subcategories listed with veterans in subcategory (i) being the last to be disenrolled and first to be reenrolled.

(5) Disenrollment. A veteran enrolled in the VA health care system under paragraph (d)(2) or (d)(4) of this section will be disenrolled only if:

(i) The veteran submits to a VA medical center or the VA Health Eligibility Center, 1644 Tullie Circle, Atlanta, Georgia 30329, a signed document stating that the veteran no longer wishes to be enrolled; or

(ii) A VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, determines that the veteran is no longer in a priority category eligible to be enrolled, as set forth in

§ 17.36(c)(2); or

(iii) A VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, determines that the veteran has been enrolled based on inclusion in priority category 5 or priority category 7; determines that the veteran was sent by mail a VA Form 10-10EZ; and determines that the veteran failed to return the completed form to the address on the return envelope within 60 days from receipt of the form. VA Form 10-10EZ is set forth in paragraph (f) of this section.

(6) Notification of enrollment status.

Notice of a decision by a VA network or facility director, or the Deputy Under Secretary for Health for Operations and Management or Chief, Health Administration Service or equivalent official at a VA medical facility, or Director, Health Eligibility Center, regarding enrollment status will be provided to the affected veteran by letter and will contain the reasons for the decision. The letter will include an effective date for any changes and a statement regarding appeal rights. The decision will be based on all information available to the decision maker, including the information contained in VA Form 10-10EZ.

Implementation of the provisions of Section 402 of Public Law 110-387:

Department of Memorandum Veterans Affairs

Date: FEB 23 2009

From: Deputy Under Secretary for Health for Operations and Management (1 ON)

Subj: Implementation of the provisions of Section 402 of Public Law 110-387

To: Network Directors (10N1-23)

1. The purpose of this memo is to establish policy for payment of unauthorized emergency care based on amendments made to Title 38, United States Code (U.S.C.) §§ 1728 and 1725 by Public Law (PL) 110-387, "The Mental Health Improvements Act of 2008". This policy is effective as of the date of this Memorandum.
2. The "prudent layperson" standard will be used to determine whether the care was emergent in nature for the purposes of 38 U.S.C. §§ 1728 and 1725.
 - a. "Prudent Layperson" definition of emergency: The claim for payment or reimbursement for the initial evaluation and treatment is for a condition of such a nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health. This standard would be met if there were an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of

the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

3. VA shall not authorize payment for non-VA emergency care beyond the point of stabilization under any circumstance other than when the non-VA facility makes and documents reasonable attempts to transfer the Veteran and a VA or other Federal facility with which VA has an agreement is unable to accept such transfer. Under this circumstance payment may be authorized until VA is able to accept transfer or the Veteran is discharged from care, whichever occurs first.
4. In order to ensure the provisions of PL 110-387 are appropriately followed, each VISN Director and Medical Center Director is responsible for establishing local policy and procedures to ensure VA ability to provide payment beyond the point of stability when VA is unable to accept transfer of a Veteran.
5. Questions may be referred to Les Niemiec, CSO Fee Program Office Manager at (303) 398-5160.

Attachment

Fact Sheet 165-09-01 February 2009

Mental Health Improvements Act of 2008 Emergency Non-VA Care

Provisions of the Mental Health Improvements Act of 2008, Public Law 110-387 authorizes the Department of Veterans Affairs (OJA) to apply the prudent layperson emergency care standard when processing non-VA emergency care claims. Additionally, the law provides VA authority to pay for continued nonemergent care under certain conditions.

Prudent Layperson Definition of Emergency Care

The following prudent layperson definition of emergency care is used when processing non-VA emergency care claims: When such care or services are rendered in a medical emergency of such nature that a prudent layperson would have reasonably expected that delay in seeking immediate medical attention would have been hazardous to life or health. This standard would be met if there were an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Payment Past the Point of Stabilization

VA is authorized to make payment beyond the point of stabilization for non-VA emergency care when:

- The Veteran meets all administrative criteria under either title 38 United States Code (U.S.C.) §§1728 or 1725
- The care rendered was emergent in nature
- VA or other Federal facilities were not feasibly available
- The non-VA provider has provided documentation of its reasonable attempts to transfer the Veteran to a Department facility or other Federal facility with which VA has an agreement. Note: Admission of certain Veterans to a non-VA facility for emergent care may be deemed a prior authorization when VA is notified within 72 hours of admission)

Veteran Responsibility to Notify VA of Non-VA Emergency Care

The nearest VA facility to where the emergent non-VA care is rendered should always be contacted as soon as possible in the event of hospital admission to a non-VA health care facility without prior VA authorization. This notification is important in order to coordinate the delivery of health care services and to ensure eligibility for non-VA benefits. A listing of VA health care

VA NORTHPORT ADVERSE ACTION:

As your (OSC) office is well aware, the VA Northport senior management at the direction of Mr. Moschitta (director) continues to harass, abuse, bully and intimidate me. I have been reassigned upon my return to work which is considered an Adverse Action; especially in the absence of any wrong doing having been cleared by the AIB resulting in no findings. In a meeting today 11/13/13 with the associate director Ms. Maria Favale and the chief of Human Resources Mr. William Sainbert, they refuse to provide me and my union the basis for the reassignment which is an Adverse Action against me and they refuse to provide me and my union with a copy of the AIB report justifying this Adverse Action. I was also told that my new office will be “in a location where I can be watched closely” by Ms. Favale who falsely accused me of not reporting to work, falsely accused me of doing union work and not knowing my whereabouts despite the fact that my reintegration after 6 months of a paid non duty status will require extensive computerized training to catch up on mandatory annual training requirements AND to be “certified” in my illegally newly reassigned position. A Return to Work letter that I received clearly states that I will report to Dr. Ed Mack (Chief of Staff), however, Ms. Favale and Mr. Sainbert insist that I report to Ms. Nancy Mirone as my supervisor in the business office. Ms. Mirone CANNOT be my supervisor since she is not a health care provider and is not a clinician. Since I am a Title 38 Nurse Practitioner Health Care Provider, I can only be supervised by another clinician (Ms. Mirone lacks the clinical competencies and credentials required to properly evaluate me). I was informed that the AIB report is now being “externally reviewed” by another VA facility, however, this is tantamount to “double jeopardy” since there were no findings at the local level – simply put they’re taking another bite at the same apple. I also expressed serious misgivings regarding my new work environment since many employees in this

department were involved in the illegal accessing of my VA medical records including but not limited to Marie Irwin and Kristen Sievers representing a severe conflict of interest in an ongoing OSC investigation. This is just another management tactic of humiliating, intimidating and bullying me since they have extensive knowledge of my service connected disabilities due to the widespread massive systematic privacy breaches of my Protected Health Information. This exposes me to increased discrimination, harassment, ridicule, scrutiny and bias just as this illegal action taken against me has been. I will not have my office in Building 10 or any other location within proximity of Mr. Moschitta and his henchmen since it increases my vulnerability to management's hostilities towards me a 100% disabled veteran. Quite frankly I am very frightened of Mr. Moschitta and his stooges since I am the victim of his veteran/ patient abuse which still has not been investigated by the agency. Mr. Moschitta also dismissed my numerous Work Place Violence complaints – I feel unsafe anywhere outside of the NFFE union office. It will take me quite a while to reintegrate involving extensive computer based training which can be done anywhere on campus, so this locality restriction is just another form of spying and increased surveillance which is a Prohibited Personnel Practice and an extension of Mr. Moschitta's illegal police escort restriction against me as a veteran. Mr. Moschitta will continue to direct others to scrutinize and falsely report my every gesture, inconvenient disabling features, cultural expressive mannerisms, facial features, voice intonations, speech pattern, etc. just as he has already adversely used these against me as a 100% disabled veteran. I also requested a special accommodation based on my disabilities including but not limited to pacing myself with computer based training since this platform along with glaring fluorescent lighting exacerbates my headaches causing excessive eye fatigue (as part of my service connected disabilities). My service connected PTSD is exacerbated by exposure to stress and noxious frightening triggers such as my aforementioned feelings of compromised safety and well-being by the director's personal animus against me. My orthopaedic/ neurological service connected disabilities require stretching, walking and changing positions to alleviate the pain, however, I am afraid that the director will continue to use this adversely against me as a 100% disabled veteran denying my access to care as he did for 6 months. I require a zone of privacy which was previously violated by management in light of the required involvement to participate freely in protected activities such as interacting with investigators for active and pending investigations against the agency, with attorneys, elected officials, union reps, etc. Your prompt assistance in this matter is greatly appreciated and quite frankly demanded as a 100% service connected veteran.

TITLE 38—Pensions, Bonuses, and Veterans' Relief

CHAPTER I—DEPARTMENT OF VETERANS AFFAIRS

PART 17—MEDICAL

PROTECTION OF PATIENT RIGHTS

§17.33 Patients' rights.

Title 38: Pensions, Bonuses, and Veterans' Relief

PART 17—MEDICAL

§17.33 Patients' rights.

(a) *General.* (1) Patients have a right to be treated with dignity in a humane environment that affords them both reasonable protection from harm and appropriate privacy with regard to their personal needs.

(2) Patients have a right to receive, to the extent of eligibility therefor under the law, prompt and appropriate treatment for any physical or emotional disability.

(3) Patients have the right to the least restrictive conditions necessary to achieve treatment purposes.

(4) No patient in the Department of Veterans Affairs medical care system, except as otherwise provided by the applicable State law, shall be denied legal rights solely by virtue of being voluntarily admitted or involuntarily committed. Such legal rights include, but are not limited to, the following:

(c) *Restrictions.* (1) A right set forth in paragraph (b) of this section may be restricted within the patient's treatment plan by written order signed by the appropriate health care professional if—

(i) It is determined pursuant to paragraph (c)(2) of this section that a valid and sufficient reason exists for a restriction, and

(ii) The order imposing the restriction and a progress note detailing the indications therefor are both entered into the patient's permanent medical record.

(2) For the purpose of paragraph (c) of this section, a valid and sufficient reason exists when, after consideration of pertinent facts, including the patient's history, current condition and prognosis, a health care professional reasonably believes that the full exercise of the specific right would—

(i) Adversely affect the patient's physical or mental health,

(ii) Under prevailing community standards, likely stigmatize the patient's reputation to a degree that would adversely affect the patient's return to independent living,

(iii) Significantly infringe upon the rights of or jeopardize the health

or safety of others, or

(iv) Have a significant adverse impact on the operation of the medical facility, to such an extent that the patient's exercise of the specific right should be restricted. In determining whether a patient's specific right should be restricted, the health care professional concerned must determine that the likelihood and seriousness of the consequences that are expected to result from the full exercise of the right are so compelling as to warrant the restriction. The Chief of Service or Chief of Staff, as designated by local policy, should concur with the decision to impose such restriction. In this connection, it should be noted that there is no intention to imply that each of the reasons specified in paragraphs (c)(2)(i) through (iv) of this section are logically relevant to each of the rights set forth in paragraph (b)(1) of this section.

(3) If it has been determined under paragraph (c)(2) of this section that a valid and sufficient reason exists for restricting any of the patient's rights set forth in paragraph (b) of this section, the least restrictive method for protecting the interest or interests specified in paragraphs (c)(2)(i) through (iv) of this section that are involved shall be employed.

(4) The patient must be promptly notified of any restriction imposed under paragraph (c) of this section and the reasons therefor.

(5) All restricting orders under paragraph (c) of this section must be reviewed at least once every 30 days by the practitioner and must be concurred in by the Chief of Service or Chief of Staff.

(f) *Confidentiality.* Information gained by staff from the patient or the patient's medical record will be kept confidential and will not be disclosed except in accordance with applicable law.

(g) *Patient grievances.* Each patient has the right to present grievances with respect to perceived infringement of the rights described in this section or concerning any other matter on behalf of himself, herself or others, to staff members at the facility in which the patient is receiving care, other Department of Veterans Affairs officials, government officials, members of Congress or any other person without fear or reprisal.

(h) *Notice of patient's rights.* Upon the admission of any patient, the patient or his/her representative shall be informed of the rights described in this section, shall be given a copy of a statement of those rights and shall be informed of the fact that the statement of rights is posted at each nursing station. All staff members assigned to work with patients will be given a copy of the statement of rights and these rights will be discussed with them

by their immediate supervisor.

(i) *Other rights.* The rights described in this section are in addition to and not in derogation of any statutory, constitutional or other legal rights.

(Authority: 38 U.S.C. 501, 1721)

ENROLLMENT PROVISIONS AND MEDICAL BENEFITS PACKAGE

§17.36 Enrollment—provision of hospital and outpatient care to veterans.

§17.37 Enrollment not required—provision of hospital and outpatient care to veterans.

§17.38 Medical benefits package.

USE OF PUBLIC OR PRIVATE HOSPITALS

§17.52 Hospital care and medical services in non-VA facilities.

§17.53 Limitations on use of public or private hospitals.

§17.54 Necessity for prior authorization.

§17.55 Payment for authorized public or private hospital

care.

§17.56 VA payment for inpatient and outpatient health care professional services at non-departmental facilities and other medical charges associated with non-VA outpatient care.

OUTPATIENT TREATMENT

§17.92 Outpatient care for research purposes.

§17.93 Eligibility for outpatient services.

§17.94 Outpatient medical services for military retirees and other beneficiaries.

§17.95 Outpatient medical services for Department of Veterans Affairs employees and others in emergencies.

§17.96 Medication prescribed by non-VA physicians.

§17.97 Prescriptions in Alaska, and territories and possessions.

38 CFR 17.106 - VA RESPONSE TO DISRUPTIVE BEHAVIOR OF PATIENTS.

§ 17.106

VA response to disruptive behavior of patients.

(a) **Definition.** For the purposes of this section:

VA medical facility means VA medical centers, outpatient clinics, and domiciliaries.

(b) **Response to disruptive patients.** The time, place, and/or manner of the provision of a patient's medical care may be restricted by written order of the Chief of Staff of the VA Medical Center of jurisdiction or his or her designee if:

(1) The Chief of Staff or designee determines pursuant to paragraph (c) of this section that the patient's behavior at a VA medical facility has jeopardized or could jeopardize the health or safety of other patients, VA staff, or guests at the facility, or otherwise interfere with the delivery of safe medical care to another patient at the facility;

(2) The order is narrowly tailored to address the patient's disruptive behavior and avoid undue interference with the patient's care;

(3) The order is signed by the Chief of Staff or designee, and a copy is entered into the patient's permanent medical record;

(4) The patient receives a copy of the order and written notice of the procedure for appealing the order to the Network Director of jurisdiction as soon as possible after issuance; and

(5) The order contains an effective date and any appropriate limits on the duration of or conditions for continuing the restrictions. The Chief of Staff or designee may order restrictions for a definite period or until the conditions for removing conditions specified in the order are satisfied. Unless otherwise stated, the restrictions imposed by an order will take effect upon issuance by the Chief of Staff or designee. Any order issued by

the Chief of Staff or designee shall include a summary of the pertinent facts and the bases for the Chief of Staff's or designee's determination regarding the need for restrictions.

(c) Evaluation of disruptive behavior. In making determinations under paragraph (b) of this section, the Chief of Staff or designee must consider all pertinent facts, including any prior counseling of the patient regarding his or her disruptive behavior or any pattern of such behavior, and whether the disruptive behavior is a result of the patient's individual fears, preferences, or perceived needs. A patient's disruptive behavior must be assessed in connection with VA's duty to provide good quality care, including care designed to reduce or otherwise clinically address the patient's behavior.

(d) Restrictions. The restrictions on care imposed under this section may include but are not limited to:

(1) Specifying the hours in which nonemergent outpatient care will be provided;

(2) Arranging for medical and any other services to be provided in a particular patient care area (*e.g.*, private exam room near an exit);

(3) Arranging for medical and any other services to be provided at a specific site of care;

(4) Specifying the health care provider, and related personnel, who will be involved with the patient's care;

(5) Requiring police escort; or

(6) Authorizing VA providers to terminate an encounter immediately if certain behaviors occur.

(e) Review of restrictions. The patient may request the Network Director's review of any order issued under this section within 30 days of the effective date of the order by submitting a written request to the Chief of Staff. The Chief of Staff shall forward the order and the patient's request to the Network Director for a final decision. The Network Director shall issue a final decision on this matter within 30 days. VA will enforce the order while it is under review by the Network Director. The Chief of Staff will provide the patient who made the request written notice of the Network Director's final decision.

Note to § 17.106: Although VA may restrict the time, place, and/or manner of care under this section, VA will continue to offer the full range of needed medical care to which a patient is eligible under title 38 of the United States Code or Code of Federal Regulations. Patients have the right to accept or refuse treatments or procedures, and such refusal by a patient is not a basis for restricting the provision of care under this section.

(Authority: 38 U.S.C. 501, 901, 1721)

[75 FR 69883, Nov. 16, 2010]

§ 17.106, Nt.

Effective Date Note: At 76 FR 37204, June 24, 2011, § 17.106 was redesignated as § 17.107 and a new § 17.106 was added before the undesignated center heading "Disciplinary Control of Beneficiaries Receiving Hospital, Domiciliary or Nursing Home Care" effective July 25, 2011. For the convenience of the user, the added text is set forth as follows:

Code of Federal Regulations - Page 711

Copayments

Code of Federal Regulations - Page 720

Ceremonies Reimbursement for Loss By Natural Disaster of Personal Effects of Hospitalized or Nursing Home Patients Reimbursement to Employees for the Cost of Repairing or Replacing Certain Personal Property Damaged or Destroyed by Patients or Members Payment and Reimbursement of the Expenses of Medical Services Not Previously Authorized Reconsideration of Denied Claims Delegations of Authority Prosthetic, Sensory, and Rehabilitative Aids Automotive Equipment and Driver Training Dental Services Autopsies Veterans Canteen Service Aid to States for Care of Veterans in State Homes

Note: Sections 17.190 through 17.200 do not apply to nursing home care in State homes. The provisions for nursing home care in State homes are set forth in 38 CFR part 51.

§ 17.106

VA collection rules; third-party payers.

(a) (1) General rule. VA has the right to recover or collect reasonable charges from a third-party payer for medical care and services provided for a nonservice-connected disability in or through any VA facility to a veteran who is also a beneficiary under the third-party payer's plan. VA's right to recover or collect is limited to the extent that the beneficiary or a nongovernment provider of care or services would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(2) Definitions. For the purposes of this section:

Automobile liability insurance means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(A) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(B) Uninsured and underinsured coverage, in which there is a third-party tortfeasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

Health-plan contract means any plan, policy, program, contract, or liability arrangement that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for medical care or services, items, products, and supplies. It includes but is not limited to:

(A) Any plan offered by an insurer, reinsurer, employer, corporation, organization, trust, organized health care group or other entity.

(B) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(C) Any Employee Retirement Income and Security Act (ERISA) plan.

(D) Any Multiple Employer Trust (MET).

(E) Any Multiple Employer Welfare Arrangement (MEWA).

(F) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

- (G) Any individual practice association (IPA) plan.
- (H) Any exclusive provider organization (EPO) plan.
- (I) Any physician hospital organization (PHO) plan.
- (J) Any integrated delivery system (IDS) plan.
- (K) Any management service organization (MSO) plan.
- (L) Any group or individual medical services account.
- (M) Any participating provider organization (PPO) plan or any PPO provision or option of any third-party payer plan.
- (N) Any Medicare supplemental insurance plan.
- (O) Any automobile liability insurance plan.
- (P) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.

Medicare supplemental insurance plan means an insurance, medical service or health-plan contract primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395, *et seq.*) and 42 CFR part 403, subpart B.

No-fault insurance means an insurance contract providing compensation for medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

Participating provider organization means any arrangement in a third-party payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization

that is recognized as a health maintenance organization.

Third-party payer means an entity, other than the person who received the medical care or services at issue (first party) and VA who provided the care or services (second party), responsible for the payment of medical expenses on behalf of a person through insurance, agreement or contract. This term includes, but is not limited to the following:

- (A) State and local governments that provide such plans other than Medicaid.
- (B) Insurance underwriters or carriers.
- (C) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.
- (D) Automobile liability insurance underwriter or carrier.
- (E) No fault insurance underwriter or carrier.
- (F) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.
- (G) Any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for healthcare services or products.
- (H) A third-party administrator.

(b) Calculating reasonable charges.(1) The “reasonable charges” subject to recovery or collection by VA under this section are calculated using the applicable method for such charges established by VA in 38 CFR 17.101.

(2) If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, VA will recover or collect reasonable charges less that deductible or copayment amount.

(c) VA's right to recover or collect is exclusive. The only way for a third-party payer to satisfy its obligation under this section is to pay the VA facility or other authorized representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy the third-party's obligation under this section.

(1) Pursuant to 38 U.S.C. 1729(b)(2), the United States may file a claim or

institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under 38 U.S.C. 1729 and this section. Such filing or proceedings must be instituted within six years after the last day of the provision of the medical care or services for which recovery or collection is sought.

(2) An authorized representative of the United States may compromise, settle or waive a claim of the United States under this section.

(3) The remedies authorized for collection of indebtedness due the United States under 31 U.S.C. 3701, *et seq.*, 4 CFR parts 101 through 104, 28 CFR part 11, 31 CFR part 900, and 38 CFR part 1, are available to effect collections under this section.

(4) A third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due a refund from a VA facility. A written request for a refund must be submitted and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part.

(d) Assignment of benefits or other submission by beneficiary not necessary. The obligation of the third-party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third-party payer, including any claim or appeal. In any case in which VA makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third-party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed VA Form 10-10EZ or VA Form 10-10EZR that includes a veteran's insurance declaration will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) Preemption of conflicting State laws and contracts. Any provision of a law or regulation of a State or political subdivision thereof and any provision of any contract or agreement that purports to establish any requirement on a third-party payer that would have the effect of excluding from coverage or limiting payment for any medical care or services for which payment by the third-party payer under 38 U.S.C. 1729 or this part is required, is preempted by 38 U.S.C. 1729(f) and shall have no force or effect in connection with the third-party payer's obligations under 38 U.S.C. 1729 or this part.

(f) Impermissible exclusions by third-party payers. **(1) Statutory requirement.** Under 38 U.S.C. 1729(f), no provision of any third-party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in or through any VA facility shall operate to prevent collection by the United States.

(2) General rules. The following are general rules for the administration of 38 U.S.C. 1729 and this part, with examples provided for clarification. The examples provided are not exclusive. A third-party payer may not reduce, offset, or request a refund for payments made to VA under the following conditions:

(i) Express exclusions or limitations in third-party payer plans that are inconsistent with 38 U.S.C. 1729 are inoperative. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(ii) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third-party payers. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(iii) Third-party payers may not treat claims arising from services provided in or through VA facilities less favorably than they treat claims arising from services provided in other hospitals. For example, no provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are eligible to receive VA medical care and services shall be permissible.

(iv) The lack of a participation agreement or the absence of privity of contract between a third-party payer and VA is not a permissible ground for refusing or reducing third-party payment.

(v) A provision in a third-party payer plan, other than a Medicare supplemental plan, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to VA by the third-party payer unless the provision expressly disallows payment as the primary

payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare Advantage plan).

(vi) A third-party payer may not refuse or reduce third-party payment to VA because VA's claim form did not report hospital acquired conditions (HAC) or present on admission conditions (POA). VA is exempt from the Medicare Inpatient prospective payment system and the Medicare rules for reporting POA or HAC information to third-party payers.

(vii) Health Maintenance Organizations (HMOs) may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 38 U.S.C. 1729 or this part.

(g) **Records.** Pursuant to 38 U.S.C. 1729(h), VA shall make available for inspection and review to representatives of third-party payers, from which the United States seeks payment, recovery, or collection under 38 U.S.C. 1729, appropriate health care records (or copies of such records) of patients. However, the appropriate records will be made available only for the purposes of verifying the care and services which are the subject of the claim(s) for payment under 38 U.S.C. 1729, and for verifying that the care and services met the permissible criteria of the terms and conditions of the third-party payer's plan. Patient care records will not be made available under any other circumstances to any other entity. VA will not make available to a third-party payer any other patient or VA records.

(Authority: 31 U.S.C. 3711, 38 U.S.C. 501, 1729, 42 U.S.C. 2651)

[http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=1854ae35b609bbdf3106c25185a900a3&c=ecfr&tpl=/ecfrbrowse/Title38/38tab_02.t](http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=1854ae35b609bbdf3106c25185a900a3&c=ecfr&tpl=/ecfrbrowse/Title38/38tab_02.tpl)
pl

Enclosed please find the VA PIV ID card fact sheet. There are also more sinister implications and ramifications for veteran employees. Standing VHA regulations, center memorandums, policy, procedure and practice are ineffective at maintaining/ ensuring/ securing veteran and veteran employee privacy as evidenced by the ongoing massive system-wide privacy breaches committed by VA senior management systematically targeting disabled veteran employees adversely using the ill-gotten Protected Health Information against me. The VHA electronic records system is sloppy despite the fact that all VA employees are required to complete annual mandatory privacy training and HIPAA focused training.

This is an excerpt from the VA annual mandatory privacy training and HIPAA focused training

The following 7 Privacy Statutes have been repeatedly violated by VA senior management, VA law enforcement, employees, etc. at the VA Northport NY against me:

*The Privacy Act of 1974 codified in 5 U.S.C. 552a

*The HIPAA of 1996

*The HITECH Act

*38 U.S.C. 5701 Confidentiality Nature of Claims

*38 U.S.C. 5705 Confidentiality of Health Care Quality Assurance Review Records (Barbara Inskip RN Performance Improvement [task organized directly under Mr. Moschitta director] illegally accessed my VA medical records on 6/26/13 – the day prior to the AIB interrogation).

*FOIA 5 U.S.C. 552 – Mr. Steven Wintch (privacy officer) refused for years to comply with FOIA as evidenced by the forwarded e-mail string showing his ignoring, refusal and dawdling over the access logs (Sensitive Patient Access Report) requests. I eventually enlisted the help of the Office of Government Information Services (OGIS).

Minimum Necessary Standard: since 4/14/2003, with the implementation of the HIPAA Privacy Rule, VA supervisors can no longer access their employee veteran's health records under a "need to know." Employee access to PHI is limited to treatment, payment or health care operations. There is no authority under HIPAA Privacy Rule to access an employee's health record without their authorization for employment purposes. There is NO authority for an employee to access another employee's or a veterans health record unless it's for the treatment, payment or health care operations – VA Northport has continually violated this in my case.

Definitions: "Treatment" means provision, coordination or management of health care and related services among health care providers (HCPs) or by an HCP with a third party, consultation between HCPs regarding a patient or the referral of a patient from one HCP to another. "Payment" means various activities of HCPs to obtain payment or reimbursement for services and a health plan to obtain premiums, fulfill coverage responsibilities and provide benefits under the plan and to obtain or provide reimbursement for provision of health care. "Health Care Operations" are certain administrative, financial, legal and quality improvement activities of a covered entity that are necessary to run its business and to support core functions of treatment and payment. None of these definitions applied to the illegal accessing of my medical records.

Functional Categories and Minimum Necessary Standard: VA Form 10-0539

“Assignment of functional categories” is found in VHA handbook 1605.02 Appendix E and can be used to assign functional categories. Employees must sign and date the form annually. The form is not required to be used but if it is not used a documented process must be in place to ensure compliance – VA Northport is not in compliance. Accessing my medical records by senior management, law enforcement, administrators, supervisors, etc. wasn’t related to the performance of their job – management, cops and staff had no “need to know.” Uses and Disclosures of Information: VHA employees may only use PHI on a need to know basis for their official job duties for the purposes of treatment, payment and/or health care operations.

Veteran Rights: when the Privacy Act and the HIPAA Privacy Rule are in conflict, the regulation that grants the veteran the most rights is used. I never received an accounting of the disclosures by Mr. Wintch’s repeated refusals and ignoring over several years – he clearly denied my right to file a complaint by failing to conduct an investigation into the privacy breaches that he was aware of. The multiple widespread deliberate targeting of my PHI by so many in VA senior management, administration, law enforcement, etc. was way beyond an “Incidental Disclosure.”

The current VA “System of Records” (SOR) is sloppy, vulnerable and shoddy; especially regarding routine uses. The VA should be required to publish this in the Federal register to provide an opportunity for interested persons to comment. The most common SOR is the “Patient Medical Records-VA” 24VA10P2. The “Patient Advocate Tracking System” (PATS) SOR – 100VA10NS10 is separate from the “Patient Medical Records-VA”, therefore the patient advocates (Mr. Marengo and Ms. Maida) should’ve never accessed my medical records since their specific SOR is different. Mr. Tom Sledge and Ms. Kristen Sievers entries should’ve been limited only to the “Enrollment and Eligibility Records-VA” 147VA16 and NOT my medical records to check eligibility and enrollment when they were ordered by Mr. Moschitta to disenroll me. The VA police should’ve only accessed the “Police and Security Records-VA” 103VA07B and NOT my medical records when Gino Nardelli cop illegally accessed my medical records multiple times. Other common categories of SOR include the “Employee Medical File System Records (Title 38)-VA” 08VA05 is used for employees. I suppose I would have two sets of SOR since I am both a veteran and an employee. The complete Index of Department of Veteran’s Affairs Privacy Act System of Records can be accessed at <http://vaww.vhaco.va.gov/privacy/SystemofRecords.htm>

Compliance: the VA Rules of Behavior are in VA handbook 6500 “Information Security Program Appendix G.” The Omnibus final rule imposes a tiered penalty structure. Offenses committed under false pretenses or with the intent to sell, transfer or use individually identifiable health information for *malicious harm* have more stringent penalties as was so brutally done to me.

Enclosures: National Security Breach MFR and PIV ID card fact sheet

Patient Abuse:

Excerpt from VA NPT annual mandatory training on Patient Abuse. I was and have continued to be the victim of patient abuse at the hands of the director Mr. Phil Moschitta. I have proven this repeatedly in all my correspondence with attachments including but not limited to the unilateral hostile personnel action that he levied and extended against me as a 100% disabled veteran and patient interfering with my rights codified by law to access my VBA/ VHA entitlements including but not limited to health care yet your (OSC) office and others have refused to investigate this. I reported this to the patient advocate which was documented in the Patient Advocate Tracking System yet the agency refused to investigate Mr. Moschitta for his patient abuse of me. He broke federal law codified in 38 CFR 17.106 barring me from the campus. All of which you have received in email correspondence along with the NFFE union complaint of patient abuse of me by the director who also refuses to investigate my Work Place Violence complaints making me feel very unsafe and failing to safe guard my physical and emotional well-being upon returning to work in a nebulous capacity at best.

Patient Abuse

VAMC NORTHPORT

Mandatory Review FY12 Education Program

Patient Abuse (all age groups)

- Defined as acts against patients that involve physical, psychological, sexual or verbal abuse. This would include:
- Intimidation, ridicule, or failure to respect the patient's religious or cultural practices, any action that conflicts with patients' rights or omission of care
- Employee intent to abuse is not an requirement for patient abuse
- The patient's perception is the essential component of determination of abuse
- Penalty for patient abuse is removal from government service
- For further information, see CM 00-134
- If abuse is not reported and corrected, it may become even more severe.
- Do not hesitate to report your suspicions to your supervisor.
- Reporting Suspected Abuse**
- Anyone at VAMC Northport who sees or knows about actual or suspected abuse of a veteran must report it immediately to a supervisor or person in charge.

- An incident report (10-2633) must be completed for any allegation of abuse for all inpatients.
- Individuals found to be guilty of abusing patients, AND those who fail to report patient abuse, are subject to disciplinary action.

Work Place Violence annual training excerpt:

It is very clear from the below excerpt that the VA applied this in a disparate, harsh, discriminatory and retaliatory manner against me. Again, the reassignment is an Adverse Action; especially in the absence of any wrong doing. The director refuses to provide the union with a basis for the reassignment (Adverse Action) and the agency refuses to release the AIB report which according to Dr. Mack (chief of staff) resulted in no findings thus his opposition to any adverse actions including but not limited to suspensions. At what threat level did the director and the Disturbed Behavior Committee assign me in the absence of any wrong doing or an assessment to justify these sustained actions against me? Isn't the reassignment enough proof that an adverse action has been taken requiring an OSC investigation? Excerpt from WPV Awareness, Disruptive Behavior and Prevention annual mandatory training:

- 2008 Aggressive Behavior Prevention Survey Results
 - 51.3% of all VAMC Northport employees have experienced some form of verbal abuse at least once or more
 - 9.5% of all VAMC Northport employees have experience some form of physical abuse at least once or more
 - 52.7% of all Northport VAMC employees have been a victim of exclusionary behavior at least once or more
- The VAMC Northport affirms its policy that employees should work in environments that are free from attack, threats, menacing, disruptive and harassing behaviors.
- ***Click below to view VAMC Northport CM 00-104, "Prevention of Workplace Violence"***
- http://vaww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Director_Office/CM%2000%20104%20workplace%20violence.doc
- VAMC Northport requires that all violent behavior be reported for review by the Disruptive Behavior Committee, which includes the Police
- ***Click below to view VAMC Northport CM 05-03 "Employee to Employee Incidents of Workplace Violence"***

- [http://vawww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Human_Resources/CM%2005-03%20EMP-EMP%20WORKPLACE%20VIOLENCE%20\(2\).doc](http://vawww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Human_Resources/CM%2005-03%20EMP-EMP%20WORKPLACE%20VIOLENCE%20(2).doc)

Levels of Violence:

Level One (Disruptive Behavior):

An employee, visitor, or veteran:

- Refuses to cooperate
- Spreads rumors and gossip to harm others
- Consistently argues with others
- Constantly swears at others
- Makes unwanted sexual comments
- Displays disrespectful behavior
- Becomes verbally abusive

Level Two (Escalation):

An employee, visitor, or veteran:

- Refuses to obey medical center policies
- Steals or damages property for revenge
- Communicates threats
- Sees him/herself as a “victim”
- Writes sexual/violent notes to co-workers or staff

Level Three (Increased Risk for or Actual Physical Violence):

The employee, visitor, or veteran:

- Becomes suicidal or homicidal

- Threatens others
- Starts physical fights
- Destroys property
- Uses weapons
- Commits murder, assault, rape, or arson

WPV Review Team (Police Service, EAP, Chief of Psychology and HR)

Local Policies:

Northport VAMC Center Memorandums

- *Prevention of Workplace Violence, 00-104*

http://vaww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Director_Office/CM%2000%20104%20workplace%20violence.doc

- *Employee-to-Employee Incidents of Workplace Violence, 05-03*

[http://vaww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Human_Resources/CM%2005-03%20EMP-EMP%20WORKPLACE%20VIOLENCE%20\(2\).doc](http://vaww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Human_Resources/CM%2005-03%20EMP-EMP%20WORKPLACE%20VIOLENCE%20(2).doc)

- *Disciplinary and Adverse Actions, 05-04*

http://vaww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Human_Resources/CM%2005-04%20Disciplinary%20Adverse%20Actions.DOC

- *Ethical Conduct & Related Responsibilities, 05-27*

http://vaww.northport.med.va.gov/Forms_Publications/Center%20Memorandums/Documents/Human_Resources/CM%2005-27%20Ethical%20Conduct.doc

- VA Employee Handbook

<http://vaww1.va.gov/ohrm/HRLibrary/VAhandbook/02Handbook.DOC>

NFFE is not at all thrilled or happy with Mr. Joseph Fasano's reassignment - it is considered an adverse action and retaliation according to VHA handbook 5021 Disciplinary Actions for Title 38 employees and it violates the Master Agreement between NFFE and management, Article 26, Section 3, Part B, #2, "A major adverse action is a transfer taken against an employee"; especially in the absence of any wrong doing. NFFE doesn't agree with the reassignment as it is punitive. As a member of management Kristen Sievers will be in the new chain of command and she illegally accessed Mr. Fasano's medical records 4 times in 8/2013. Some of Mr. Fasano's new co workers such as Marie Irwin illegally accessed his medical records multiple times between 5/2013 - 9/2013 which is extremely awkward, uncomfortable, humiliating and intimidating for him; especially in light of the ongoing OSC investigation into the wide spread invasive privacy breaches. This will only enable continued agency discriminatory practices and subtle forms of workplace violence/hostile work environment against Mr. Fasano so much so that NFFE has been warned/advised Mr. Fasano is being set up for failure and not success in this new unsupportive work environment instead of placing him in a clinical milieu that highlights his strengths such as under Dr. Nasir in the Anesthesia Pain Clinic as per prior email correspondence - Mr. Fasano does not feel safe going anywhere alone without Mr. Thomesen since he's afraid that Mr. Moschitta's stooges will file false allegations against him now that they are well armed with the knowledge of his service connected disabilities such as PTSD. NFFE shares these serious misgivings since Mr. Moschitta refuses to have any of Mr. Fasano's Work Place Violence complaints properly investigated. NFFE and Dr. Mack are advising Mr. Fasano to remain in the union office to complete the necessary training modules for the Comp and Pension exam certification recognizing that since the agency imposed such a brutal restriction for 6 months Mr. Fasano's reintegration will take many weeks with outstanding TMS mandatories requiring completion, reviewing hundreds of email, prepping for EEOC hearings, active participation in the ongoing OSC privacy breach investigations, involvement in other protected activities, reviewing of AIB materiel, etc. - this is the work environment that Mr. Fasano is returning to. Despite a return to work letter stating that the AIB was concluded, according to Ms. Tulloch (regional counsel), the AIB remains unresolved and open ended since NFFE feels that Mr. Moschitta wants to "screw Joe Fasano any way he can" by having an "outside" (unsure if external to the agency or just another VA entity) "review" the AIB report to support Mr. Moschitta's wrongful suspension notice. This also violates VHA handbook 0700 regarding AIBs and VHA handbook 5021 regarding disciplinary/ adverse actions against Title 38 employees. NFFE is concerned that regardless of the findings there has been no progressive discipline violating VHA handbook 5021 and the Master Agreement between NFFE union and VA management Article 26 Section 1 along with the fact that Mr. Moschitta (as the deciding official) threatened Mr. Fasano into a suspension as the proposing official in the absence of any wrong doing since Dr. Mack feels there were no findings. This "external review" is an unprecedented form of disparate treatment consistent with a Prohibited Personnel Practice. The conflicting agency information is purposely deceitful. To reassign Mr. Fasano in the absence of any wrong doing is retaliation; especially with the agency's refusal to provide the AIB report. To take an adverse action against Mr. Fasano such as a reassignment requires 30 days advanced written notification with the terms, conditions and basis for the adverse action without written notification violates the agency's own regulations. Taking adverse actions against Mr. Fasano without an AIB conclusion is a retaliatory Prohibited Personnel Practice since the agency is clearly delaying this sending conflicting deceitful signals. NFFE requests the AIB report and findings that support Mr. Moschitta's proposed suspension and Mr. Fasano's reassignment which

is a change in work conditions. NFFE requests that Mr. Fasano's office will be in the NFFE union office until such time that the agency can provide a secured private office for Mr. Fasano to complete his requirements whilst maintaining his comfort and safe well being away from Mr. Moschitta. Mr. Fasano also requires a special accommodation to work at his own pace since his service connected migraine headaches preclude prolonged excessive working/ viewing a computer monitor due to the extreme eye fatigue and exacerbating nature of same. Mr. Fasano requires an office space where the lighting can either be dimmed or shut off because of same service connected disability. NFFE requests a management meeting to resolve/ discuss the many above issues regarding Mr. Fasano's reintegration. Mr. Fasano's supervisory, clinical and administrative service line is way too convoluted and complicated with too many supervisory overseers pulling Mr. Fasano in too many competing directions. NFFE requests a clarification on Mr. Fasano's supervisory, clinical, disciplinary and administrative service line and a linear service line in keeping with all other employees.

The VA police violated the minimum necessary requirement since they easily could have obtained information such as demographic data from HR and they're computer ID system which contains all demographics such as my picture, finger prints, security clearance, full name, date of birth, full SSN, gender, height, weight, hair/ eye color, address, phone #, etc. without delving into my medical records. All VA employees are mandated to use their PIV ID cards to access the computer system including the medical records by inserting the cards into the corresponding computer card slot reader on the keyboard - this means that they intentionally accessed my medical records.

My family and me have suffered greatly over the years with all these issues. I also have an obligation as the guidon bearer for all the brave, wonderful and courageous men that I had the honor and privilege of having served with since these actions against me as a 100% disabled veteran desecrates their memories. We have spent much money on health care and legal expenses over the years as a result of the stress. Perhaps Dr. Mack's ROC and email correspondence along with squeezing out his testimony during discovery depositions (according to Rich Thomesen, Mack is prepared to sing like a canary) can be leveraged against the agency in an aggressive manner. Additional claims can be filed against the AIB members as the 65 pages of testimony out of the 225 that I emailed were devoted to my disabilities and relevant privacy breaches (refer to that corresponding email). Moschitta's EEO ROI clearly states, they were "personally handpicked" by him as "superstars...superlative professionals" - if that's the best they can do they're in trouble. Claims can be filed against the Disturbed Behavior Committee members that Moschitta blames in the EEO ROI for "a clinical decision" to justify taking such wicked brutal actions against me in clear violation of 38 CFR 17.106. An additional claim can be filed against Moschitta for the reassignment and stalling the AIB process to have an "external review." All of this can be packaged in a blistering press release to publicly embarrass the agency for their actions against me. I'd also like to see a copy of the AIB report that Moschitta is basing his actions contrary to what Mack believes is bogus. The Department of Health and Human Services Office of Civil Rights contacted me and again offered a verbal confirmation that my HIPAA/ Privacy breach complaint has met the threshold for acceptance, however the Manhattan OCR regional office has been so overwhelmed with complaints against the agency that this matter has been assigned to their Washington DC office as part of a special investigatory task force - accordingly I will still have an individual right of action. I have made significant

contributions to the agency over the years despite the horrific work conditions and HWE without any sort of recognition since Moschitta chooses to falsely crucify me instead on the rumors and innuendos of mine enemies v. acknowledging my positive impact to veteran care in each of the clinical settings that I've been assigned.

I have some concerns/ misgivings regarding the VA's Office of the Medical Inspector team that has been tasked by the VA to conduct the investigation. After only 2 very brief telephone interviews my concerns are:

*How are conflicts of interest avoided/ managed since the agency is investigating themselves? The OMI team seemed less interested/ disinterested in conducting a thorough/ extensive investigation and seemed more interested in focusing on what they weren't going to do and what they weren't going to investigate.

*The OMI's stated focus stressed a very limited scope of investigation without delving into the broad extent of the privacy breach (including senior management's involvement) and without exploring the damage that this has caused me with the potential for actual ongoing future harm. And without caring about how this illegally obtained information has been negatively used against me.

*How is a fair and objective investigative process ensured?

*The OMI team kept asking me for proof beyond the Sensitive Patient Access Report that I have submitted, however, I made it clear that the VA Northport's privacy officer Mr. Steven Wintch refuses to comply with the FOIA requests that I submitted on 6/14/13 and 7/1/13. Mr. Wintch only released very limited information contained in the Sensitive Patient Access Report. It should be up to the OMI team to investigate how extensive the data/ privacy breach is, how much of my PHI was printed, copied and transmitted, what the agency did with the information, etc.

*The OMI team includes: Dr. Ed Huyke, Hala Maktabi epidemiologist, Gladys Felan RN, Brigitte Booker health system specialist and Carol Farr OMI privacy officer. Their contact info is, P: 202-443-5096, F: 202-495-6200/202-501-2196.

*Any correspondence/ information that this OMI team and others have sent to the agency has not been forwarded to me and the agency also refuses to release that information.

Enclosed please find a notarized copy of Dr. Mack's report of contact against Mr. Moschitta for being forced to sign the suspension order against me under duress. Mack wants to desperately testify that this is a Prohibited Personnel Practice against me forced upon him by Moschitta. I will type what the hand written ROC states:

"This morning, Nov-1-2013, at 10:00 AM after morning report, the director confronted me and brought up the issue of why Mr. Fasano NP's suspension was not signed. He raised his voice and shouted that he knew why I did not sign the letter (i.e. I am afraid of being sued). He stated in a loud voice that Mr. Fasano is found by the AIB to be abusive and denigrate women and that I am delaying the process. He further stated that if I don't sign the letter my situation will be escalated and he will have this signed by someone else! I tried to explain to him that I have not read the evidence file yet and I still am under of the *illegible*. He again stated that he WANT the letter signed by noon today!! I tried to state that Mrs. Carrington states that she had no letter prepared yet and this issues is he want to have this signed by NOON today. I was extremely stress by this and went to talk to Dr. Mohan (the Chief of Surgery). I also tried to call my old VISN director (Mr. Farsetta for advice). He had advise me that he was concern with this process (i.e. the deciding official had already decided the disciplinary action and demand the proposing official to sign a pre decided action with no due process). At 10:35 AM I went to the Director's office. In there was Cheryl Carrington (the HR specialist), Doug Murdock and the Director. The letter was presented to me to be signed and I signed it in their presence. I again attempt to express that there was no progressive discipline in this case irregardless of what the charges are and the director again stated that he AIB and Regional Counsel recommend this disciplinary action. I left the room after I signed the letter."

Mack's ROC appears that he was forced to sign an Adverse Action order against an employee and 100% disabled veteran without clear clarification of the specific portions of the AIB report that OO and/ or HR feel warrants any sort of adverse action and/or "proposed" adverse/ corrective action including suspensions. Upon review of the report and speaking with key management officials along with the union Dr. Mack and I are confused with and do not concur with any sort of "proposed" adverse action other than the issuance of a return to work order for. Furthermore, Dr. Mack considers the duress and implied retaliatory threats for refusing to sign the order which he was forced to sign against his will a Prohibitive Personnel Practice. As the COS, he never authorized, ordered or agreed to any sort of restrictions on Mr. Fasano from accessing his benefits/ health care as a veteran in accordance with 38 CFR 17.106. This action was taken solely by the director and the Disturbed Behavior Committee circumventing his role as the deciding official. Any further laws, statutes or regulations that were violated during this action rest with those deciding/ issuing authorities.

It is very clear that the enclosed e-mail correspondence between HR and Dr. Mack + his ROC that Dr. Mack had serious misgivings constituting a PPP in accordance with the enclosed report titled Merit System Principle Employee Perception Report. Dr. Mack as the proposing official was forced to sign the suspension under duress and threats from the director Mr. Moschitta who is the deciding official despite Dr. Mack's serious misgivings, discomfort, objections and protests since he feels that the judgement was unfair and predetermined by the director as the deciding official.

Appendix A: Merit System Principles – 5 U.S.C. § 2301(b)

Federal personnel management should be implemented consistent with the following merit system principles:

- (9) Employees should be protected against reprisal for the lawful disclosure of information which the employees reasonably believe evidences—
- (A) a violation of any law, rule, or regulation, or
 - (B) mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.

After the NFFE monthly meeting yesterday and in discussion with many of our members, our NFFE members feel that the way that Joe Fasano NP /Veteran has been treated is disgusting, disrespectful and unlawful. **He is a 100 % Service Connected Veteran** that has served our Nation honorably with courage and distinction. He left Service (Army) as an Officer and a Gentleman and has dedicated his career to serving our veterans. NFFE views this treatment as Patient Abuse. Phil; I want to remind you that I brought to your attention issues that were accruing in the Nursing Homes earlier this year. With your agreement and with Mr. Fasano's trepidation, you guaranteed in our meeting that there would be NO retaliation against Joe for bring forward the issues within the Nursing Home. I our meeting Joe gave you straight forward, concrete issues, such as the fear and intimidation of managers, the inability to bring forward issues to management, patient abuse issues and so on. You sent out both Barbara Albanese and Stephanie Nelson to do an informal survey which can back that the issues that Joe brought forward were correct. All this information has been documented and archived. After this discussion with you Phil, within a few weeks Joe is removed from the Grounds by VA Police (unprecedented) breaking many policy, Federal Code of Regulations and the Law and has been out of his job for 6 months. He has had his Medical Records invaded by staff, 3 OMI investigations, requiring him to file an Office of Special Counsel complaint which is now founded and he will be going in front of a Judge (In Open Court) where the media will be notified of what has happened to this 100% Service Connected Veteran by his attorneys. This will happen in the near future, in addition the proposed suspension what you discussed with me in your offices is a Prohibited Personnel Practice under the Office of Special Counsel. **5 U.S.C. § 2301(b). I have added Mr. Sabo on the emails and last week's email so that he is now aware of the treatment of not only an employee but of the treatment of a 100% Service Connected Veteran.**

Richard Thomesen NP
President NFFE Local 387
National V/P NFFE Counsel

E-mail correspondence between Dr. Ed Mack the COS and HR re: the Adverse Action (suspension) reveals senior management criminal activity. 00 refers to the director Mr. Moschtta. I was just informed by my union president that Dr. Mack was forced to sign off on the 3 day suspension under duress, however, Dr. Mack will be submitting a Report of Contact that he was threatened with actions tantamount to retaliation if he refused to sign off on the suspension. Dr. Mack wants to speak with investigators, however, he wants it to be official - please let's make this happen ASAP. Also, upon review of 38 CFR 17.106 and Part 1 Chapter 17, it appears that many laws were broken re: the police restrictions and other adverse actions taken against me as an employee and being extended to me as a veteran.

The VA Northport NY has consistently and criminally violated their own privacy policies, procedures, practices and regulations in addition to other federal laws, statutes and regulations

governing privacy targeting me at the behest of the director. Mr. Moschitta ruthlessly used that illegally obtained Protected Health Information against me as an employee and a veteran/ patient consistent with a PPP. The enclosed (documents titled VANoPP1 - 8) clearly shows that the director and his henchmen were involved with evidence tampering since VA central office indicates that I was enrolled in VA health care as of 7/1/2013 which pre-dates the OSC investigation file # DI 13-3661 and the director's subsequent attempts on 8/6/13 - 8/7/13 to disenroll me from the VA to cover up his illegal activities against me the day prior to the agency's OMI initial site visit (the temporal proximity beyond a mere coincidence). This also appears to be tampering with and obstructing/ interfering with an OSC investigation by directing others to disenroll me and by appointing Joanne Anderson (whom I had an active EEO against that was settled) to be in charge of the investigation at the local level despite a pending hearing before the EEOC representing a conflict of interest as I've previously communicated these misgivings to your office. Furthermore, the letter that I received from VA central office dated 3/1/2013 (document titled VA NoHC1 - 3) clearly shows that the director clearly violated the VA policy, practice, procedure and regulation regarding emergency vs. non-emergency care by placing me on such a barbaric restriction (see also enclosed document titled VAp4). Finally the VA practice of flagging all veteran employee's charts with a warning cover page titled, "Sensitive Patient" includes such information as my disabilities and my disability rating (100%) so by design even if an employee doesn't actually bypass this alert page they will still obtain detailed health information about me, however, it is impossible to capture the employees that just merely clicked on the alert page cover sheet without actually going into my chart since the tracking system is designed only to capture those individuals that bypass the alert cover page and delve into the medical records representing a fatal fundamental privacy flaw/ vulnerability jeopardizing my rights to privacy. This only serves to reinforce the handicapped/ disabled stigma. Laws, regulations, policies, procedures, practices, etc. are only as good, credible and valuable as the integrity of those enforcing them, however, in my case the criminal conduct of VA management and VA law enforcement has jeopardized this process as it was adversely used against me in a tangible employee action. Deliberately placing Mr. Steven Wintch (privacy officer) on the AIB as Mr. Moschitta testified to in the EEO ROI intentionally represented a retaliatory process since I've had issues for years with my privacy breaches that Mr. Wintch and Mr. Moschitta ignored, instead they decided to retaliate against me for whistle blowing rather than fixing a problem constituting a PPP.

A scanned excerpt from my supervisor's EEO ROI testimony. She clearly states on the record on page 9 lines 21 - 22 "I did not feel there was any problem with his performance as a Nurse Practitioner." Again this is proof positive that the director's and the Workplace Violence Committee's allegations against me are false and their actions constitute a PPP since my supervisor felt that there were no problems with me. This is contrary to the director's and the agency's actions against me.

OGIS Case No. 201300690:

I am forwarding e-mail correspondence from the Office of Government Information Services (OGIS). I actually had to enlist their assistance with denied and ignored FOIA requests by the agency privacy officer. It's discrimination that I had to go to such extremes; especially since it's my right as a veteran to have the access logs (SPAR) of my medical records.

Date: Thu, 5 Sep 2013 09:38:23 -0400
Subject: Re: OGIS Case No. 201300690
From: corinna.zarek@nara.gov
To: joesepe@msn.com

Dear Mr. Fasano,

Thank you for your patience while I worked with the VA over the last few weeks to try to determine the status of your request. I learned that the VA provided you with a response in three parts, with those parts having been sent on July 11, 2013, August 2, 2013 and September 3, 2013. The VA has now closed that request as complete.

If you have not received any of the three parts, please let me know and I can follow up with the VA and double check that. If you disagree with the VA's release determination in any way, we would encourage you to file an administrative appeal to allow the agency the opportunity to review its actions and also to preserve your administrative rights.

If you have any questions, please feel free to call me directly at 202.741.5777. Otherwise, I believe this addresses the delay issue regarding the matter that you brought to OGIS and we will close your case at this time.

Sincerely,
Corinna Zarek

On Wed, Aug 7, 2013 at 5:01 PM, Corinna Zarek <corinna.zarek@nara.gov> wrote:
Dear Mr. Fasano,

This is a follow-up to the email message sent by the Office of Government Information Services (OGIS) on July 30, 2013 confirming your request for assistance. Your request to OGIS pertains to a delay with your Freedom of Information Act (FOIA) request with the Veterans Health Administration (VHA). I am the OGIS staff member who will be working with you on this matter.

To start, I wanted to share some basic information about OGIS. Congress created OGIS to serve as the Federal FOIA Ombudsman and the office's jurisdiction is limited to assisting with the FOIA process.

OGIS:

- Advocates for neither the requester nor the agency, but for the FOIA process to work as intended
- Provides mediation services to help resolve disputes between FOIA requesters and Federal agencies
- Strives to work in conjunction with the existing request and appeal process

- May become involved at any point in the FOIA administrative process
OGIS does not:

- Compel agencies to release documents
- Enforce FOIA
- Process requests or review appeals
- Provide assistance outside the realm of FOIA
- Make determinations or dictate resolutions to disputes

Thank you for providing copies of your correspondence. I see that the VHA wrote you approximately one month ago to say that they are actively working on your request. As you may know, agencies process requests on a first-in, first-out basis and are often overloaded with many requests and few resources with which to answer them. I am glad to hear that the VHA is already working on your request and you are not in a backlog where you could experience even greater delays.

My next step will be to contact the VHA to learn more about its efforts with regard to this request. We can work with the VHA to determine its estimated response date and share that with you. Please know that we cannot order an agency to move a request ahead of other requests. I will be back in touch with you as soon as I have more information to share. In the meantime, if something should come up on your end my contact information is below.

Sincerely,

Corinna Zarek

Corinna Zarek

Attorney Advisor

Office of Government Information Services

Mailing address:

8601 Adelphi Rd. -- OGIS College Park, MD 20740

Street address:

800 N. Capitol St., N.W., Suite 795

Washington, DC 20002

Dir: 202.741.5777

Main: 202.741.5770

Fax: 202.741.5769

www.archives.gov/ogis

AIB privacy breaches/ discrimination:

Enclosed please find scanned excerpts from the AIB interrogation. Since I was interrogated mercilessly for 2 days there are many pages - please forgive me in advance that I will have to send the attachment over a series of separate e-mails to file attachment limitations. Please note that there are greater than 40 pages mocking and ridiculing me for my disabilities. Please read the hand written annotations as side bar notes that I manually entered. There are over 20 pages regarding the privacy breaches of my medical records. The fact that they placed my disabilities on trial which was way beyond the scope and purview of the AIB makes the privacy breaches and my disabilities inextricably linked to the agency's reprisals and discrimination against me. However what is lost in the transcripts is the aggressive, hostile, vicious and insensitive tone of the interrogators yelling at me with angry facial expressions. It is very clear by this AIB partial transcript that my disabilities and illegally obtained protected health information has been continually adversely used against me as an employee, a 100% disabled veteran and a patient which constitutes a PPP. My disenrollment negatively effects me since I am denied emergency care by design of the director's restrictions at his direction. As your office is aware, the facility privacy officer failed to investigate each and every case of privacy breaches and failed to notify me with each and every occurrence in violation of the VA privacy practice regulations and VHA handbooks 1605, 1605.1, 1605.2 and 1605.03.

Enclosed please find the VA's policy and procedures re: the Disturbed Behavior Committee. On document titled DBCPg29, the VA clearly violated their own policy and procedure when the director applied his draconian harsh interpretation of a discriminatory and retaliatory PPP against me. It clearly states,

1. "On November 16, 2010, CFR 38, Part 17.106 was published in the Federal Register, effective on December 16, 2010, prohibiting the practice or barring seriously threatening or violent patients from care. Key sections of this new regulation state that "the time, place, and/or manner of the provision of a patient's medical care may be restricted by written order of the Chief of Staff of the VA Medical Center of jurisdiction or his or her designee..." but that "the order [must be] narrowly tailored to address the patient's disruptive behavior and avoid undue interference with the [disruptive] patient's care."
3. The regulation also specifies that "the patient receives of copy of the order and written notice of the procedure for appealing the order to the Network Director of jurisdiction as soon as possible after the issuance".

Without a statement of charges on the absence of any wrong doing, how can the director so harshly prevent me as a veteran from receiving care; specifically disenrolling me and the PTSD exacerbation of the restrictions that he is aware of violates this codicil within the VA policy and procedure. My VA medical records have never been flagged since I was never "dangerous" so

again how can the director be allowed to get away with breaking the law? The Chief of Staff NEVER ordered this. The order was enacted by the director and it was not narrowly tailored as he extended a discriminatory and retaliatory PPP as an employee action interfering with my rights as a veteran from accessing the benefits and health care that I am entitled to by law. By repeatedly denying fee basis requests he further endangered my well being which is veteran/patient abuse. Since I was not deemed a dangerous person in the absence of a Chief of Staff order without a flag this is a violation of law which evinces the director and the agency of wrong doing. I NEVER received a copy of the order. I NEVER received assistance from the Patient Advocate, Human Resources, COS, etc. informing me of my rights and my rights to appeal this order. In so doing the director and the Disturbed Behavior Committee violated VA policy and procedure and rule of law codified within CFR 38 without first consulting with the Chief of Staff.

Included is the VA Center Memorandum on Workplace Violence. This will demonstrate the following:

- *Disparate treatment based on disability, military service, illegally obtained protected health information and how that information was adversely applied to me
- *Retaliation and discrimination based on a harsh interpretation and severe application of the CM to me vs. other employees/patients (I can provide their names and situations upon request)
- *The VA violated their own center memorandums, policy, procedure and regulations as I've stated in all prior correspondence
- *The mere fact that the director is now proposing a suspension and a reassignment in addition to barring me from campus unless I have a police escort as an employee and a veteran is a tangible employee action
- *This is also proof that the illegally obtained protected health information was adversely used against me and weaponized by senior management which is considered a PPP
- *A proper OSC investigation will expose the PPP on a massive industrial scale at the VA Northport by senior management
- *I'm very frustrated that no agency seems to claim that the illegally obtained PHI and how it was adversely used against me falls within their purview - this is a clear violation of law, rule and regulation
- *If I was deemed such a danger to self/others as the director contends barring me from campus as a veteran for greater than 5 months now then why wasn't I properly evaluated? The director rushed to conclusions based on illegally obtained PHI and my service records screen based on my disabilities as a result of my military service

Enclosed please find some documentation that may be of some benefit. They are the director's EEO ROI testimony and the patient advocate's notes known as the Patient Advocate Tracking System (which are separate from my VA medical records). Precious little documentation has

been released to me despite many FOIA requests. I am hopeful that the OSC CEU will accept my complaint for investigation which would open up a treasure trove of data and dirty little agency secrets. At my level it is nearly impossible to go up against the monolithic bureaucratic behemoth that is the VA.

As I've indicated I've been denied care and benefits by design of the director's severe restrictions:

*the police escort restriction so severely exacerbates my PTSD that I cannot return to the facility under any circumstances - this was clearly communicated to the agency to the extent that the patient advocate documented such in the Patient Advocate Tracking System. The exacerbation is very crippling and incapacitating.

*the director's response to multiple fee basis requests to have my health care benefits including but not limited to mental health counseling by private physicians paid for by the VA (which is an option for a 100% disabled veteran) was met with an emphatic "...tough shit..." as per the patient advocate. The director further stated, "...Joe Fasano can either man up and come to Northport with the police escort...or he can go to the other VISN hospitals..." according to the patient advocate. I've explained many times that I cannot endure this arduous 100 mile round trip commute in NYC metro traffic in light of the painful condition of my disabilities and the director denied transportation arrangement requests to the other facilities which I am entitled to as a 100% disabled veteran. This would still be a major inconvenience since I have the right to choose which facility I receive care/benefits. So again I was denied health care, benefits and alternative requests. I've incurred private medical and travel expenses as a result without reimbursement.

*the severe restrictions clearly state that I must coordinate 24 hours in advance with the VA police prior to setting foot on the Northport campus. This denies my health care and benefits in the event of an emergency since by definition an emergency cannot be predicted and/ or planned 24 hours in advance. So by design I cannot return to the campus in an emergency/ crisis since I would be violating the severe terms and conditions of his restrictions.

*the removal appears to be limited to Northport. I've confirmed this via a confidential high ranking source who spoke directly to Mr. Tom Sledge regarding his access to my medical record on 8/6/2013.

*according to the union president I am the only employee that this has ever occurred to. I can provide you a by name list of employees that are convicted felons who did not face this type of personnel treatment and were never disciplined by the agency.

*the agency has mostly denied most of my FOIA requests for any documentation so it may be difficult at my level to obtain certain documents, however, an OSC investigation by the Complaints Examining Unit may shed light on this debacle.

VA overrun with privacy violations:

Today's Top News

1. VA overrun with privacy violations

By Marla Durben
Hirsch

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The Veterans' Administration (VA), one of the nation's leaders in electronic health record use, also leads the nation in EHR privacy violations, according to an [article](#) in the *Pittsburgh Tribune-Review*.

A two month *Tribune-Review* investigation found that VA employees or contractors committed 14,215 privacy violations at 167 facilities from 2010 through May 31, 2013, involving at least 101,018 veterans and 551 VA staffers. The breaches ranged from snooping and posting protected health information on social media websites to identity and prescription theft. The reasons for the many violations included failure to encrypt, "shoddy" safeguards and lack of accountability.

The investigation also found that most of the privacy violations were preventable, such as giving information to the wrong patient or failing to confirm that a fax number was correct before using it.

"It's hard to argue against the notion that VA holds the dubious distinction of being the largest violator of the nation's health privacy laws," Deven McGraw, director of the Washington-based Health Privacy Project of the nonprofit Center for Democracy and Technology, told the *Tribune-Review*. "Protecting the privacy of every American is important, but you would think that we would be very careful when it came to our veterans. They sure earned it."

McGraw also serves as co-chair of the Office of the National Coordinator for Health IT's Health IT Policy Committee "tiger team."

The article also noted that while the U.S. Department of Health & Human Services can investigate the VA for HIPAA violations, it can't penalize the VA for them. However, the VA has taken little disciplinary action against the violators.

EHRs, with their large amounts of patient information, portability and relative ease of access, are **particularly vulnerable** to privacy and security breaches.

To learn more:
- here's the [article](#)

Related Articles:

Health care privacy thieves deserve no mercy

Beware cloud EHR vendors who don't follow HIPAA rules
HIPAA mega rule thrusts EHR users into uncharted territory
If we're restoring trust, we might want to clue the patient in

Read more about: [HIPAA privacy rule](#)

*The unilateral hostile personnel action with VA police escort restrictions taken against me on 5/28/13 was illegally extended to me as a 100% disabled veteran interfering with my ability to access my VA benefits/entitlements including but not limited health care, mental health counseling, etc. The director and the agency is fully aware that the restrictions so severely exacerbate my SC PTSD that I cannot return to the VA campus which interferes with my rights and abilities to access my benefits that I am entitled to by law. Desperate pleas to the patient advocate which was recorded in the Patient Advocate Tracking System (PATS) for fee basis health care was equally rebuffed with an emphatic "tough shit" by the director - I was given the option of either going to Northport with the restrictions or to any of the other facilities within VISN 3 without the restrictions (the director was fully aware that neither option was feasible - I cannot endure the greater than 100 mile round trip commute to the other facilities since my service connected disabilities prevent this arduous journey in NYC metro traffic, again preventing me from accessing my benefits). Their logic is also flawed since they labeled me a dangerous person based solely on hearsay and baseless complaints with a "clinical decision" rendered by the Workplace Violence Committee in the absence of any wrong doing and a clinical evaluation. So is my danger only limited to the 11768 zip code of the VA Northport campus?

*The restriction prevents me from accessing emergency treatment since it clearly states that I must contact the VA police 24 hours in advance and coordinate an escort with them. So if I am in any sort of emergency I cannot go to Northport since it would violate the terms of the restriction. Emergencies are right now without the luxury of 24 hour advance notification. By design the restrictions prevent me from accessing even emergency mental health counseling.

*An ongoing OSC investigation into the wide spread illegal accessing of my VA medical records is proof positive that the agency adversely used this illegally obtained Protected Health Information against me.

*Many comments made about me regarded me "dangerous" based solely on my massive physical appearance and features, cultural gestures and mannerisms, my SC PTSD resulting in me "snapping" and knowledge of my Airborne and Special Forces background.

*The disparate treatment of how I was abused compared to other employees including convicted felons.

*The director refuses to have my Workplace Violence complaints investigated.

The ROI EEO case against Joanne Anderson. It's riddled with lies and contradictions as expected. When reviewing Mr. Phil Moschitta's (facility director) lies, it's interesting to note that at first he plays the tough guy and takes full responsibility for the unilateral hostile action against me, however, he shifts his pants when confronted on disparate treatment re: comparing similarly situated instances. He then does a complete 180 and blames the workplace violence committee for being part of his decision making process to the extent that he states that the decision to take this wicked action against me was a "clinical decision" based on the "assessment" of the committee including Dr. Marino (chief psychology), Heidi Vandewinckel social worker (EAP rep) and Mr. Squicciarini (VA police chief). He repeats this shared blaming several times citing his decisions were based on a "clinical assessment", however, NO assessment for ever performed on me supporting my claims that this was a unilateral action in a complaint letter that I sent to my congressman since they endangered my well being. This statement further supports my claims that the director ordered others to illegally access my VA medical records using that info adversely against me, hence, the ongoing OSC investigation. However, when I FOIA'd all documentation regarding same, the facility privacy officer responded that no such documents existed. The director also falsely alleges that he, "...had to keep moving me around because of all the problems I was causing..." Yet I was transferred to the Health Screening clinic after sustaining wicked brutal abuse in Primary Care despite an exemplary performance as the Pain Specialist. In fact every single effort by Dr. Tank to terminate me as a probationary employee failed (7 fact finding investigations, 5 professional standards boards) - every single board disagreed with his false accusations against me. I excelled under the supervision of normal people like Marge Mitchell and Joe Ciulla having received 3 consecutive outstanding performance evals with 3 consecutive supplementary outstanding evals. Problems were again encountered when he moved his pet Joanne Anderson to oversee Community Relations to cover for her fraudulent Rural Health program. I was selected among others that interviewed for the Long Term Care NP position - he never moved me to that position. His timeline and authenticity is completely fraudulent. At one point he becomes so flustered during his testimony that he refers to Joanne Anderson as Timothy Anderson. This AIB that the director initially takes credit for before soiling himself on the record resulted in no findings to support the claims or actions against me. Falsification of evidence, namely testimony during an investigation by a federal employee is a removable offense on the first instance under 18 USC 1519, P1 113-36. Send a letter to Shinseki petitioning the investigation of management officials who provided the false evidence. Particularly against a veteran. This is clearly disparate treatment. I filed workplace violence complaints against individuals that committed significant threats/ actions against me leading up to the AIB against me. How come no action was taken against them? Why did the director decide to dismiss my safety and well being in favor of his maniacal unilateral attempts to terminate me? The director clearly stated in the EEO ROI that the action taken against me was a "clinical decision on behalf of Dr. Marino." They can't just pick and choose which complaints to investigate. The director clearly stated in response to all of my congressionals and the EEO ROI that the, "AIB process was to protect all parties." How does dismissing my complaints en masse

protect me and my rights? I am furious! I want this added as an addendum for disparate treatment.

From: Joseph Fasano [mailto:joesepe@msn.com]

Sent: Monday, September 16, 2013 8:36 PM

Subject: FW: FOIA response

proof that steve wintch (privacy officer and aib member) was being a jerk to me.

joe

From: Steven.Wintch@va.gov

To: joesepe@msn.com

Date: Mon, 16 Sep 2013 13:57:50 -0400

Subject: FOIA response

Mr. Fasano,

I understand that you raised some concerns about my e-mail transmission on Wednesday, September 11th. I apologize if my reply seemed discourteous to you. As you can note in all my other correspondence to you on this subject I have tried to be courteous and timely in responding to your questions.

While I have previously responded as fully as I am able, I appreciate that this response could be perceived as terse. That was not my intention. As of September 11th, I have responded to all of your requests. I now am working on the five requests you sent since the 11th. They will be responded to in a timely and appropriate manner.

Sincerely,

Steven Wintch, MHA

Privacy & FOIA Officer

Northport VAMC

ph: (631) 261-4400 x4544

fax: (631) 486-6162

I have additional disturbing updates re: the continued illegal accessing of my medical records. According to the Sensitive Patient Access Report that I received today under a FOIA request, despite an ongoing OSC directed investigation, my medical records continue to be illegally accessed by VA Northport employees including but not limited to Gino Nardelli a VA cop who illegally accessed my medical records on 5/24/13, again illegally accessed my medical records on 8/8/13 violating my 4th, 5th, 6th and 14th Amendment rights. Please add this as an

additional/ supplemental investigative requirement for the agency since my rights continue to be violated. This has to stop; especially since a VA cop keeps going into my medical records (being a veteran employee places me at a distinct disadvantage v. my civilian counterparts since the agency has ease of access to my medical records being the maintainer of my medical records as my employer). The question is, if I was a civilian employee, would all of these people have easily accessed my private medical records? What reason and what information was obtained in my medical records that if I was a civilian the agency would've obtained from other legal/ legit sources?

This is the hyperlink to the article involving identity theft at the VA.

http://www.justice.gov/usao/flm/press/2013/july/20130703_Lewis.html

The Fee Basis requests were illegally denied at the level of the director (Mr. Phil Moschitta) instead of being processed by the Chief of Staff (COS) Dr. Ed Mack in coordination with the Business Office (this was NEVER done in my case). Also dove tails into the illegal privacy breaches since NONE of the Business Office staff had any authority or right to access my medical records since the below processes were violated compromising my PII, SPI, PHI and identity. I am eligible and qualify for all benefits as previously communicated to your office based on: my 100% service connected disability rating, all of my service connected disabling conditions, special authority since I am also service connected for Military Sexual Trauma (MST), I have more than 6 SC adjudicated SC conditions, my VIC, enrollment, etc.

National Center for Ethics in Health Care Veterans Health Administration (10E)
810 Vermont Avenue, NW Washington, DC 20420

Tel: 202-501-0364

Fax: 202-501-2238

Email: IntegratedEthics@va.gov